

NORTH AUSTIN GASTROENTEROLOGY
VIJAY POREDDY, M.D. PA

PATIENT INFORMATION – PLEASE PRINT

LAST NAME: _____ FIRST NAME: _____ MI: _____ DATE OF BIRTH: _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE: _____ CELL PHONE/PAGER: _____ WORK: _____

EMAIL ADDRESS: _____

SEX: M F MARITAL STATUS: MINOR SINGLE MARRIED LONG-TERM PARTNER DIVORCED WIDOWED SEPARATED

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____ ST: _____

EMPLOYER: _____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY: _____ PHONE #: _____

PRIMARY CARE PHYSICIAN: _____
NAME ADDRESS/PHONE #

CONSENT FOR CARE

I authorize North Austin Gastroenterology and any employee working under the direction of a physician to provide medical care for me, or to this patient for whom I am the legal guardian. This consent includes contact and discussion with other health care professionals for care and treatment.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination, and test results. I have been given the opportunity to receive a copy of North Austin Gastroenterology's Privacy Notice. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing.

RECEIPT OF NOTICE OF FINANCIAL POLICY

I have been given the opportunity to receive a copy of North Austin Gastroenterology's Financial Policy. I understand that the terms of the Financial Policy may change and I may obtain a these revised notices by contacting the practice by phone or in writing.

ASSIGNMENT OF BENEFITS

I hereby assign to North Austin Gastroenterology any insurance or other insurance company benefits be made on my behalf for any services furnished me by the practice for health care services provided. I understand that the practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice, I agree to forward to the practice all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by my current insurance company may not be able to be confirmed at this time. I wish to receive medical service from North Austin Gastroenterology, and if it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services rendered.

RELEASE OF INFORMATION

I authorize North Austin Gastroenterology to release all medical information requested by health insurance carrier, Medicare, or any other third-party payers. I authorize the practice to release all medical information to my referring physician and or primary care physician. I authorize the practice to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to the practice.

PATIENT SIGNATURE DATE