Etowah Gastroenterology Associates
Vipul T. Amin, M.D.

Patient Information

PATIENT NAME (LAST, FIRST, MIDDLE)				PRIMARY TELEPHONE		SECONDARY TELEPHONE	
ADDRESS		CITY		STATE		ZIP CODE	
PATIENT'S EMPLOYER				OCCUPATION (INDICATE IF STUDENT)		WORK TELEPHONE	
SEX ☐M ☐F	RACE	AGE	MARTIAL STATUS ☐S ☐M ☐D ☐W	BIRTHDATE	RETIRED ☐Y ☐N	DISABLED ☐Y ☐N	SOCIAL SECURITY NO.
SPOUSE'S NAME				SPOUSE'S EMPLOYER		SPOUSE'S WORK TELEPHONE	
NEXT OF KIN (NOT LIVING WITH YOU)						DAYTIME TELEPHONE	
FRIEND (NOT LIVING WITH YOU)						DAYTIME TELEPHONE	
WHOM MAY WE CONTACT IN CASE OF EMERGENCY						DAYTIME TELEPHONE	
REFERING PHYSICIAN				FAMILY PHYSICIAN			
PHARMACY/CITY		PREFERRED LANGUAGE		ETHNICITY		EMAIL ADDRESS	
PERSON RESPONSIBLE FOR PAYMENT				RELATION TO PATIENT			
ADDRESS	CITY	STATE	ZIP CODE	PRIMARY TELEPHONE		SOCIAL SECURITY NO.	
BIRTHDATE	EMPLOYER			WORK TELEPHONE			
NAME OF PRIMARY INSURANCE CO.		CONTRACT NO.		GROUP NO.		EFFECTIVE DATE	
NAME OF INSURED (AS IT APPEARS ON YOUR INSURANCE CARD)							
NAME OF SECONDARY INSURANCE CO.		CONTRACT NO.		GROUP NO.		EFFECTIVE DATE	
NAME OF INSURED (AS IT APPEARS ON YOUR INSURANCE CARD)							

I (Or my legal guardian or parent) authorize Etowah Gastroenterology Assoc. to provide medical care reasonable by today's standards.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO Etowah Gastroenterology Associates, P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the physician's regular charges for these services. I understand that I am financially responsible to Etowah Gastroenterology Assoc., P.C. for charges not covered by this assignment. I authorize the refund of overpaid benefits where my coverage's are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees, and waiver all claims of exemption under the law of the State of Alabama.

By signing this form, you are granting consent to Etowah Gastroenterology Assoc. to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change out notice, you may obtain a copy of the revised notice by contacting our organization at (256) 467-4477. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature of patient/legal guardian: _____ Date_____