WESTERN CAROLINA DIGESTIVE CONSULTANTS PA
WESTERN CAROLINA ENDOSCOPY CENTER LLC

PATIENT REGISTRATION

Date: Referring Doctor:

Patient's Full Name: Last: First: Middle:

Former Legal names/Maiden Name: Preferred Name:

Patient's Date of Birth: Age: Gender: Male Female

Social Security Number: Marital Status: Married Single Divorced Widowed

Address: City: State: Zip:

Cell Phone: Home Phone:

Email Address:

Primary Insurance: Secondary Insurance:

Race: American Indian Caucasian African American Native Hawaiian/Pacific Island Asian Other
Ethnicity: Non-Hispanic Hispanic

CONSENT FOR PATIENT COMMUNICATION

May we call you at home? Yes No May we leave a detailed message Yes No
May we call you at work? Yes No

Please list any person(s), their relationship to you and contact information that you wish to grant access to your personal and protected health information. These people will also be utilized as your emergency contacts.
IN ORDER FOR ANYONE TO OBTAIN INFORMATION ON YOUR BEHALF THEY MUST BE LISTED BELOW

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Physician/Practice. I understand that I am financially responsible for any balance. I also authorize Western Carolina Digestive/Western Carolina Endoscopy Center or insurance company to release any information required to process my claims. The notice of Privacy Practices/Patient Bill of Rights has been made available to me.

Patient Signature: **Date:**

WESTERN CAROLINA DIGESTIVE CONSULTANTS, P.A.
WESTERN CAROLINA ENDOSCOPY CENTER, L.L.C

FINANCIAL POLICY

We are dedicated to providing you with the best medical care and service. Your understanding of our financial policy is an essential element of your care and treatment. All patients must read and sign this document, which will become a part of their medical record.

As a courtesy to our patients, we will bill your primary and secondary insurance carriers based on the information you provide us with on your registration forms. You are responsible for all deductibles, co-payments, co-insurance and non-covered services. Our practice will assist in estimating the cost of procedure with your insurance company; however, this information should be verified with the patient and your insurance company as well. It is important to understand that this practice can only code a claim for a visit or procedure with a diagnosis that was documented in the medical record. We are not allowed to change diagnosis codes for better insurance reimbursement.

OFFICE VISITS (CONSULTATIONS):

*Your copay as listed on your insurance card for a specialist is due at the time of your office visit.
*We participate with most major insurances and will file a claim on your behalf to your insurance plan.

NO SHOW – SHORT NOTICE APPOINTMENT CHANGES:

*A $50.00 fee will be applied to your account if you do not keep your appointment or call 48 hours prior to inform us of any schedule changes. We strive to schedule all patients in a timely matter. Due to the current high volume of appointment requests, we ask that you help us by keeping your scheduled appointment or calling 48 hours prior if you need to cancel or reschedule. This allows us to make sure we provide appointment times for patients in need of those spots.

PROCEDURES:

*We will work with your insurance plan to verify coverage and expenses related to your procedure. We will contact you prior to your appointment to advise you of any out-of-pocket expenses. We recommend that you contact your insurance company as well prior to your procedure to understand your benefits.

*Deductibles and coinsurance amounts will be estimated based upon information provided by your insurance company. This "estimate" is the amount that will be due at the time of your procedure. We will file your claim and if the estimate changes you will be billed for any outstanding amounts or refunded if you have overpaid.

*If your procedure is scheduled at Western Carolina Endoscopy Center, your claim will be billed as an outpatient Ambulatory Surgical Center claim. We will bill both the professional (Doctor) and facility (ASC) to your insurance. You will be billed separately for pathology as well as anesthesia.

*If your procedure is scheduled at Harris Regional Hospital or Angel Medical Center, you will be billed by Harris Regional/Angel Medical for facility charges and Western Carolina Digestive for the professional (Doctor) charges. You may also be billed separately for anesthesia, pathology, and any other ancillary services from the hospital.

I have read and agree to the above Financial Policies of Western Carolina Digestive Consultants, P.A. and Western Carolina Endoscopy Center, L.L.C.

Patient Name (Print): _____

Signature: _____

Date: _____

Western Carolina Digestive Consultants, P.A. & Endoscopy Center, LLC

Franklin - 197 Riverview Street, Franklin, NC 28734 | Phone: 828.349.3636 | Fax: 828.349.0311
Sylva - 26 Westcare Drive, Suite 302, Sylva NC 28779 | Phone: 828.586.9200 | Fax: 828.586.7459

MEDICAL RECORDS RELEASE

Patient Name (Printed): _____

Date of Birth: _____

I hereby authorize and request Western Carolina Digestive Consultants, P.A. and Western Carolina Endoscopy Center, L.L.C, to obtain/release any information regarding my health care from/to any health care facility which has participated in my health care.

OFFICE USE ONLY: _____

_____

_____

_____

_____

PATIENT SIGNATURE: _____

DATE: _____

STAFF SIGNATURE: _____

DATE: _____

The information contained in this facsimile is privileged and confidential, intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, any distribution or copying is strictly prohibited. If you receive this communication in error, please notify us immediately at the number listed above.