Jordan & Associates
GASTROENTEROLOGY, P.A.

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HIPAA DATA FORM

First Name: _____ Middle Name_____ Last Name: _____
Home Address-Street_____
Home Address-City, State, Zip _____
Mailing Address (if different from Home) _____

Phone numbers:
Home: _____ Work: _____ Cell: _____ Sex: M_____ F_____
SS# _____ Date of Birth: _____ Age: _____ Race _____ Language _____
Email address: _____ Marital Status: _____
Employer Name & Occupation: _____
Referring Physician & phone number _____
Primary Care Physician & phone number _____

Power of Attorney Information (if applicable)

Name: _____Relationship to patient: _____
Home phone: _____ Work: _____ Cell: _____
Address: _____
Do you have a Living Will? _____Yes _____No

Emergency Contact Information/Designated Individuals Release:

JAG may release to, or discuss my personal health information (PHI) with the individuals listed below, verbally or in writing. I understand that JAG (Jordan & Associates Gastroenterology, P.A.) will make best efforts to verify the identity of the designated parties before disclosing my PHI.

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone:_____

If/when any of the above information changes, I will provide the updated information promptly. I also understand that I may change any of the Emergency Contact Information/Designated Individuals Release information at any time, by asking for and completing a new Patient Information Form. I have reviewed and understand the HIPPA Notice of Health Information Practices (posted in the lobby) and understand that I may request a copy for my records at any time.

Payment Authorization and Payment Agreement

I hereby authorize payment of medical benefits made on my behalf to be paid directly to Jordan & Associates Gastroenterology, P.A. by Medicare or any insurance company I have a contract with. If I do not have insurance coverage, I agree to pay all fees at the time of service unless payment arrangements have been made with the Practice Manager in advance. If I have insurance coverage or Medicare, I agree to pay all co-payments, co-insurance and deductibles at the time of service. If I am billed for any fee balance, I agree to pay the balance in full within 30 days of receipt of invoice. I understand that I may be charged a $50 fee if I fail to appear for my scheduled office visit or a $200 reservation fee if I give less than 48 hours notice of cancellation or fail to appear for an endoscopic procedure scheduled at either the hospital or the Jordan & Associates Gastroenterology, P.A office.

I have read and understand the above.

Signature of patient or legal guardian: _____ Date: _____