GASTROINTESTINAL ASSOCIATES OF CLEVELAND, P.C.

Date:_____

Patient Name:_____Birthdate:_____ Age:_____
Last First Middle

Address: _____
Street or PO Box City State Zip Code

SSN:_____ Male Female Marital Status S M D W

Employer:_____ Occupation:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Is it okay to leave test results on personal answering machine or voice mail?: Yes No

E-Mail Address: _____

Spouse's Name:_____ Employer:_____

Confidential Communications

Contact Person:_____ Phone Number:_____
Your privacy is important to us. Unless above is completed, we cannot discuss your healthcare, test results or your billing account with anyone other than you.

Emergency Contact Residing at a Different Address

Name:_____ Relationship:_____

Address:_____ Phone:_____
Street City State Zip

Referral Information

Referring Physician:_____

Family Physician:_____

Insurance Information

Primary Insurance:_____ Insured's Name:_____

I.D. No.:_____ Group No.:_____ Birthdate:_____

Secondary Insurance:_____ Insured's Name:_____

I.D. No.:_____ Group No.:_____ Birthdate:_____

Other Insurance:_____ Insured's Name:_____

I.D. No.: _____ Group No.: _____ Birthdate: _____

Welcome: We want to welcome you to our practice and make sure your experience with every aspect of our service meets or exceeds your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or physicians. Listed below are several notices that outline certain responsibilities of ours, and yours. Please read them carefully and sign where indicated that you have read each statement.

General Consent for Treatment: We look forward to treating you as a patient. However, we need your permission for our physicians or nurse practitioners to examine you, provide treatment and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.

I consent to be treated by the doctor or nurse practitioner working on the day of my visit.

Authorization for Release of Information: I hereby authorize Gastrointestinal Associates of Cleveland, PC to release any medical information to my referring physician, my family physician, and my insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time, as it is revoked in writing. I further understand that I can withdraw this consent for release of information at any time except to the extent that action has been taken in reliance hereon.

Assignment of Benefits: I authorize my health insurance benefit plan to pay directly to Gastrointestinal Associates of Cleveland, PC the medical benefits, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charge for those services. I understand I am financially responsible to Gastrointestinal Associates of Cleveland, PC. for charges not covered by this assignment. I understand that if my insurance company does not pay within 90 days, I am responsible for all charges.

Medicare and Medigap, Claim Authorization and Payment Request: I authorize any holder of medical or other information about me, to release to the social security administration and health care financing administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Cost of Collection: In the event this account is unpaid and is turned over to an outside collection agency for collection, I agree to pay the cost of collection (25%) and consent for automated systems to dial my cell phone as a means of collection from the collection agency.

By signing below, I acknowledge that I have read, understand, and agree to the above statements. I have been given the opportunity to ask questions regarding any of the above statements that I do not understand.

_____ _____

PATIENT SIGNATURE **DATE**