Commonwealth Endoscopy Center

PATIENT INFORMATION CONFIDENTIAL

(PLEASE PRINT)

DATE _____

NAME _____ (FIRST MI LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE _____ E-MAIL _____ SOCIAL SECURITY NO. _____ - _____ - _____

CHECK APPROPRIATE BOX: O MINOR O SINGLE O MARRIED O DIVORCED O WIDOWED O SEPARATED

RACE: O ASIAN O OTHER PACIFIC ISLANDER O BLACK/AFRICAN AMERICAN

O AMERICAN INDIAN/ALASKAN NATIVE O WHITE O MORE THAN 1 RACE O REFUSE TO REPORT

ETHNICITY: O HISPANIC/LATINO O NOT HISPANIC/LATINO O REFUSE TO REPORT

PREFERRED LANGUAGE: _____

NAME OF INSURANCE: _____ INSURANCE ID# _____

SUBSCRIBER NAME AND DOB _____

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

PRIMARY CARE PHYSICIAN _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

CELL _____

PHARMACY NAME AND ADDRESS _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. Stern, Dr. Finklestein, Dr. Salomons, Dr. Slye, Dr. Teixeira, Dr. Prodanovic, Dr. Stone, Gastrointestinal Specialists (GIS) or Commonwealth Endoscopy Center (CEC) for services rendered by the Gastrointestinal Specialists Group or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Stern, Dr. Finklestein, Dr. Salomons, Dr. Slye, Dr. Teixeira, Dr. Prodanovic and Dr. Stone to use or disclose my medical or incidental information, which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while this consent is voluntary if I refuse to sign this consent Gastrointestinal Specialists or Commonwealth Endoscopy Center can refuse to treat me.

MEDICARE - MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. I have received a copy of the Notice of Privacy Standards ("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 understand that I may revoke this consent at any time by notifying GIS/CEC, in writing, but if I revoke my consent, such revocation will not affect any actions that GIS/CEC took before receiving my revocation. I understand that GIS/CEC 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 GIS/CEC restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that GIS/CEC does not have to agree to such restrictions, but that once such restrictions are agreed to, GIS/CEC must adhere to such restrictions.

A photocopy of these assignments shall be valid as the original.

PATIENT _____ DATE _____

PARENT/GUARDIAN _____ RELATIONSHIP TO PATIENT _____