Fall Hill Gastroenterology Associates
2601 Fall Hill Avenue
Fredericksburg VA 22401
540-371-9696/540-369-6912 fax
or email forms to FHGA@FallHillGastro.com

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Welcome to Fall Hill Gastroenterology Associates!

PLEASE PRINT

Name_____
LAST FIRST MIDDLE INITIAL

Mailing address_____
STREET CITY STATE ZIP

Physical Address (if different)_____

Home phone_____Cell phone_____

Social Security #_____ Date of Birth_____

Sex_____ Marital Status: S M D W E-Mail (for patient portal)_____

Employer_____ Work Phone_____

Primary Physician_____Pharmacy_____

RESPONSIBLE PERSON (if different from above)_____

Phone_____

Address (if different from above)_____
STREET CITY STATE ZIP

EMERGENCY CONTACT_____
NAME RELATIONSHIP PHONE #S

_____

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION (PHI)

I hereby give my permission to the person(s) listed below to receive information about me. For example:
Spouse, daughter, son, neighbor, parent, friend, other family member, etc. **(PATIENT IDENTIFIER:PATIENT DATE OF BIRTH)**

NAME	RELATIONSHIP

NOTICE OF INFORMATION PRACTICES

This notice describes how information about you may be used, disclosed, and how you can gain access to this information. PLEASE REVIEW CAREFULLY.

1. Fall Hill Gastroenterology Associates (FHGA) may use and disclose protected health information for treatment, payment and healthcare operations. Treatment examples include, but are not limited to, referrals to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers or collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. FHGA is permitted or required to use or disclose Protected Health Information (PHI) without the individual's written consent or authorization in certain circumstances. Examples include for public health requirements or court orders.
3. FHGA will not make any other use or disclosure of a patient's PHI without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. FHGA will abide by the terms of this Notice currently in effect at the time of disclosure.
5. FHGA reserves the right to change the terms of its Notice and to make new Notice provisions effective for all PHI that it maintains. FHGA will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose the PHI of the patient. Copies may also be obtained at any time at our office.
6. Any patient, guardian or personal representative has the right to inspect and obtain copies of their medical records.
7. Any patient, guardian or personal representative has the right to request amendments be made to their medical records.
8. Any patient, guardian or personal representative has the right to request to receive confidential communications of PHI by alternative means or at alternative locations. Such request must be in writing and the practice must accommodate reasonable requests.
9. Any patient, guardian or personal representative has the right to request a six year accounting of all disclosures of their medical records. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12 month period.
10. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested, but if the Practice does agree, the Practice must abide by those restrictions.
11. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. All complaints will be addressed and the results will be reported to the Privacy Officer. To file a complaint with the Practice, please contact the Privacy Officer at the following address and/or phone number: Karen Craig, 540-371-9696, 2601 Fall Hill Ave., Fredericksburg VA 22401.
12. It is the policy of FHGA that no retaliatory action be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
13. With this consent, FHGA may:
    a. Call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out Treatment Plan Orders (TPO), such as appointment reminders, insurance items, and calls pertaining to my clinical care, including lab results, etc.
    b. May mail to my home or other designated location any items that assist the Practice in carrying out TPO.
    c. May e-mail to me appointment reminders and patient statements.

14. By signing, I am consenting for FHGA to use and disclose my PHI to carry out my TPO. I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent.
    If I do not sign this consent, FHGA may decline to provide treatment to me.

Financial and Office Policies

We appreciate the opportunity to help you with your healthcare concerns. Here are our office policies.

Test results/Procedures

- Procedures are scheduled within **30 days** of your consultation with the doctor.
- Please allow ***7-14* BUSINESS** days for the doctors to **receive** test results.
- Test results may be obtained through the patient portal or office visit to discuss results.

Prescription refills

- Please contact your pharmacy for refills first and they will contact our office for approval.
- Please contact our nursing department for any new prescriptions.
- Please allow **5-7 BUSINESS** days for processing.

Medical Records

- There is a fee to obtain your personal ***medical records***.
- Please allow ***7-10* BUSINESS** days for copies of your medical records or for them to be sent to another physician.
- Due to administrative costs, there will be a ***$45 fee*** associated with completion of any paperwork not generated from our office. This includes but is not limited to FMLA, Handicap application, paperwork for any work or school requirements.

- I authorize the release of my medical information to FALL HILL GASTROENTEROLOGY ASSOCIATES for insurance purposes.

Cancellation & missed appointments

- There will be a ***$35 fee*** for each ***missed appointment.***
- When canceling an appointment, we ask for a **48 hour** prior notice to avoid a ***$35 cancellation fee***.
- If you have missed a total of **3** appointments, we reserve the right to deny another appointment for you.

- When canceling or rescheduling your Procedure appointment, you must notify us **5 business days prior to your procedure day or incur the following fees:**
  - A $250.00 fee for the missed procedure appointment
  - A $150.00 fee for missed hemorrhoid banding appointment

Insurance and Referral Policies

- I hereby assign payment directly to the designated physician for any medical/surgical procedures performed. Furthermore, I acknowledge that I am financially responsible for the entire amount billed, regardless of any insurance that may exist. If my account is turned over to an attorney/collection agency, I agree to pay all cost of collections, including attorney fees, interest and court cost.

- We participate with many insurance plans and programs and as a courtesy, we will file your claims however, please be aware that your insurance is a contract between you and your insurance company. If for any reason your insurance company denies payment, you will be responsible for the services rendered. Be aware that if your account should be sent to collections your patient/physician relationship will be terminated until you have resolved the account in full.
- We ***DO NOT*** file to third party insurance.
- We require ***you*** to provide us with your current insurance card(s) and a photo ID.
- Payment is required at the ***time of service*** for all co-pays, co-insurances, deductibles, uninsured and any prior balances.
- Even though we participate with many HMO plans, it is your responsibility to contact your primary care physician immediately to obtain a referral for your visit. If you fail to obtain a referral you will be responsible for paying for the visit.
- We gladly accept ***cash, check, money order and credit cards***.

- **OUR OFFICE POLICY STATES THAT ONCE YOU HAVE AN ESTABLISHED PHYSICIAN, YOU WILL NOT BE ABLE TO SWITCH PHYSICIANS WITHIN THE PRACTICE.**

If you have any questions regarding the above information, please do not hesitate to discuss them with our staff. We ask that you sign this form for our records and to indicate that you aware of our policies. We will gladly offer you a copy of this form if you wish.
Thank you.

_____/_____
Patient signature Date