NORTHERN
Gastroenterology
a department of Northern Regional Hospital

708 S. South Street
Mount Airy, NC 27030
336-786-6277

Patients Legal Name _____
Last **First** **Middle**

Date of Birth_____Sex: ☐ F ☐ M Race:_____Ethnicity: _____SS#_____

Email address_____I Decline to give an email address_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

I acknowledge that I have received a copy of Northern Gastroenterology's (Northern Hospital of Surry County) Notice of Privacy Practices. I acknowledge that I have been informed of my rights and responsibilities.

I give permission to Northern Gastroenterology to file any claims on my behalf to my insurance company for billing purposes. I also give permission to Northern Gastroenterology to send any medical records requested by my insurance company to process these claims.
I understand that I am responsible for any charges in full at time of visit if I do not have insurance. I am responsible to pay the co pay or deductibles at the time of my visit. I further understand that I am responsible for any charges that are NOT a covered service with my insurance plan. I understand that an insurance card presented to Northern Gastroenterology is not a guarantee of payment. I understand if I am self -pay or pay a percentage that the quote I am given is just an estimate and may receive a bill.

I give Northern Gastroenterology permission to treat and to send information to my referring physician and referred physician if deemed necessary by my physician.

I give the names listed below permission to discuss my treatment, pick up prescriptions and pick up any forms.
_____

I understand that I may revoke this authorization at any time by presenting a request for revocation in writing to aHealth Information Department of Northern Gastroenterology; however, a revocation will not reverse any action already taken in reliance upon this Authorization.
I also understand that the information disclosed pursuant to the authorization may include information concerning patients' mental health, use or treatment concerning drugs and/or alcohol, HIV/AIDS and/or other communicable diseases and/or genetic testing results.

I give Northern Gastroenterology permission to retrieve my medication history through the Sure scripts E-Prescription Network.

I understand that I have the right to request restrictions concerning the use of my information. Below are those restrictions:
_____
_____

Patient or Guardian
Signature_____DATE:_____Time:_____