Gastroenterology Specialists

Diplomate, American Board Internal Medicine and Gastroenterology

Steven A. Meckstroth, M.D.
Manuel F. Bustamante, M.D.
William Gonzalez, PA-C
Karina Hooper, PA-C

Name: _____
Last First Middle Initial

Current Address: _____

_____

Northern Address: _____

Social Security#: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D, Sex: ☐ M ☐ F

Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Northern Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

In case of emergency please list a name, relationship and phone number **OTHER** than the above numbers

_____

Referring Doctor: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

E-mail: _____

Primary Insurance Company Name: _____

Subscriber: _____ Subscriber Date of Birth: _____

Secondary Insurance Company Name: _____

Subscriber: _____ Subscriber's Date of Birth: _____

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INSURANCE:

In an area of different insurances policies, our office staff cannot possibly know the terms of your individual policy. Please review your plan booklet or check with your insurance representative if you are unsure weather services at Gastroenterology Specialists of Southwest Florida, P.A. are covered under your policy. It is your responsibility to know if the procedure you are having needs to be pre-certified. If this has not been done, make sure you contact your insurance company. _____

(Initials)

If your insurance plan is terminated after we have checked eligibility or if your employer terminates your coverage retroactively, **YOU WILL BE RESPONSIBLE FOR THE BALANCE.** _____

(Initials)

PAYMENT:

Unless other payments are approved by us in writing, your balance is due and payable when your statement is issued and past due if not received within 30(thirty) days of the issue date on the statement. Your responsibility will be the amount indicated on your stamen under “pay this amount”. We reserve the right to add any fees incurred by us for additional billing and collection services. For your convenience, we accept most VISA, MasterCard, Discover, bank debit cards and personal checks. There is a $15.00(fifteen) fee for any check returned by your bank. If necessary, we can set up a regular payment schedule for you. This form acknowledges that you have given us permission to report your account status to any credit agency such as a credit bureau if the agreed upon amount is not paid each month. You understand that if your account is submitted to an attorney or collection agency, or results in litigation, or if your past due amount is reported to a credit reporting agency, the fact that you have received treatment services at our office may become a matter of public record. Nonpayment of overdue balances may jeopardize continued care with Gastroenterology Specialists of Southwest Florida, P.A.

APPOINTMENTS:

If you are unable to keep your appointment, kindly give a 24 hour notice. Otherwise, a charge of $60.00(sixty) will apply. Your insurance will not cover this fee and you will be responsible for it._____

(Initials)

RECORDS:

All requests for medical records must be requested in writing with a medical record release form.

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You acknowledge and agree to all of the terms and conditions contained herein and this agreement will become effective on the date indicated below.

Patient's name: _____

Responsible party: _____

Signature of patient or responsible party: _____ Date: _____

1656 Medical Blvd • Suite 301 • Naples, FL 34110-1423 • Telephone: (239) 593-6201 • Fax: (239) 593-6202

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PATIENT CONSENT FORM HIPAA COMPLIANT

With my consent, Gastroenterology Specialists of Southwest Florida, P.A. ("The Practice"), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the notice of privacy practices prior to signing this consent. The practice reserves the right to revise its notice of privacy practices at any time. A revised notice of privacy practices may be obtained by forwarding a written request to the practice at the address listed on this form.

With my consent, the practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others. With my consent, the practice may mail or email to my home, or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminders, patient's statements and others.

I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

I wish to allow the following person(s) access to my medical record.

_____ _____
Name Relationship

_____ _____
Name Relationship

Signature: _____ Date: _____