DIGESTIVE HEALTH PHYSICIANS

CONSULTATIVE GASTROENTEROLOGY ◆ GASTROINTESTINAL ENDOSCOPY ◆ HEPATOLOGY

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About Our Practice

Digestive Health Physicians is dedicated to providing high quality medical care incorporating the latest advances in our specialty. We have physicians board certified in Internal Medicine, and Gastroenterology. Our office staff is trained to provide excellent, courteous, personal care for our patients. We specialize in the diagnosis and treatment of digestive and liver diseases. This includes a wide range of problems such as swallowing disorders, heartburn, hepatitis, ulcers, abdominal pain, weight loss, diarrhea, colitis, constipation, jaundice, internal bleeding, colon polyps and cancer of the digestive tract. As consultants, we are often asked to assist in the management of difficult, complex cases with other physicians.

Gastrointestinal endoscopy (literally "to look within") is the specialized procedure we use to examine the upper gastrointestinal tract, colon, pancreas, liver and biliary tree. Should an endoscopy be needed, your physician will utilize delicate fiber optic video instruments, which enable us to accurately diagnose a wide variety of conditions affecting the digestive organs. In many cases, these procedures eliminate the need for major surgery. The procedure is most often performed as an outpatient using mild sedation.

We also perform highly specialized procedures such as ERCP for diagnosis and treatment disorders of the pancreas and bile ducts. Laser therapy is available for treatment of cancer and certain other conditions. Nonsurgical hemorrhoid treatments can be performed in our office. Within our practice we are happy to announce specialization in the art and science of liver disease. Some of our physicians have a special interest and years of experience in the management of challenging problems with hepatitis C, inherited liver diseases, management of cirrhosis and its complications. These physicians work closely with others around the country to provide up to date treatment options. We believe that liver disease requires specialized care and are pleased to announce the formation of a clinic dedicated exclusively to the need of patients who have this problem.

Registration- On the day of your appointment you must bring with you a **photo ID**, and your **insurance cards**. Bring all the paperwork you received in the mail from us completely filled out. If you do not have a photo ID you must bring a copy of a utility bill with your current address, and another form of ID. For your protection we must verify and protect your identity. You must also be prepared to pay any amount due before you see the physician or you may be asked to reschedule your appointment.

Appointment Cancellation - As a courtesy to our physicians, and other patients, we request cancellations or changes in scheduling be made at least **24 hours in advance**. Please call (239)-939-9939, Option #3.

Prescription Refills - Please plan ahead and call for refills during regular office hours. We will have your prescriptions called in within 48 hours. Please call (239)-939-9939, Option #6. Medications cannot always be prescribed for a problem that has not been previously evaluated or if you have not been seen during the previous year.

Insurance Questions - If you have questions or problems with your bill, insurance claims, or authorizations please call (239)-939-9939, Option #1.

Main Office
7152 Coca Sabal Lane,
Fort Myers, FL 33908
(239) 939-9939

Bonita Springs
3501 Health Center Blvd., Suite 2410,
Bonita Springs, FL 34135
(239) 947-2244

Parker Plaza
9400 Gladiolus Dr., Suite 250
Fort Myers, FL 33908
(239) 939-9939

Main FAX: (239) 931-5060
www.digestivehealth.com

Acknowledgment Receipt of Notice of Privacy Policy
And
Confidential Communication Requests

I hereby acknowledge that I was offered to read, or take with me a copy of the Privacy Policy issued by **Digestive Health Physicians**, on the date indicated below.

_______________________________ _____________________
Signature Date

If you are not the patient, please state relationship:
- ❑ Parent (s)
- ❑ Legal Guardian
- ❑ Son or Daughter
- ❑ Facility Caretaker
- ❑ Other ___________________

I understand that **Digestive Health Physicians** will call my contact number to remind me of my office appointments by an **automated phone system**.

❑ I wish to be placed on the **Do Not Call List** for the automated phone reminders

All other tests results or concerns someone will personally call me. To respect my privacy see choices below:

Cell or Home Phone-
- ❑ You may leave a message with the following person(s) if I am not available: **List Name below**
- ❑ You may leave DETAILED Information on my cell phone or answering machine.
- ❑ You may leave your NAME and PHONE NUMBER ONLY and I will return your call.

