

THE GASTROENTEROLOGY GROUP, INC.

M. Shill, M.D.

S. Fulton, M.D.

R. Gacad, M.D.

R. Salvino, 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 # _____

Social Security # _____ Cell Phone # _____

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 Spouse:

Spouse's Name _____ Employed Full time ___ Part time ___ Retired ___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Birth Date _____ Spouse's 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 The Gastroenterology Group, 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 _____