The Colon, Stomach and Liver Center

Patient Registration

PATIENT INFORMATION

Name:	Social Security #:
Address:	Sex:
City:	Employer:
State: Zip:	Emergency Contact:
Home Phone #:	Emergency Home #:
Work Phone #:	Emergency Work #:
Cell Phone #:	Emergency Cell #:
Date of Birth:	Relationship to Emergency Contact:
Referring Physician:	Referring Phone #:

Insurance Information

Primary Insurance:	Secondary Insurance:
ID #:	ID #:
Group #:	Group #:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:

FollowMyHealth

FollowMyHealth is a secure web-based portal that allows patients to access their health information. By creating an account, you'll be able to view lab and pathology results; send messages to the office; fill out documents prior to your visit; request prescription refills; and access other information related to your care. Most importantly, though, Follow My Health allows you to save time. To get started, please provide your email below. You'll then be sent an invite to register and create your account. If you have any questions, please contact the office manager at 703-723-3670 at ext. 210.

Email: ______________________________ @ ______________

Patient Responsibilities and Information:

For every office visit, I will have a valid photo I.D. and provide a valid insurance card/information. If my insurance requires it, I will provide a referral from my PCP to The Colon, Stomach and Liver Center before my scheduled appointment. It is my responsibility to know if this is required or not. For my appointment, I will arrive a few minutes early. I am aware that I may visit www.loudouncslcenter.com to complete a demographics sheet and medication/pharmacy sheet for The Colon, Stomach and Liver Center prior to my scheduled appointment. If am 15 minutes late for my appointment, I understand that I may be rescheduled to a later date.

Any voicemails left after 3pm will be returned, in the order received, on the following business day. When leaving a message, please speak clearly and slowly, providing the following information: full name, date of birth, contact number and a brief description of the service needed. If you r message has not been returned on the following business day, please contact the office manager at extension 210.

Signature of Patient/Guardian: ______________________________ Date: ____________________

Acknowledgement of Notice of Privacy Practices:

I certify that I have been made aware of The Colon, Stomach and Liver Center's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the types of uses and disclosures of my protected health information that might occur during my treatment or in the performance of The Colon, Stomach and Liver Center's health care operations. The Notice also describes my rights and The Colon, Stomach and Liver Center's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration area of The Colon, Stomach and Liver Center and on the website at www.loudouncslcenter.com. I may request that a copy be mailed to me by calling 703-723-3670 ext. 205.

The Colon, Stomach and Liver Center reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy to be mailed to me, by asking for one at the time of my next appointment, or by accessing The Colon, Stomach and Liver Center's website above to view the most current version.

Signature of Patient/Guardian: ______________________________ Date: ____________________

Cancellation Policy:

If you are unable to keep your scheduled appointment with The Colon, Stomach and Liver Center, we require a 24 hour notice to avoid a no-show/cancellation fee. This allows us to see another patient in need of care. Failure to provide an appropriate cancellation notice will result in a $50.00 fee. This fee must be paid prior to scheduling another appointment. Appointments may be cancelled or rescheduled Monday through Friday, 08:30 am to 04:30 pm.

Signature of Patient/Guardian: ______________________________ Date: ____________________

Authorization for Treatment and Payment:

I hereby request treatment by The Colon, Stomach and Liver Center and consent to care and treatment as ordered by my physician(s)/healthcare provider. I authorize the release of information related to my treatment to my referring physician(s)/healthcare provider. I authorize The Colon, Stomach and Liver Center to submit this claim on my behalf for the medical services provided. I hereby authorize my health insurance company to make payment(s) directly to The Colon, Stomach and Liver Center, for any benefits I may receive. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney, or third party payer is involved with payment. I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services along with yearly deductibles. Payment for services is expected at the time services are rendered. I authorize the release of any information necessary to process my insurance claims and facilitate payment of my account by a third party.

Signature of Patient/Guardian: ______________________________ Date: ____________________

Copayments

All copayments due and not collected on the day of the office visit will incur an additional fee when collected.

Sharing Medical Information

In case I am unavailable, The Colon, Stomach and Liver Center can share my medical information with:

Name: ______________________________ Relationship: ____________________