EndoHealth
ENRICHING CHILDREN'S LIVES

GAYATHRI DEVINENI M.D.

PATIENT INFORMATION

Patient Name: Last_____, First_____ Middle Initial____
Gender: _____ Race: _____ Ethnicity: _____ Best contact #: _____ H or C?
Patients Address: _____ City: _____
State: _____ Zip Code: _____ Email: _____
Preferred Pharmacy name and Phone #: _____
Referring Dr and Phone #: _____

INSURANCE INFORMATION

Name of insurance company: _____
Name of the insured (the person the insurance is through): _____
Relationship to patient: _____ Employer: _____ Phone: _____
Patient's Insurance ID #: _____ Insurance Group #: _____
Insured's Date of Birth: _____
*If your insurance does not have a standard copay for a specialist visit, we will collect the standard Co-Insurance amount.

FINANCIAL RESPONSIBILITY

I agree that I am financially responsible for all charges incurred on this account and I assign all insurance benefits to **EndoHealth Atlanta**. **EndoHealth Atlanta** will bill your insurance as a courtesy to the patient. I am responsible for any portion of the account not paid in full by the insurance company. Please note that payment of any co-pay, coinsurance or deductibles or self-pay amounts will be collected at the time of service. IT IS UNDERSTOOD THAT THERE MAY BE ADDITIONAL CHARGES FOR LABORATORY TESTS AND IMAGING TESTS PERFORMED BY PROVIDERS OR ORGANIZATIONS OTHER THAN **ENDOHEALTH ATLANTA** THAT WILL BE BILLED SEPARATELY. Balances left unpaid for longer then 180 days will be turned over for Collections and an addition fee of $35 will be added to this balance.

MEDICATION REFILL POLICY:

All medications need to be requested at the office visit. We handle all medication via E-Script. Rescheduling appointments may cause a lapse in treatment.

PATIENT ACKNOWLEDGEMENT:

The **EndoHealth Atlanta** Notice of Privacy Practices provides information about the privacy right of our patients; and how we may use and disclose protected health information (PHI) about our patients. Federal regulations required that we give our patients or their authorized representative the opportunity to review our Notice before signing this acknowledgement. A copy of our Notice will be made available to you upon request.
May we leave a message regarding appointments or lab results? Yes, or No?
Please list any family member that personal health information may be discussed with:
_____

By Signing below, you acknowledge that you have been provided with notice of the Privacy Practices, and your financial responsibility.

Printed Name of Patient: _____
Signature of Patient: _____ Date: _____

135 Vann St NE, Marietta, GA 30060
Ph:678-829-6030, Fax: 888-813-4517