Eric D. Weston, MD, FACG
401 Corbett Street, Suite 350
Clearwater, FL 33756
(727) 298-0802
Fax (727) 298-0272

PATIENT INFORMATION

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: ____/____/_____ SEX: ☐ MALE ☐ FEMALE ☐ OTHER SSN: ____ - ____ - _____

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

(Please check the box to indicate your preferred means of communication)

☐ HOME PHONE: _____ ☐ WORK PHONE: _____

☐ CELL PHONE: _____ ☐ EMAIL: _____

EMPLOYER: _____ MARITAL STATUS: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

CARDIOLOGIST: _____ PULMONOLOGIST: _____

RACE: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK/AFRICAN AMERICAN ☐ WHITE/CAUCASIAN ☐ ASIAN
☐ HAWAIIAN/PACIFIC ISLANDER ☐ OTHER ☐ UNKNOWN ☐ DECLINED

ETHNICITY: ☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO ☐ DECLINED ☐ UNKNOWN

LANGUAGE: _____ ☐ INTERPRETER NEEDED: _____

PHARMACY NAME AND ADDRESS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

PHONE: _____ OTHER PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ SSN: _____

INSURANCE ID#: _____ GROUP #: _____ PLAN #: _____

SECONDARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ SSN: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **ERIC D. WESTON, MD.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

SIGNED: _____ DATE: _____

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-727-298-0802.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-727-298-0802.
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-727-298-0802.

POS Reorder # 1802649

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FINANCIAL POLICY OF ERIC D. WESTON, MD

Thank you for choosing Eric D. Weston, MD as your gastroenterologist.

We are committed to providing you with the best possible medical care, and we are available to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our relationship. Your assistance in complying with our payment policies will help control our overhead expenses, thereby keeping medical fees at a reasonable cost.

If you cannot keep an appointment, please give us at least one day's notice. That way we can schedule another patient to see the doctor.

Full payment or copayment is due at the time of service. We accept cash, check, Visa, MasterCard, Discover or American Express.

There will be a $25.00 service charge for any returned check.

Our office will file primary and secondary insurance for Medicare, managed care plans (HMO/PPO), and other commercial insurance plans with which we are contracted. If we accept your insurance, you must pay any copayments at the time of service. If you are scheduled for a procedure and you have an unmet deductible, we will collect a deposit when we schedule your procedure. Any amount indicated as patient responsibility by your insurance company is due within 30 days.

As all insurance plans have specific rules and regulations regarding the use of certain labs and treatment centers, as well as referrals to specialists, we ask that you be aware of your plans directives and inform the doctors of them so that they can try as much as possible to keep within the scope of your plan, especially if the need arises at night or over the weekend.

Please notify our office immediately when you change medical insurance, home address or telephone numbers.

Bring your current insurance card every time you visit our office. It contains valuable information regarding coverage and benefits. If your insurance card has not been issued to you by the time of your visit you will be treated as a self-pay patient. Payment will be expected at the time of the visit and the claim will be submitted for you when you receive your card.

I have read and I agree to the terms of this financial policy.

_____ Date _____

(Signature of patient or legal guardian)

Thank you for understanding our financial policy.
Please let us know if you have any questions or concerns.

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USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION (PHI)

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine health care operation, such as assessing quality, and reviewing the competence of staff

I have been provided with a "Notice of Patient Privacy Practices" that provides a more complete description of information uses and disclosures.

Tell us with whom we may discuss your protected health information:
(Name and relation - Example: Jane Doe, Wife; Jan Doe, Daughter)

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Messages or Appointment Reminders
Messages will be of a non-sensitive nature, such as appointment reminders.

May we leave a message on your voice mail using doctor's/practice name? ☐ Yes ☐ No
May we leave a message with another individual using doctor's/practice name? ☐ Yes ☐ No
May we leave a message at your work using doctor's/practice name? ☐ Yes ☐ No

I understand that as part of treatment, payment or health care operations, it may become necessary to disclose health information to another entity, e.g. referrals to other health care providers. I understand that my information may be used or disclosed, without an authorization, as permitted or required by law.

