Associates in Gastroenterology / Associated Endoscopy
Patient Information Form
(Please bring your insurance card, photo ID and a list of your current medications to your appointment)

Patient Information (Please use your legal name on this document)

Last Name_____ First Name_____ M.I.___ M / F

Ethnicity: Caucasian _____ African American _____ Other _____

Social Security Number_____ Date of Birth_____

Address_____ City_____ State_____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone _____

E-mail address _____ Are you a full time student: Yes _____ No _____

Employer Name and Address_____

Spouse Information
Last Name_____ First Name_____ M.I._____

Social Security Number_____ Date of Birth_____

Home Phone_____ Work Phone_____ Cell Phone _____

Employer Name and Address_____

Complete the section below regarding person responsible for insurance coverage:

Primary Coverage: Insurance Name _____

Last Name _____First Name_____ M.I._____

Secondary Coverage: Insurance Name _____

Last Name_____First Name_____ M.I._____

Name of person to contact in the case of an emergency other than spouse:

Name_____ Relationship_____
Phone#_____

Pharmacy of choice (List name and Location)_____Phone#_____
(All new prescriptions and refills of prescriptions will be submitted electronically to your pharmacy)

Who referred you to our practice? _____

Name of your primary care physician: _____

I hereby authorize payment of medical benefits billed to my insurance to Associates in Gastroenterology, LLC or Associated Endoscopy, LLC. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I understand that in the event of default in the payment of any amount due and if this account is placed in the hands of a collection agency or attorney for collection or legal action an additional charge equal to the cost of collection, including the collection agency and attorney fees and any court cost incurred. I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered. I also hereby authorize Associates in Gastroenterology LLC or Associated Endoscopy LLC to leave information or message regarding my care at my home phone number including voice mail or answering service devices.

_____ _____

Signature of patient or guardian *date*

Please turn page over

Associates in Gastroenterology
Associated Endoscopy LLC

[This form is required by the federal government]

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____ , hereby authorize Associates in Gastroenterology,LLC or Associated Endoscopy,LLC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Associates in Gastroenterology,LLC or Associated Endoscopy,LLC can refuse to treat me.

I have been informed that Associates in Gastroenterology,LLC or Associated Endoscopy,LLC has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I have been given a copy of this notice

I understand that I may revoke this consent at any time by notifying Associates in Gastroenterology,LLC or Associated Endoscopy,LLC , in writing, but if I revoke my consent, such revocation will not affect any actions that Associates in Gastroenterology,LLC or Associated Endoscopy,LLC took before receiving my revocation.

I understand that Associates in Gastroenterology,LLC or Associated Endoscopy,LLC has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Associates in Gastroenterology,LLC or Associated Endoscopy,LLC restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Associates in Gastroenterology,LLC or Associated Endoscopy,LLC does not have to agree to such restrictions, but that once such restrictions are agreed to, Associates in Gastroenterology,LLC or Associated Endoscopy,LLC must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____

Printed name of patient or patient's representative

_____

Relationship to the patient

Release of Medical and Billing Information

I, _____, authorize the physicians and staff of Associates in Gastroenterology, LLC or Associated Endoscopy. LLC to release information on file regarding my medical treatment and my medical billing account to the persons listed below:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I understand that by signing this release that designated person(s) above will be able to speak to any member of the medical staff. Furthermore, I understand that these medical practices cannot be held liable for any information the above stated person(s) may obtain regarding my medical and billing information.

Signature of Patient / Guardian _____ Date _____

Witness Signature _____ Date _____

I, _____, do not authorize anyone to have access to my medical and billing information.

Signature of Patient / Guardian _____ Date _____

Witness Signature _____ Date _____