PITTSBURGH GASTROENTEROLOGY ASSOCIATES
1350 Locust Street, Suite 406 • Pittsburgh, PA 15219
Phone: 412.232.8104 • Fax: 412.281.1898
www.pghgastro.com

PATIENT INFORMATION QUESTIONNAIRE & CONSENT FORM

*This sheet **must be completed** at the time of your first visit and updated on a yearly basis or as changes in your information warrant. **The patient "Consent for Release of Information for Treatment, Payment and Health Care Operations" and "Assignment of Benefits" on the reverse side of this form must all be signed prior to your visit.** If you are being seen for a procedure, outside of our office, please complete this form, bring it with you and to give to the doctor.*

NAME_____

MAIDEN NAME_____

DATE OF BIRTH_____

SEX: MALE____ FEMALE____

MARITAL STATUS:

SINGLE___ MARRIED___ DIVORCED___ WIDOWED___

ADDRESS_____

_____

_____

TELEPHONE_____

PHARMACY #_____

• ARE WE PERMITTED TO LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? YES_____ NO_____

IF YOU WOULD LIKE THE OFFICE STAFF TO SPEAK WITH A FAMILY MEMBER YOU WILL BE REQUIRED TO SIGN A DISCLOSURE OF PROTECTED HEALTH INFORMATION.

EMAIL ADDRESS _____

CAN WE LEAVE YOU A MESSAGE? YES____ NO____

WORK TELEPHONE _____

ARE WE PERMITTED TO CALL YOU AT WORK?

YES___ NO___

EMPLOYER_____

_____

EMERGENCY CONTACT

NAME_____

RELATIONSHIP TO PATIENT_____

TELEPHONE_____

DO YOU HAVE A LIVING WILL? YES____ NO____

DATE COMPLETED_____

SOCIAL SECURITY NUMBER_____

REVIEWED BY_____

PRIMARY CARE PHYSICIAN_____

PRIMARY CARE PHONE_____

HEALTH CARE COVERAGE:

• **PRIMARY INSURANCE COVERAGE/CO. NAME:**

_____

Insurance Company's Address_____

_____

_____

Policy Holder's Name_____

Relationship to Patient_____

Policy Holder's ID/Policy #_____

Policy Holder's Group #_____

Policy Holder's Date of Birth_____

Policy Holder's Address (if other than patient's):

_____

_____

_____

• **SECONDARY INSURANCE COVERAGE/CO. NAME:**

_____

Insurance Company's Address_____

_____

_____

Policy Holder's Name_____

Relationship to Patient_____

Policy Holder's ID/Policy #_____

Policy Holder's Group #_____

Policy Holder's Date of Birth_____

Policy Holder's Address (if other than patient's):

_____

_____

_____

Signature/Submitted by: _____

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SOUTH HILLS ENDOSCOPY CENTER
2589 Boyce Plaza Road
Upper St. Clair, PA 15241
Tel 412.838.0400 • Fax: 412.838.0401

www.pghgastro.com

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I,_____, hereby authorize Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center can refuse to treat me.

I have been informed that Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center has prepared a notice ("Privacy Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center, in writing, but if I revoke my consent, such revocation will not affect any actions that Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center took before receiving my revocation.

I understand that Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center does not have to agree to such restrictions, but that once such restrictions are agreed to, Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative ***Date***

(Form MUST be completed before signing.)

ASSIGNMENT OF BENEFITS

I,_____, hereby assign all medical and/or surgical benefits to which I am entitled, including major medical, Medicare, Medigap, private insurance and any other health plans to Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center in exchange for health services provided. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ _____

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

_____ _____

Printed name of patient or patient's representative **Relationship to the Patient**