SYRACUSE GASTROENTEROLOGICAL ASSOCIATES, P.C.

MUST BE FILLED OUT YEARLY FOR BILLING

Appointment Date: _____ Sex: ☐ M ☐ F (maiden name_____)

Name (FIRST)_____ (LAST)_____ (Middle)_____ Date of Birth _____

Address _____ SSN _____

City _____ State _____ Zip code _____ County _____

Home Telephone # _____ Cell Phone _____ Work Phone _____

For access to our patient portal, PLEASE PRINT your email address: _____

Preferred contact method: ☐Home ☐Cell ☐Work ☐Email thru the portal ☐Mail

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Partner ☐Other

Race (circle one): White - American indian/Alaskan Native - Asian - Black/African American - Native Hawaiian - More than one race - Unreported/Declined

Ethnicity (circle one): Hispanic or Latino - Not hispanic or Latino - Unreported/Declined **LANGUAGE** _____

DO YOU NEED AN INTERPRETER? ☐Yes ☐No

Other doctors:

Primary Care MD: _____ Address:_____ Phone:_____

Referring Doctor: _____ Address:_____ Phone:_____

Emergency Contact:

Name: _____ Relationship _____ Sex: ☐ M ☐ F

Home Telephone #:_____ Cell Phone _____Work Telephone #: _____

Insurance Information:

1. Primary Insurance Name: _____ ID#: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscribers Employer _____ Relationship to subscriber _____ Group #: _____

Claims address _____ Phone _____

2. Secondary Insurance Name: _____ ID#: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscribers Employer _____ Relationship to subscriber _____ Group #: _____

Claims address _____ Phone _____

3. Other insurance (if applicable): _____ ID#: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscribers Employer _____ Relationship to subscriber _____ Group #: _____

Claims address _____ Phone _____

PLEASE TURN OVER

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

ALL PATIENTS:

1. STATEMENT TO AUTHORIZE PAYMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private insurance, and any other health plan to Syracuse Gastroenterological Associates, P.C. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid or allowed by insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event my account is assigned for collection, I agree to pay all costs of collection including reasonable attorney fees.

PATIENTS SIGNATURE _____ DATE : _____

2. I acknowledge that I am aware that I can be held personally responsible for payment of some or all medical expenses incurred for services at or ordered by Syracuse Gastroenterological Associates, PC.
I have been given the option of rescheduling my appointment for a later date if I elect not to be seen today.

I UNDERSTAND AND AGREE TO PAY FOR ALL SERVICES PROVIDED THAT MAY NOT BE A PAID BENEFIT UNDER MY HEALTH INSURANCE POLICY FOR ONE OF THE REASONS OUTLINED BELOW.

1. An insurance referral was not received from the Primary Care Provider
2. I do not have health insurance
3. The service may not be deemed medically necessary
4. The service is not a covered benefit under the terms of my insurance contract
5. Service(s) applied toward deductible
6. Prior authorization was not obtained for my procedure (and/or any related charges).
7. Prior authorization was not obtained for any outside testing, radiology, labs, or referrals to another doctor.
8. Co-payments and non-covered services are expected at the time of service.

This waiver will stay in effect until such time I terminate treatment with Syracuse Gastroenterological Associates, P.C. by written letter.

PATIENTS SIGNATURE _____ DATE : _____

3. I AM AWARE THAT THE OFFICE HAS NO SHOW/LATE CANCELLATION POLICIES:

1. Office visit appointments require 1 business day prior notice or you may be charged a fee of $30.00.
2. Appointments scheduled at our Endoscopy suite (Syracuse Endoscopy Associates) require 3 business days prior notice or you may be charged a fee of $150.00.
3. Capsule Endoscopies require 3 business days prior notice or you may be charged a fee of $150.00.

PATIENTS SIGNATURE _____ DATE : _____

MEDICARE PATIENTS PLEASE SIGN: STATEMENT OF AUTHORIZATION FOR PAYMENT OF MEDICARE BENEFITS. I certify that the information by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carrier, any information about me to process my Medicare claim. I request that payment under the Medical Insurance Program be made to Syracuse Gastroenterological Associates, P.C. for services rendered to me during the period of my treatment or lifetime.

MEDICARE BENEFICIARY SIGNATURE _____ DATE : _____