Colon and Digestive Health Specialists
Dr. Karim Shakoor
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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:** _____

**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 ensure 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 #: _____ May we leave a message: Yes ___ No ___**

**Cell Phone #: _____ May we leave a message: 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: _____ Phone #: _____**
**Parent: _____ Phone #: _____**
**Other: _____ Phone #: _____**

**Signature: _____ Date: _____**