Digestive
MEDICINE ASSOCIATES, LLP

PATIENT INFORMATION FORM

Patient Full Name: _____ Sex: Female □ Male □

Date of Birth: _____ Social Security #: _____

Address: _____

_____

House Phone: _____Cell Phone: _____

Email: _____

Marital Status: _____ Race: _____ Ethnicity: _____

Primary Care Physician: _____ Phone #: _____

Referring Doctor: _____

Emergency Contact: _____ Phone #: _____

Insurance Name: _____ Policy #: _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Digestive Medicine Associates to disclose my protected health information to:

Name: _____ Relation: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize payment directly to Digestive Medicine Associates of benefits due to me from my Insurance Company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s) and to any Healthcare provider involved in my treatment upon written or oral request of such provider. A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim.

I understand that I am fully responsible for the payment of all charges that are not covered and paid for by the insurance. I further understand that I shall be wholly responsible for all collection charges. This includes Court cost reasonable attorney fees incurred in any attempts to collect delinquent unpaid charges and all charges shall accrue interest at the rate of eighteen percent (18%) per annum from the initial billing date:

Patient's Signature: _____ Date: _____