Colon and Digestive Health Specialists
Dr. Karim Shakoor
1805 Honey Creek Commons SE, Suite B
Conyers, GA 30013
Phone: 770-922-7000 Fax: 770-922-8070 / 770-809-3667

Patient Registration Form (Please print clearly)

ALL INFORMATION MUST BE COMPLETED; IF NOT APPLICABLE, PLEASE WRITE "**NA**"!

Today's Date: _____

Last Name: _____
First Name: _____
Middle Name: _____
Name you wished to be called: _____
Date of Birth: ____/____/_____ (MM/DD/YYYY)
Social Security Number: _____
Mailing Address: _____
PO Box or Apt #: _____
City: _____ **State:** ____ **Zip Code:** _____
Home Phone: _____
Work Phone: _____ Ext: _____
Cell Phone: _____
Email Address: _____
Preferred Method of Communication:
Portal ___ Cell Ph. ___ Home Ph. ___ Mail ___

* **Portal Opt-In** ☐ **Portal Opt-Out** ☐

Ethnicity: Hispanic (Latino) _____ (Y/N)
Patient Declines ____ (Check if applicable)
Race: Asian ___ **Black/African American** ____
Hispanic ___ **White** ___ **Other** ____
Circle one: Female Male
Marital Status (Circle one):
Single Married Divorced Widowed
Spouse, Parent, or Guardian Name: _____
_____
Preferred Language:
English: _____ Spanish _____ Other _____
Pharmacy Name: _____
Pharmacy Phone: _____
Pharmacy Address: _____
Primary Care Physician: _____

Referring Physician: _____

Insurance Information:
Subscriber Name (if other than yourself): _____; Subscriber Date of Birth: _____

Secondary Insurance (if any): _____

I have completed this form fully and certify that I am the patient or dully authorized general agent of the patient authorized to furnish information requested. Office Policy: I understand and agree that I will be responsible for any balance not covered by my insurance company. In the event that my account balance is 30 days past due, I agree that I will be addressed a monthly $10 rebilling fee. In the event that my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fee (35%), attorney fees, court costs, etc. Any NFS/checks will be assessed a $25 fee. I consent for this office to contact my email or phone number by text or auto dialer. Should my account be placed with an outside agency for collection, this consent will be transferred to the outside agency.

Authorization to Release Information: I hereby authorize the above mentioned physician to release information contained in my medical records 1) To my insurance company, their agent, or third-party payor, and/or government or social services agencies which may or will pay for my care; 2) As mandated by Law; 3) to alternate care providers, including community agencies and services, as ordered by my physician or as requested by me or an authorized general agent for my care. This information shall include, but not limited to, infectious or contagious disease information, including HIV or AIDS related evaluations, diagnosis, or treatment; information about drug or alcohol use or treatment; and/or psychiatric or psychological information, I waive any privilege pertaining to such confidential information.

Please Note: There will be a $25 charge for all missed appointments, or appointments that are not cancelled at least 24 hours in advance. This charge will not be covered by your insurance company and must be paid in full prior to receiving services again at our office.

Patient or Guardian Signature: _____

HIPAA
PATIENT CONSENT FORM

Patient Name: _____ DOB: _____ (MM/DD/YYYY)

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient, to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum information necessary to only those we feel are in need of your records. We may have indirect treatment relationships with you (such as laboratories, that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal information, but this must be in writing. Under law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give your consent to this document, at some time in the future you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restriction and revoke consent in writing after you have reviewed our privacy notice.

PLEASE FILL THIS OUT COMPLETELY TO LET US KNOW HOW YOU PREFER TO BE REACHED

Home Telephone #: _____ Yes ___ No ___ Answering Machine: Yes ___ No ___

Work Telephone #: _____ Yes ___ No ___ Voice Mail: Yes ___ No ___

Cell Phone #: _____ Yes ___ No ___ Voice Mail: Yes ___ No ___

If you would like to have information released to someone other than yourself please complete the following: I authorize Colon and Digestive Health Specialists to leave medical information pertaining to my health to the following person(s) and will assume responsibility to notify them whenever this information changes:

PLEAST LIST NAMES OF PEOPLE WE CAN DISCUSS YOUR MEDIACL CARE WITH:

Spouse/Partner: _____ Yes ___ No ___ Phone #: _____
Parent: _____ Yes ___ No ___ Phone #: _____
Other: _____ Yes ___ No ___ Phone #: _____

Signature: _____ Date: _____

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1805 Honey Creek Commons Ste. B
Conyers, GA 30013
Ph. (770) 922-7000 Fax. (770) 809-3667

Authorization for Use/Release of Health Information:

(This form applies only to the release and disclosure of information. It is not a consent for treatment or intended for any other purposes.)

By signing this form, I authorize Colon and Digestive Health Specialists, LLC to obtain the protected health information described below:

Name and address of Person and /or Organization to whom information should be obtained from:

_____

_____

_____

Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.)

_____

I authorize the following information to be obtained from the address above:

___ Copies of all medical records for the period of ____ /____/_____ to ____ /____/_____

___ Copies of the information described below for period of ____ /____/_____ to ____ /____/_____

___ History & Physical Exam ___ Lab, X-ray, etc. Reports ____ Reports from Other Physicians

___ Other (Please Specify) _____

I hereby request that the following information not covered by a general release also be released:

___ Drug & Alcohol Records ___ Psychotherapy Records ___ AIDS/HIV records

I understand that there may be information in these records that I would not want released. The following information should not be released, even if occurring during dates above:

_____

** Please describe any special requirements such as faxing, mailing extended expiration date and the like:

_____

I understand that the Notice of Privacy Practices and I understand that Colon and Digestive Health Specialist, LLC assumes no responsibility for the use of or misuse by other of my health information disclosed under this authorization. I release Colon and Digestive Health Specialist, LLC from all legal liability that may arise from this authorization.

Patient Signature: _____ Date: _____

SS#: _____ DOB: _____ Printed Name: _____

If the signature above is not that of the patient, I am acting for the patient because _____
My relationship to the patient is: _____ Signed: _____

The patient or their representative may revoke this authorization by notifying, in writing, the office of Colon and Digestive Health Specialist, LLC. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subjected to redisclosure by the recipient. This release will expire one year after day signed or if revoked by the patient.