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**GASTRO ONE
G.I. DIAGNOSTIC AND THERAPEUTIC CENTER, L.L.C.**

For Office Use Only - Please fax or mail medical records for:
Patient Name: _____ **SSN** _____ **to location indicated below.**

- | | | |
|---|--------------------|--|
| <input type="checkbox"/> 6005 Park Ave., #323B, Memphis, TN 38119 | Fax (901) 684-5518 | Office (901) 684-5500 |
| <input type="checkbox"/> 1324 Wolf Park Dr., Germantown, TN 38138 | Fax (901) 755-4321 | Office (901) 755-9110 |
| <input type="checkbox"/> 7668 Airways Blvd. Building B, Southaven, MS 38671 | Fax (662) 349-6634 | TN #Office (901) 766-9490
MS #Office (662) 349-6950 |
| <input type="checkbox"/> 1407 Union, #1400 Memphis, TN 38104 | Fax (901) 272-1786 | Office (901) 272-9296 |
| <input type="checkbox"/> 1310 Wolf Park Dr. Germantown, TN 38138 | Fax (901) 624-5280 | Office (901) 624-5151 |
| <input type="checkbox"/> 3350 N. Germantown Road Bartlett, TN 38133 | Fax (901) 377-5105 | Office (901) 377-2111 |
| <input type="checkbox"/> 76 Capital Way Cove, #E, Atoka, TN 38004 | Fax (901) 377-5105 | Office (901) 377-2111 |

APPOINTMENT REQUEST (Please check one)

[] SELF REQUESTED - You have asked to see a Gastro One physician or your physician has recommended one of the physicians at the Gastro One.

[] PHYSICIAN REQUESTED - Name of the physician requesting an evaluation from a Gastro One physician. _____

CONSENT FOR CARE

The physicians & staff of Gastro One &/ or the G.I. Diagnostic and Therapeutic Center, L.L.C. will be hereafter referred to as "Gastro One". I hereby give my consent for treatment.
My signature indicates I have read and understand the information on the front and back of this form.

Signature _____ Date _____

EMERGENCY CARE

DO YOU HAVE A LIVING WILL? () YES () NO

In the event of a life threatening emergency, it is the policy of Gastro One to perform Cardiopulmonary Resuscitation (CPR) as necessary to stabilize our patients for transfer to an acute care health facility.

FINANCIAL POLICY

We are committed to providing our patients with the best possible care. If you have medical insurance, we will do all that we can to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will file your insurance claim for you; however, we ask that you pay any co-payment or deductible at the time our services are rendered and the balance in full within 90 days regardless of insurance filing. We accept Cash, Check, Discover, MasterCard, or Visa. We realize temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If your account is turned over to a professional collection agency you will be dismissed from care by physicians employed by Gastro One &/or G.I. Diagnostic & Therapeutic Center, L.L.C.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to help you.

I have read and understand this explanation of the financial policy of Gastro One and hereby authorize the release of any medical information deemed necessary to process any insurance claim for services rendered. This form is authorization for all medical benefits from any insurance company on said claims to be paid directly to Gastro One &/or G.I. Diagnostic & Therapeutic Center, L.L.C.

MEDICARE EXTENDED PAYMENT REQUEST (one time authorization)

I request payment of authorized Medicare benefits to be made either to me or on my behalf to: the physicians of the Gastro One and/or G. I. Diagnostic & Therapeutic Center, L.L.C. for any services provided me. I authorize any holder of medical information about me, to release to the Center for Medicare and Medicaid Services and its agents, any information needed to determine these benefits or the benefits payable for related services.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

My signature on this form indicates I have received a copy of the "Notice of Privacy Practices" from Gastro One and I understand how my health care information will be used and /or disclosed.

COMMUNICATIONS REGARDING YOUR HEALTH CARE INFORMATION

Please indicate with whom we may discuss your healthcare. Check all that apply.

Gastro One may communicate information regarding my healthcare with anyone receiving telephone calls at my residence.

Gastro One may communicate information regarding my healthcare with the individuals listed below:

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

Gastro One may not communicate my healthcare information with anyone other than me.