

F A X

TO: **Practice:** Alabama Digestive Disorders Center
Physician: Smita S. Shah, MD, AGAF
TEL: (256) 882 - 7888 **FAX:** (256) 882 - 7886
WEB: http://www.AlabamaDigestiveDisordersCenter.com

FROM: **Practice:** _____

Physician: _____

Contact: _____

TEL: (____) ____ - ____ **FAX:** (____) ____ - ____

Patient Information (please send all medical records):

Name: _____

Date of Birth: ____ / ____ / ____ **Gender:** _____

Cell: (____) ____ - ____ **Home:** (____) ____ - ____ **SSN:** ____ - ____ - ____

Address: _____

Diagnosis: _____

Date of last Colonoscopy: ____ / ____ / ____ **if done, polyps?** _____

We accept most major insurances. Some exceptions are: **Beechstreet, Champ VA, Essential Staff Care, Fisterv Health, Health Springs, Horizon, Humana, Medicaid, Starbridge, Tricare Prime, VA, VIVA.** ALL Medicare patients must have a secondary plan.

Primary	Secondary	Tertiary
		Insurance Name
		Contract Group From Date
		Name of Insured
		Relationship to Insured DOB

Thank you for referring your patient to Dr. Shah. For same day appointments please call the office at (256) 882-7888. We will contact your patient to notify date, time and place of appointment.

Appointment Information (to be completed by the ADDC office staff):

Physician: Smita S. Shah, MD, AGAF

Appointment Day, Date, Time: _____, ____ / ____ / _____ at ____ : ____ m

The information contained in this facsimile may be privileged and confidential and protected from disclosure. If the reader of this facsimile is not the intended recipient, you are hereby notified that any reading, dissemination, distribution, copying, or other use of this facsimile is strictly prohibited under the Federal HIPAA Privacy Rule. If you have received this facsimile in error, please notify the sender immediately by telephone at (256) 882-7888 and destroy this facsimile. Thank you.