Patient/guardian signature _____ Date _____

Print name of person signing _____

If other than the patient (patient name) _____
is signing, are you the legal guardian, custodian, or have Power of Attorney for this patient, for treatment, payment or health care operations? ☐ Yes ☐ No

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POS Reorder # 1802652

Harborside Gastroenterology

Eric D. Weston, MD, FACG
401 Corbett Street, Suite 350
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_____FINANCIAL RESPONSIBILITY AGREEMENT:
Initials

I agree to assign insurance benefits to Eric D. Weston, MD. I acknowledge full financial responsibility for services rendered by Eric D. Weston, MD and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co-Insurance, Pre-existing Clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility. I further authorize all insurance payments to be made directly to Eric D. Weston, MD. Payment is expected at the time of service. We bill all insurance companies that we are contracted with as "network" providers as a courtesy to our patients. We will file your insurance as a courtesy to you. If your deductible has not been met and/or you are responsible for a co-payment under your plan, we will expect the payment of such upon delivery of services at the time of your visit. If you are scheduled for a procedure and you have an unmet deductible, we will collect a deposit when we schedule your procedure. There will be a $25.00 fee for returned checks.

_____PATIENT PRIVACY PRACTICES:
Initials

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent, or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our Notice of Privacy Practices policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

_____CONSENT OF TREATMENT:
Initials

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of Eric D. Weston, MD or other provider, which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures, anesthesia or other services rendered to the patient under the general and special instructions of the patient's physician. Eric D. Weston, MD has the right to refuse to treat you if you refuse to sign this consent or if you choose to revoke this consent.

_____TELEPHONE CONSUMER PROTECTION ACT (TCPA):
Initials

I agree that the facility, Eric D. Weston, MD or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

_____PROOF AND CHANGE OF INSURANCE:
Initials

Patients are required to show both proof of insurance and a Government issued photo ID at their initial and all subsequent visits. The patient (parent/legal guardian) is responsible for informing our office of any changes in your insurance coverage since your last visit. Please assure that notification is made no later than 24 hours prior to your appointment to avoid having to reschedule your appointment.

_____DISABILITY PAPERWORK/MISSED APPOINTMENT POLICY:
Initials

Please give all forms regarding disability to the nursing staff. Please do not give these forms to the physician. You will need to expect 72 hours for these forms to be completed. Fill out the portion of the disability form that is for the patient and leave physician's area blank.

We must be notified 24 hours in advance of an office appointment cancellation/need to reschedule. For a procedure cancellation/ reschedule (colonoscopy or EGD), we must be notified at least 48 hours in advance of the procedure date.

_____DISCLOSURE OF FINANCIAL INTEREST:
Initials

Eric D. Weston, MD has ownership interest in Clearwater Endoscopy Center. He created the center due to his commitment to provide quality healthcare services to his patients at a reasonable cost. You have the right to choose where to receive services, including an entity in which your physician may have a financial relationship. Dr. Weston may also provide endoscopic services at Morton Plant Hospital, 323 Jeffords St., Clearwater, FL 33756, (727) 462-7745.

_____CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY:
Initials

I authorize Eric D. Weston, MD and its affiliated providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. My initials and signature certifies that I read and understood the scope of my consent and that I authorize the access.

ACKNOWLEDGMENT:

- I acknowledge that I have received access to the "Notice of Privacy Practices" for Eric D. Weston, MD. I have read and understand the "HIPAA & Release of Medical Information Policy".
- I hereby authorize Eric D. Weston, MD to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment for any and all services rendered.
- I understand that I am financially responsible to the physician for any and all charges incurred by myself and/or dependents.
- I have read and understand the "Consent for Treatment" and "Disclosure of Financial Interest".
- I further acknowledge and understand that I accept the terms outlined in each of the policies.

X_____ _____
Patient or Guardian Signature Date

BayCare
Health System

Electronic Medical Records

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange **(BayCare eHX)** is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your **"health information"**) to the BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you check the **"I DENY CONSENT"** box below, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices: You can fill out this form now or in the future. You have two choices:

☑ **YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

☐ **NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

Printed Name of Patient/Representative	Signature of Patient/Representative	Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: _____

_____

_____

Relationship to Patient: _____