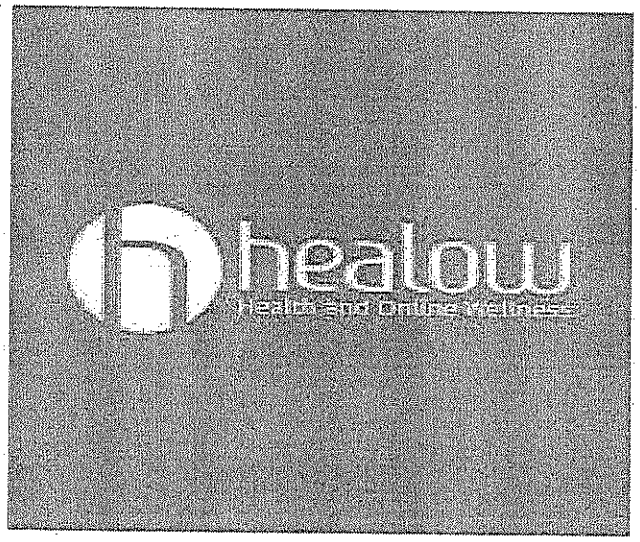
"Your Health Is In Your Hands"

With Healow Patient Portal



- Access Office Notes and Medical Records quickly and securely.
- Send Refill Requests to your Provider
- Message your Provider
- Change and Cancel appointments
- App is available for Apple and Android users.
- Free and secure, access puts your medical history, lab results, test results, and medication in the palm of your hand!

SIGN UP TODAY!!

Email: _____

PLEASE PRINT CLEARLY

Mid-State Gastroenterology (dba-Advanced Health Network)
1115 B Dow Street
Murfreesboro, Tn. 37130

Patient Name	SSN	Date of Birth	Age	Gender ☐ Female ☐ Male
Mailing/Street Address		City, State, Zip Code		
Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Greek ☐ Hispanic ☐ Indian ☐ Multi-Racial ☐ Native Hawaiian or other Pacific Islander ☐ White				Ethnicity ☐ Hispanic ☐ Non-Hispanic
Marital Status ☐ Divorced ☐Married ☐ Single ☐Separated ☐Widowed		Primary Care Physician		Referring Physician
Home Phone Number ( )	Day Phone Number ( )	Cell Phone Number ( )		Email Address
Patient's Employer Name	Employer Address	City, State, Zip Code		
Spouse or Parent's Name	Home Phone Number ( )	Street Address		City, State, Zip Code
Spouse or Parent's Employer	Business Phone Number ( )	Emergency Contact		Phone Number ( )
Pharmacy Name:	Pharmacy Address:	Pharmacy Phone #:		

IMPORTANT! PLEASE READ CAREFULLY.
INSURANCE AUTHORIZATION AND ASSIGNMENT AND/OR MEDICAL RELEASE.

I hereby authorize Mid-State Gastroenterology(dba Adv.Health Network) to furnish any information or to obtain any information from any insurance carrier, physician, attorney, employer, hospital, other health care provider, or any affiliated entity concerning my medical history, illness and treatments. I hereby assign Mid-State Gastroenterology(dba Adv.Health Network) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date _____ Signature _____

Name of Primary Insurance Company		Effective Date of Policy
Insurance Company's Address, City, State, Zip Code		Phone Number ( )
Insured's Name	Insured Date of Birth	SSN
Policy Number	Contract Number	Group Number
Name of Secondary Insurance Company		Effective Date of Policy
Insurance Company's Address, City, State, Zip Code		Phone Number ( )
Insured's Name	Insured Date of Birth	SSN
Policy Number	Contract Number	Group Number
Name:	Relationship	

Name: _____ DOB: _____

ALLERGIES:

MEDICATION LIST:

(Please include ***ALL*** over the counter, herbal supplements, and vitamins, that you take regularly.)

NAME OF MEDICATION	DOSAGE AMOUNT (*i.e. mg, mcg, unit*)	FREQUENCY *(i.e. once a day, at night, as needed)*	LAST TIME TAKEN

ADVANCED DIAGNOSTIC IMAGING | Advanced HEALTH | Premier Radiology | Saint Thomas Health | PHY DATA

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

_____

AdvancedHEALTH

General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____

AdvancedHEALTH

BILLING INFORMATION

STATEMENTS:
A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

DELINQUENT ACCOUNTS:
We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non emergency treatment for any and all debtor-related unpaid account balances.

WAIVER OF CONFIDENTIALITY:
You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS:
You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. If the request is for a party other than the originally billed insurance and/or party, a **$20.00 medical records fee** will be required on each occasion.

Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you.

We accept the following: Cash Check Credit Card *(Visa, MasterCard, Discover, American Express)*

A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. ***Patients who no-show may be subject to a no-show fee.***

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: _____ Date _____/_____/_____

Additional financial explanations are continued on the back side of this page

AdvancedHEALTH

Release Of Medical Information

NAME *(Please print)*: _____

By Signing Below, I Authorize (Practice Name) To Release My Medical And Billing Information To:

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

We ask that if you have any change in this request, that you please inform the receptionist.

(PRACTICE NAME) MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE _____ DATE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

RELATIONSHIP

SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT (PRACTICE NAME) WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.

AdvancedHEALTH

Mid-State Gastroenterology

Sunil Sarvaria M.D., Alpesh Patel, M.D., Francisco Garcia-Gonzalez, M.D.
and Lisa Garwood ANP-BC

1115 Dow Street, Suite B Murfreesboro, TN 37130 615.896.6996 phone 615.896.6985 fax

Authorization for Release of Confidential Health Information

Patient name:_____**SS#**_____**DOB:**_____

Address:_____**City:**_____**State:**_____

Phone# (_____**)**_____**-**_____

I, the above patient, authorize: ____ **To Furnish to:** _____**To Receive From:**

Mid-State Gastroenterology, PLLC (DBA Advanced Health)
1115 B Dow Street
Murfreesboro, TN. 37130
Phone: (615) 896-6996
Fax : (615) 896-6985

_____
Name of Healthcare Facility, Physician, Agency, Etc.

_____
Address

_____
City/ State / Zip

(____)____-_____ (____) ____-_____
Phone Fax

The Following Information:
Check One _____Complete Chart
_____All G.I. Related Records

_____Other:_____
_____

For the Following Time Period: From:
_____To:_____

This disclosure is made for:_____
(Personal Records, Further Care, Transfer of Care, Insurance Legal Counsel, Disability)

- I understand that my medical records may include information relating to sexually transmitted disease, Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about a behavioral or mental health service, developmental disabilities or treatment for alcohol and/or drug abuse.
- I understand that information disclosed pursuant to this Authorization might be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying the privacy officer of MSG in writing. Notwithstanding the foregoing, I Understand that I may not revoke this authorization to the extent that MSG has taken action in reliance upon it.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my ability to receive treatment.
- I understand that this authorization shall expire, without my revocation, on the year following the date of signature unless otherwise indicated.

_____
Signature of Patient or Patient Representative
Date

Signature of Witness
Date

For Office Use Only: __ _____Faxed _____Mailed
Date:_____By:_____