CONSENT FOR TREATMENT
COMMUNICATIONS CONSENT
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
AND
AUTHORIZATION FOR RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

1. CONSENT TO TREATMENT

I, the undersigned, acting on my behalf or as the legally authorized representative of ____________ ____________________________ (PATIENT) hereby consent to examination, diagnostic testing and treatment by Florida Digestive Health Specialists, LLP, and its employees and agents (together, FDHS). I understand that the physical examination may include a medically appropriate examination of my pelvic area, and/or rectum and I consent to such examination. I acknowledge that no guarantees have been made to me regarding the results of any examination, care or treatment provided by FDHS.

2. RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of my medical information, including protected health information, concerning my treatment to any third-party payor, including but not limited to health plans and insurers, Medicare, Medicaid, TRICARE and CHAMPVA for payment purposes.

Further, I authorize payment of any insurance or other benefits that may be made on my behalf by any party, including any health plan or insurer, Medicare, Medicaid and any other federal or state health care programs, directly to FDHS. I understand that this assignment of benefits does not relieve me of my obligation to pay FDHS for any charges not covered by this assignment or not paid by insurance or health care benefits.

I understand and agree, whether I sign as Agent or Patient, that I am responsible for and guarantee payment of any charges incurred for the services provided to PATIENT by FDHS. I further understand and agree that I will be responsible for payment of any deductible, co-payment or co- insurance amounts, or any charge that is not covered or paid by insurance, health care benefits or third-party payors.

I authorize FDHS to release PATIENT's medical information, including HIV testing and treatment information, to other parties (which may include providers, payors, business associates or other entities) for the purpose of treatment, payment or healthcare operations.

____
Signature of Patient or Patient's Legal Representative

____
Name of Patient's Legal Representative and relation to Patient

Date:___________________________

COMMUNICATIONS CONSENT

_________(initial) I authorize Florida Digestive Health Specialists (FDHS) to leave telephone messages for PATIENT that may contain medical information at the following number(s):

____

_________(initial) I authorize FDHS to contact PATIENT at the following email address:

____

_________(initial) I authorize FDHS to share PATIENT medical information with

____(Name and Relationship)

3. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you are agreeing that you have received a copy of FDHS's Notice of Privacy Practices, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

____
Signature of Patient or Patient's Legal Representative

____
Name of Patient's Legal Representative and relation to Patient

Date:___________________________

For Office Use Only:

I personally delivered the Notice of Privacy Practices to the above-named patient (or authorized representative of the patient). A written acknowledgement of receipt by the patient or representative was not obtained for the following reason(s):

____

__________________________________ [Signature of Office Staff Member]

____________________________ [Date]

Name: _____________________________

Communication Agreement Form

Dear Valued Patient,

Thank you for choosing Florida Digestive Health Specialists as your digestive health provider.

As a participant in your own care, it is your responsibility to ensure that there is a clear and open method of communication from our office to you. It is also your responsibility to make sure that this office always has a way to contact you to communicate test results and other important matters related to your medical care.

We may recommend/perform diagnostic studies that we feel are important to your well-being. These studies are to diagnose your ailment(s), define treatment strategies and to maintain your health. As with all diagnostic studies, at times we find results that, if undiagnosed or diagnosis is delayed, can result in death or a serious disability. Some of these studies will be at the time of an active issue, and other times it will be recommended for the future.

We attempt to contact every patient with results of diagnostic studies and reminders for follow-up issues. Ultimately, if you do not hear from us within 14 days about your test results, it is your responsibility to contact us.

By initialing below and signing this letter you agree to the following:

(Please initial each line)

1. Call our office two weeks after any diagnostic study, if we have not notified your with results. ______
2. Call our office again, for any issue, if we do not return your call. ______
3. Immediately notify our office of a change of address and/or contact telephone numbers. ______
4. Keep a written record of when your diagnostic studies are scheduled and notify our office if you cannot comply. ______
5. Keep a written record of your future follow-up needs, even if it is ten years in the future. ______

By signing this letter you are agreeing that the responsibilities and obligations outlined in lines 1 through 5 are important to your future health and that you will comply with these obligations.

Thank you for trusting us with your care.

_______________________________________ ___________________________________

Patient Name Printed Witness Name Printed

__________________________ ________ _______________________ ________

Patient Signature Date Witness Signature Date

F03-2/29/16

Dear Patient,

We believe that patients and your caregivers should have easy access to your medical information, no matter where you receive care. That's why we're participating in CommonWell, a service that allows a network of healthcare providers to identify you, securely send and receive your medical information, and help ensure that you receive optimal care.

What is CommonWell?

