

**GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C.
GAINESVILLE ENDOSCOPY CENTER, LLC**

WELCOME TO OUR PRACTICE!!

We are glad you have chosen us to provide your healthcare needs.

PATIENT INFORMATION

PLEASE PRINT

Last Name: _____ First: _____ MI: _____

Sex: _____ Date of Birth: _____ Social Security #: _____

Mailing Address: _____ Physical Address _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

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

Referring Doctor: _____

Race: _____ Marital Status: (circle one) S M W D

Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Nearest Friend or Relative (Not at your address): _____

Relationship: _____ Phone Number: _____

SPOUSE INFORMATION

Last Name _____ First _____ MI _____

DOB: _____ Social Security #: _____

NOTICE OF PRIVACY PRACTICES

I have been notified of the “NOTICE OF PRIVACY PRACTICES” for my records and have had an opportunity to read them.

Date: _____ Initials: _____

**GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C.
GAINESVILLE ENDOSCOPY CENTER, LLC**

ALTERNATIVE CONTACT INFORMATION

I DO DO NOT authorize **GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC** to contact me or leave messages for me at my place of work..

Date: _____ Initials: _____

I hereby authorize **GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC** to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are available. The laboratory results are **NEVER** left on the answering machine. I realize that I must call the office to get them. Please allow 5 business days for test results.

Date: _____ Initials: _____

I DO DO NOT authorize **GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC TO DISCUSS MY APPOINTMENTS, MEDICAL EVALUATION, TREATMENT, AND RESULTS TO RELATIVES OR OTHER PERSONS AS INDICATED, INCLUDING RECEIVING COPIES OF MY MEDICAL RECORD IF REQUESTED:**

Authorized person(s)/relationship: _____

FINANCIAL AGREEMENT

I request that payment of authorized benefits be made to **GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC**. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.

Date: _____ Signature: _____

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC** for all medical and/or surgical benefits including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to **GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC** by any insurance policy, self-insurance program or other benefit plan. I understand that if an overpayment results in a credit balance to either entity, that the credit will first be applied to any outstanding balance to the other entity before being refunded to me.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

PERSON PROVIDING THE AUTHORIZATION:

DATE:

RELATIONSHIP TO PATIENT IF NOT:

GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C.
GAINESVILLE ENDOSCOPY CENTER, LLC

FINANCIAL POLICY

- **We participate in most insurance plans, including Medicare.**
 1. It is your responsibility to check with your plan prior to your visit to make sure we are participating physicians. Failure to do this could result in reduced payments by your insurance company.
 - 2. We do not file automobile, general liability, homeowner's or workman's compensation insurance.**
 3. If you have HMO/POS insurance, it is **your responsibility to obtain a referral number** from your PCP prior to being seen. If you fail to obtain this, the bill is your responsibility.

- **You and your insurance company are responsible for your bill.**
 1. We realize that insurance requirements are confusing, but knowing your insurance benefits is your responsibility.
 2. Any questions concerning your coverage should be directed to your insurance company.
 3. We will file secondary insurance but if the secondary insurance denies payment, you are responsible for the balance.

- **If your primary insurance company requires a co-payment, you must make the co-payment at the time of service.**
 1. Failure to pay your co-pay at the time of service will result in a **billing fee of \$25.00**. *Please remember that we are contractually obligated by your insurance company to collect your co-pays at time of service.*
 2. The balance of your charges will be billed to your insurance company. After payment of insurance company, any remaining balance will become patient responsibility which is due upon receipt of statement.
 3. If payment of any service results in a credit balance on either entity, the credit balance will first be applied to any outstanding balance you have before being refunded to you.

- **Proof of current, valid insurance must be provided at time of service.**
 1. If you do not provide this information, you will be considered a self-pay patient.
 2. Self-pay patients are required to pay their office visit charges in full. *Please ask about your advance payment responsibility when making your appointment.*
 3. Failure to pay your office visit charges at the time of service will result in a billing fee of \$25.00.
 4. You will be billed for the balance of your charges. Payment in full will be expected with receipt of your statement.

- **Failure to receive your statement does not relieve you of your financial obligation. It is your responsibility to notify us of any changes in you billing information.**

- **We accept cash, checks, money orders, and major credit cards.**
 1. Returned checks are subject to a \$25.00 return check fee.

- **Past due accounts are subject to our collections process and any fees assessed by a collection agency.**

Patient Signature (or responsible party)

Date