

**Digestive & Liver Disease Specialists**  
**885 Kempsville Rd. Suite 114**  
**Norfolk, VA 23502**  
**Phone 757-466-0165**

**PLEASE COMPLETE OR UPDATE THE FOLLOWING INFORMATION:**

<b>Name:</b>	<b>Account #:</b>
<b>Address:</b>	<b>Social Security:</b>
	<b>Date of Birth:</b>
<b>City:</b>	<b>Sex:      Marital:</b>
<b>State:    Zip:</b>	<b>Employer Name:</b>
<b>Home Phone:</b>	<b>Emergency Contact:</b>
<b>Work Phone:</b>	<b>Emergency Phone:</b>
<b>Cell Phone:</b>	<b>Referring Doctor:</b>

**INSURANCE INFORMATION**

<b>Primary Insurance:</b>	<b>Secondary Insurance:</b>
<b>Subscriber Name:</b>	<b>Subscriber Name:</b>
<b>Subscriber's Date of Birth:</b>	<b>Subscriber's Date of Birth:</b>
<b>Certificate:</b>	<b>Certificate:</b>
<b>Group Number:</b>	<b>Group Number:</b>
<b>Relationship to Patient:</b>	<b>Relationship to Patient:</b>

<b>Third Insurance:</b>	<b>Prescription Coverage:</b>
<b>Subscriber Name:</b>	<b>Subscriber Name:</b>
<b>Subscriber's Date of Birth:</b>	<b>Subscriber's Date of Birth:</b>
<b>Certificate:</b>	<b>Certificate:</b>
<b>Group Number:</b>	<b>Group Number:</b>
<b>Relationship to Patient:</b>	<b>Relationship to Patient:</b>

**AUTHORIZATION**  
**PLEASE INITIAL EACH LINE**

\_\_\_ I hereby authorize treatment by Digestive and Liver Disease Specialists and/or their assistants. Such treatment may include injections and/or other office procedures they deem necessary.

\_\_\_ I understand that my insurance policy is a contract between my insurance company and me and accept full responsibility to pay Digestive and Liver Disease Specialists for all services rendered on my behalf.

\_\_\_ If, in the event of default on my payments due Digestive and Liver Disease Specialists, I agree to pay all costs of collection at the rate of 33.3% and attorney fees associated in collecting the unpaid balance on my account.

\_\_\_ I authorize Digestive and Liver Disease Specialists to release my medical records to other healthcare professionals involved in my medical care.

\_\_\_ I authorize the filing of any insurance in force and the release of any medical information necessary to process my insurance claims for the direct payment to Digestive and Liver Disease Specialists.

\_\_\_ If I fail to appear for a scheduled appointment, it is my responsibility to reschedule. I, furthermore, acknowledge that if I fail to show for a recommended follow-up appointment, I may be jeopardizing my medical health and I accept responsibility for this action. I understand that I may be subject to a "no show" fee if I fail to appear for a scheduled appointment without reasonable notice. **A \$50.00 fee will be charged for failure to notify us of cancellation of an office endoscopic procedure within 48 business hours.**

\_\_\_ **Digestive & Liver Disease Specialists does NOT recognize Advance Directives.** During my care at DLDS, all practical measures will be utilized to prevent loss of life.

\_\_\_ Our organization participates with the Accreditation Association for Ambulatory Health Care's (AAAHC) requirements for quality improvement. Due to these requirements, I acknowledge that there is a Continuous Quality Improvement program in place which requires that a small portion of patient medical records periodically be reviewed. I agree to allow my medical record to be reviewed in the event that it is selected as part of this program. I understand that my information will be maintained under strict confidence and will not leave this facility.

\_\_\_ A copy of the Notice of Privacy Practices is posted at Digestive & Liver Disease Specialists. Copies are available in our waiting rooms and at our reception desks.

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

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**NOTICE OF DEEMED CONSENT FOR HIV BLOOD TESTING**

A law was enacted in Virginia in 1989, which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies pursuant to this provision, the testing would be explained, and you would be given the opportunity to ask any questions you might have. I have read and understand the above Notice of Deemed Consent to HIV Blood Testing.

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**FAMILY MEMBER AUTHORIZATION**

I authorize the release and/or discussion of my medical condition and results with the following individual (s):

\_\_\_\_\_

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_