Athens Digestive Healthcare Associates
Asif Qadri, M.D.
1360 Caduceus Way, Bldg 300
Watkinsville, GA 30677
Phone 706-850-4985
Fax 706-850-4989

HIPAA CONTACT RELEASE FORM

Patient Name:_____
DOB:_____

I authorize the release of information including diagnosis, records, examination rendered to me and the following:

Spouse:_____
Phone #:_____

Child(ren):_____
Phone #:_____

Other:_____
Phone #:_____

☐ Please check if you do not wish to release your information to anyone.

I authorize ADHA to call: (please select)

- My Home Phone
- My Work Phone
- My Cell Phone

If unable to reach me, I authorize ADHA to: (please select)

- Leave a Detailed Message
- Leave a message asking me to return the call
- DO NOT LEAVE A MESSAGE

***This release of information will remain in effect until I terminate in written form. ***

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HIPAA Acknowledgement and Consent Form

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

- Conduct, Plan, and Direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third party payers.
- Conduct normal healthcare operations, such as quality assessments or evaluations, and physician certification.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and I may contact this organization at the time at the addresses) below to obtain a current copy of the Notices of Privacy of Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand the organization is not required to agree to my request restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date

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Financial Policy

Dear Patient,

You need to be aware that you are financially responsible for deductibles, co-insurance, co-pays, or any amount not paid, not covered or denied by your carrier for the physicians before the day of your procedure or office visit. Please be prepared to make this payment or your procedure/office visit can and will be rescheduled until further arrangements are made. As a courtesy to you, Athens Digestive Healthcare Associates/Endoscopy Center will call and verify your insurance coverage and will pre-certify your procedure with your insurance carrier.

It is your responsibility as a patient to be aware of your insurance coverage and how your plan works. Please remember that the policy is between you and your insurance carrier. If you have questions about your policy, call your insurance company for a detailed explanation of Outpatient Surgery benefits. Endoscopy is considered a non-invasive outpatient surgery by federal guidelines and it is not an inpatient procedure.

Should you have any questions, please call the billing department at 706-850-4985.

I have read and agreed to the above financial agreement.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date

*** You must bring cash, check or credit/debit card to pay any copay or deductible** *

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Medical Records Release

Date:_____

To:_____

_____

Office:_____ Fax:_____

I hereby authorize you to release my records to:

Athens Digestive Healthcare Associates

Office: 706-850-4985 Fax: 706-850-4989

To include all information, including the diagnosis and records of any treatment or examination rendered to me.

_____
Print Name

_____
Signature

_____
Date of Birth

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Watkinsville, GA 30677
Phone 706-850-4985
Fax 706-850-4989

Medical Records Release

Date:_____

I hereby authorize **Athens Digestive Healthcare Associates** to release my records to:

To:_____

_____

Fax:_____

To include all information, including the diagnosis and records of any treatment or examination rendered to me.

_____
Print Name

_____
Signature

_____
Date of Birth