A *free, secure service* offered by your doctor, so your health information can be available to you and your doctors regardless of where you've received care.

You simply need to enroll in the service with a driver's license and then confirm the other CommonWell network doctors you see. Don't worry if you don't have a government-issued picture ID; you can still register.

How do we use the health information we share through CommonWell?

- ***Better coordinate your care across different doctors*** — We'll provide and request to receive your information *where* and *when* it's needed for your healthcare provider to deliver the care you need as you move from doctor to doctor.
    - Only healthcare staff directly involved in your care will access your medical information shared through CommonWell.
- ***Support better care decision-making*** — With timely access to information from other healthcare providers you've seen, your doctors may be able to make better decisions about your health.
    - This information will only be used to help improve your care, and won't be shared without your permission or unless it's required by law.
- ***Deliver care more promptly and efficiently*** —With less time wasted on tracking down your test results and other health information, your healthcare providers can treat you more efficiently and spend less time on paperwork and more time on your care.
    - We do need your help in confirming the other doctors or hospitals you've visited when you enroll in CommonWell.
- ***Securely and confidentially*** — Your Protected Health Information ("PHI") will always be confidential and used to inform the CommonWell participating healthcare providers. We won't use your PHI for discriminatory purposes of any kind or to deny medical treatment.
    - You can opt-out of this service anytime by calling or visiting this doctor's office and asking them to unenroll you from CommonWell.

☐ Accept ☐ Decline

Patient Name ____ MR #_____________________

Patient Signature ____ Date_____________________

CommonWell Health Alliance

The CommonWell services are provided by the CommonWell Health Alliance trade association. We are devoted to the notion that patient data should be safely, securely, and immediately available to patients and doctors regardless of where care occurs to deliver better care. We are committed to fostering standards that make this possible, and in having health information technology companies build these capabilities into their systems—the results: higher quality, more timely, more cost-effective care that delivers better health outcomes. Some of the participating vendors are Allscripts, athenahealth, Cerner, CPSI, eClinicalWorks, Greenway, McKesson, and Sunquest. Please visit https://www.commonwellalliance.org/connect-to-the-network/commonwell-connected-products/ for a complete list of connected vendors.

FLORIDA DIGESTIVE HEALTH SPECIALISTS, LLP
FINANCIAL POLICY

MR#____________________

Our practice is dedicated to providing the best possible care for you, and we want you to understand our Financial Policy completely.

1. Payment for all co-pays, deductibles, and outstanding patient balances is due at the time of service. We accept cash, checks, and most major credit cards. There will be a minimum charge of $25.00 on all returned checks.

2. Please be advised that your insurance policy is a contract between you and your insurance company.

   We are participating providers with many insurance companies and other health plans, and we will file a claim and accept assignment of benefits on these claims. Payment will be made by the insurance company directly to Florida Digestive Health Specialists, LLP (FDHS).

   If we do not participate with your insurance company, you will be responsible for paying your charges at the time of service. We will, however, provide you with a superbill summary of your visit for you to submit to your insurance company. If your insurance company covers such charges, then the insurance company will pay you directly.

3. Not all insurance companies cover all services. If your insurance company determines a service to be “non covered,” you will be responsible for the entire charge. Your payment is due upon receipt of a statement from our office.

4. If you provide incorrect or false information that results in a denial of a claim(s), you will be responsible for any unpaid claims and/or all charges for services provided.

5. We will bill your insurance company for services that were provided to you in a hospital setting. If your insurance company does not pay, you are responsible for any balance due.

6. If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred, included but not limited to all reasonable collection fees and/or reasonable contingency fees added by a third party to the outstanding or referred balance.

7. If you cannot keep your appointment for any reason, we require 24 hours notice for office visits. If you do not give us the required notice, your account will be charged a $25.00 no-show fee. If you do not provide 24 hours notice for an ultrasound appointment cancellation, your account will be charged a no-show fee of $50.00. If you do not give 72 hours’ notice that you are canceling your procedure(s), you will be charged a $75.00 no-show fee.

8. If the patient or responsible party fails to pay for services rendered under standard practices, then such nonpayment will result in the patient/undersigned’s provider, and all providers of FDHS, terminating their provider relationship with the patient/undersigned, in accordance with applicable law. All outstanding balances for services rendered will be referred to a collection agency.

I have read and understand the FDHS Financial Policy, and I agree to be bound by its terms. I also understand and agree that FDHS may amend such terms from time to time.

____ _____________________________

Signature of Patient (or Responsible Party) Date

____

Please Print Name of Patient

____ _____________________________

Please Print Name of Responsible Party (if different from patient) Witness

F05-09/2/2020