North Suburban Gastroenterology Associates SC

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Written Disclosures

Please let us know if we may LEAVE A PHONE MESSAGE for you by checking one of the following:

__________ The doctors and staff of North Suburban Gastroenterology Associates, S.C. (NSGA), **have my permission** to leave messages regarding my medical condition and/or finances on my answering machine/voice mail/cell phone.

__________ The doctors and staff of NSGA **do not have my permission** to leave messages regarding my medical condition and/or finances on my answering machine/voice mail.

__________ I do not have an answering machine/voice mail.

Please let us know WHOM WE MAY SPEAK TO if you are not available to take our call:

Until further written and/or verbal notice, I ______________________________ **(PRINT patient name)** authorize the people listed below to discuss my medical conditions and finances with NSGA:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Do you have a Power of Attorney for medical and financial decision-making? YES – NO

If YES: Name:______________________________ Contact Number: ____________________

Relationship to patient: ____
Please provide a copy of the Power of Attorney notice for our files

Do you have a Living Will on file? YES – NO
IF YES, who has the authorization to use this document? Name: __________________________

Contact Number: ______________________________ Relationship to patient: ______________

Patient Signature **Date** NSGA Staff Initials/Date
NOT VALID IF NOT SIGNED AND DATED