Work Phone
- ❑ You may call my work place.
- ❑ You may leave DETAILED INFORMATION on my answering machine at work.
- ❑ You may leave NAME AND PHONE NUMBER ONLY on my answering machine at work and I will return your call.
- ❑ You may NOT call my work place.

Please list below spouses, family, friends, caretakers, etc... that WE **may communicate with** in regards to your personal medical and financial information. This will include but not limited to: test results, appointment dates and time, billing information. **Only the names that are listed below** will be able to receive your information. Do not include your physicians on this list.

Persons Name	**Relationship to the patient**
_________________________	____________________________
_________________________	____________________________

Unless you **notify us in writing** stating otherwise, the above person(s) will always be able to receive information about you.

Patient's Signature _______________________________ Date: ________________

Patient's Name: __________________________________ Chart #: ______________

Digestive Health Physicians - Patient Information Sheet

Patient Account #

Name:	Date of Birth:
Address:	Social Security #:
City:	Sex:
State: Zip:	Race:
Home Phone#:	Preferred Language:
Work Phone#:	Ethnicity:
Cell Phone#:	Emergency Contact Name:
Emergency Contact Relationship:	Emergency Contact Phone# :

email Address: ______________________________

Please print clearly we need this for Portal Access

Referring MD Name: ______________________________

Primary Care MD Name: ______________________________

Northern Address Information- (If applicable)

Name:	
Address One:	
City:	
State: Zip:	
Home Phone#:	
Cell Phone#:	

Insurance Information

Primary Insurance:	Secondary Insurance:
Subscriber/Policy #:	Subscriber/Policy #:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber SS#	Subscriber SS#:
Subscriber DOB:	Subscriber DOB:

If all information is correct, please sign. If incorrect, please make changes, and then sign.

______________________________ ______________________________

Signed Date

Digestive Health Physicians
Financial Policy

Welcome, we are so pleased you have selected our facility for your healthcare needs.

Below, we have answered a variety of commonly-asked financial policy questions. If you need further information about any of these policies, please ask us, we will be happy to assist you.
Your financial responsibility depends on a variety of factors, explained below.

What Is My Financial Responsibility for Services?

If You Have :	You Are Responsible For....	Our Staff Will....
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visits, injections, and other charges is expected from you at the time of the office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim on your behalf.
HMO & PPO plans with which we have a contract and are participating physicians	If the services you receive are covered by the plan: All applicable co-pays and deductibles are expected at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine co-pays, deductibles, and non-covered services for you. File an insurance claim on your behalf.
HMO with which we are not contracted.	Payment in full for office visits, injections, and other charges at the time of office visit.	File an insurance claim as a courtesy to you.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, co-pay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, co-pays, deductibles, and non-covered services. File an insurance claim as a courtesy to you.
Medicare	If you have Medicare Part B as primary and also have a supplement, no payment is necessary at the time of the visit. If you have Medicare Part B and no supplement, you will be asked to pay your 20% co-insurance. Non-covered services will be paid in full at the time of service as well as the Medicare Part B deductible if it has not been met.	File the claim on your behalf, as well as any claims to your secondary insurance.
Medicare HMO	All applicable co-pays and deductibles at the time of the office visit.	File the claim on your behalf.
No Insurance	Payment in full at the time of the visit.	Self pay rates available

- I understand that it is my responsibility to provide the office of Digestive Health Physicians with current, accurate billing information at the time of check in and to notify Digestive Health Physicians of any changes in this information.

- I understand that it is my responsibility to know my **specialist co-pay** (which can be different than my Primary Care co-payment) and to pay it at the time of service. I understand that this is a contractual agreement that I have with my health plan and that Digestive Health Physicians also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.

- I understand that there is a $20 fee to complete disability paperwork, family leave, life insurance claim forms, insurance claims forms to recover payment and assistance in addition to the claims associated with my care. I understand that the $20 fee (payable prior to completion) is required.

- I understand that Digestive Health Physicians will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any outpatient procedures that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to my procedure with Digestive Health Physicians. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated procedure to be performed and 2) current information provided to Digestive Health Physicians by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

- I understand that the Digestive Health Physicians will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

- I understand that Digestive Health Physicians may also take a verbal request to use my credit card for payment on my account.

- I understand and acknowledge that I am personally responsible to pay Digestive Health Physicians in full for services that my health insurer will not cover due to non-payment of my health insurance premiums.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Digestive Health Physicians.

I authorize Digestive Health Physicians to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date	**Signature**	**Printed Name**