AKRON DIGESTIVE DISEASE CONSULTANTS, INC.

E. J. Esber, M.D. A. Venkat, M.D. C. H. Kefalas, M.D. W.F. Shaheen, M.D. G.Veerappan, M.D.

Patient Information

Last Name________________________ First Name____________________ Middle Initial_____

Address_______________________________ City, State, Zip_____________________________________

Birth Date ___/___/_____ Age_____ Sex: M___ F___ Marital Status_________ Student: Yes____ No____

Home Phone #___________________ Work Phone #____________________________

Cell Phone # ____________________________ Email:____

Social Security # _________________________

Occupation_____________________________________ Employer______________________________________

Primary and/or Referring Physician:_______________________________ Pharmacy:_________________________

Do you have a Living Will? __________ Do you have a Power of Attorney? ____________

If you have either, please provide us a copy. If you need a blank form, let us know.

If Insurance provided by Someone else, provide the following: Name_____________________________________

Occupation_________________________ Employer_______________________________

Birth Date_____________ Social Security #____________________________

Insurance Information

Primary Insurance Company____

Name of Insured: ________________________________ Relationship to patient: Self____ Other_______________

Secondary Insurance Company____

Name of Insured: ________________________________ Relationship to patient: Self____ Other_______________

Authorization for Treatment, Assignment of Benefits and Information Release,:

I hereby request and consent to treatment and services reasonable and proper by today's standards provided by Akron Digestive Disease Consultants, Inc. and authorize payment directly to the physician of medical benefits, if any, otherwise payable to me by Medicare or other insurance companies for his/her services and I assume responsibility for any unpaid balance including non-covered services except as limited by law. I also hereby authorize the physician to release any information to the Health Care Financing Agency or its agent, to third party payers and anyone assisting the provider in obtaining payment including billing, coding and collection agents, provider's attorney, consultants, and to my insurance company as required in the course of my examination or treatment. This authorization will remain in effect until revoked by me in writing.
I reviewed and accept the authorization, assignment and information release.

Signed (Patient or Representative)____ Date_______________

ADDC 06.17.13