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ALEX JOHN, MD
CORY HALLIBURTON, MD
DAVID N. SCHWARTZ, MD
DEBORAH MOORE, NP

Please fill out this form and return it to our office before your scheduled appointment. DATE: ____________

LAST NAME: ________________________________ FIRST:______________________________ INITIAL:_______

DOB:___________________ GENDER:____________ SSN:____________________ MARITAL STATUS:_______

COMPLETE MAILING ADDRESS:____

Home #:________________________ Work#:_________________________ Cell#:_____________________________

Preferred phone # for calls?: _______________________ E-Mail address: _______________________________________

Do you want access to our PATIENT PORTAL (secure email – requires separate consent at log-in)? _______________

Emergency Contact:________________________________PH#:_____________________ RELATIONSHIP:_________

Name of Referring and Primary Physician: ____

PREFERRED PHARMACY:________________________________ Pharmacy Location:_________________________

All medical offices are being asked to participate in Health Care Quality Improvement. One aspect of this is to standardize the reporting of Race, Ethnicity and Primary Language. This confidential information is for quality monitoring purposes only. ****Please note – a response to the Primary Language is required.** If you choose not to answer the questions on Race or Ethnicity, please check "Unreported/Declined". Thank you.

1. **Primary Language** ____________________________
2. **Race** ____American Indian/Alaska Native
   ____Asian
   ____Black/African American
   ____Native Hawaiian/Pacific Islander
   ____Other Race
   ____Caucasian/White
   ____Unreported/Declined
3. **Ethnicity** ____Hispanic/Latino
   ____NOT Hispanic/Latino
   ____Unreported/Declined

INSURANCE INFORMATION: ***Please be as complete and accurate as possible! A copy of your card is appreciated!***

Primary Health Insurance: ____

CERTIFICATE/ID #:____________________________________ GROUP #: _______________________________

Secondary Heath Insurance: ____

CERTIFICATE/ID #: ____ GROUP #:____________________________

PLEASE SEE BACK SIDE OF FORM FOR ADDITIONAL INFO!

PAYMENT IS YOUR RESPONSIBILITY

Some insurance companies require a referral from your primary care physician or prior authorization. **IT IS YOUR RESPONSIBILITY** to follow the guidelines of your insurance plan. PLEASE INFORM THIS OFFICE OF SPECIFIC REQUIREMENTS. If procedures are not followed, your insurance company may deny payment and you may be responsible for the entire bill**.** **Any co-pay for office visits is expected at the time of service**. If you have questions, please ask us. Thank you.

***** ***Please also be aware that the charges from Vermont Gastroenterology are completely separate from any procedure or laboratory charges incurred at the University of Vermont Medical Center.*** *****

I HAVE READ THE ABOVE PARAGRAPH AND UNDERSTAND MY RESPONSIBILITY.
PLEASE SIGN BELOW:

Signature: ____ DATE: _________________________

PATIENT CONSENT FORM

The Department of Health and Human Service has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain the 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 records and will do all we can to secure and protect the privacy. We strive to always take reasonable precautions to protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical 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. **With your signature below, you are giving this office permission to electronically retrieve your prescription record from your pharmacy.**

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this 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 consent in this document, at some future time 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 or previously signed consent.

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

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

PRINT NAME:_____________________________ SIGNATURE:______________________________

DATE:_____________