GASTROENTEROLOGY CONSULTANTS, P.A.

PATIENT INFORMATION

Last Name_____ First Name_____ M/F ___Marital Status_____

Address _____City _____ State _____Zip_____

Home Phone_____ Cell Phone_____E-Mail_____

SS#_____-_____-_____D.O.B.____/____/_____Age_____ Race_____ Preferred Language_____Ethnicity_____

Patient's Employer _____Work Phone _____

Spouse's Name _____Spouse's D.O.B._____/_____/_____ Spouse's SS#_____-_____-_____

In Case of Emergency Notify _____ Relationship_____Phone _____

PRIMARY INSURANCE

Name of Insurance _____Policy #_____Group #_____

Insurance Claims Address _____ City _____ State _____Zip _____

Subscriber Name (if not patient) _____ D.O.B._____/_____/_____Relationship_____

Pre-cert Required Yes Telephone#_____ Pre-cert #_____

Contact Person _____ Referral # _____ Primary M.D. _____

SECONDARY INSURANCE

Name of Insurance _____Policy #_____Group #_____

Insurance Claims Address _____ City _____ State _____Zip _____

Subscriber Name (if not patient) _____ D.O.B._____/_____/_____Relationship_____

Pre-cert Required Yes Telephone#_____ Pre-cert #_____

Contact Person _____ Referral # _____ Primary M.D. _____

PLEASE NOTE THAT IT IS YOUR RESPONSIBILITY TO OBTAIN A REFERRAL FORM FROM YOUR PRIMARY DOCTOR BEFORE SEEING OUR DOCTORS. COPAYMENTS ARE REQUIRED BEFORE SERVICES ARE RENDERED (NO EXCEPTIONS)

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO DR. WOLFMAN, HODES, ROSENHECK AND GOLDBERG FOR SERVICES RENDERED BY HIM IN PERSON OR UNDER HIS SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE. I AGREE THAT IF MY ACCOUNT IS REFERRED TO AN OUTSIDE AGENCY OR ATTORNEY FOR COLLECTION, I WILL BE RESPONSIBLE FOR AN ADDITONAL COLLECTION FEE OF 25% OF THE BALANCE OWED. **INITIAL**_____

AUTHORIZATION OF RELEASE OF INFORMATION

I HEREBY AUTHORIZE DRS. WOLFMAN, HODES, ROSENHECK AND GOLDBERG TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATIONS FOR FINANCIAL BENEFITS. **INITIAL**_____

CANCELLATION POLICY

AS A COURTESY, AND IN ORDER TO ACCOMMODATE ALL OF OUR PATIENTS, WE ASK THAT YOU GIVE 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING OF AN APPOINTMENT. A $25.00 FEE WILL BE CHARGED FOR FAILURE TO COMPLY WITH THIS REQUEST. THIS APPLIES TO ALL OFFICE VISITS AND PROCEDURES. **INITIAL**_____

A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL

PATIENT/PARENT/GUARDIAN SIGNATURE:_____DATE:_____