

# PATIENT INFORMATION

## DIGESTIVE DISEASE CONSULTANTS

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PATIENT'S NAME: (Last, First, Mid. Int.)			REFERRING PHYSICIAN		
PATIENT'S ADDRESS: (Street)					
(CITY, STATE, ZIP)					
SOCIAL SECURITY NUMBER		PATIENT'S DATE OF BIRTH		AGE	HOME PHONE NUMBER
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		RACE	MARITAL STATUS	OCCUPATION	CELL PHONE NUMBER
PATIENT'S EMPLOYER				EMPLOYER'S ADDRESS	
EMPLOYER'S PHONE NUMBER			EXTENSION		
E-MAIL ADDRESS					

SPOUSE'S NAME			SPOUSE'S SOCIAL SECURITY NUMBER		
SPOUSE'S EMPLOYER			SPOUSE'S DATE OF BIRTH		
SPOUSE'S EMPLOYER'S TELEPHONE			SPOUSE'S OCCUPATION		

### INSURANCE

PRIMARY INSURANCE		ID #:		GROUP #:	
COMPLETE ADDRESS OF PRIMARY INS. CO. AND TELEPHONE NUMBER					
SECONDARY OR ANY OTHER INSURANCE POLICY		ID #:		GROUP #:	
COMPLETE ADDRESS OF SECONDARY INS. CO. AND TELEPHONE NUMBER					

WHOM MAY WE CONTACT IN THE CASE OF AN EMERGENCY?			PHONE #:		
NEAREST RELATIVE NOT LIVING WITH YOU:			PHONE #:		
NEAREST FRIEND NOT LIVING WITH YOU:			PHONE #:		

PHARMACY NAME:	PHARMACY NAME ADDRESS:		PHONE #:
PHARMACY NAME:	PHARMACY NAME ADDRESS:		PHONE #:
PHARMACY NAME:	PHARMACY NAME ADDRESS:		PHONE #:

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**AUTHORIZATION FOR RELEASE OF INFORMATION:** THE UNDERSIGNED HEREBY AUTHORIZES SAID PROVIDER TO RELEASE ALL INFORMATION PERTAINING TO THE ABOVE SAID PATIENT'S TREATMENT TO HIS/HER INSURANCE COMPANY OR COMPANIES.

**AUTHORIZATION FOR PAYMENT:** I HEREBY AUTHORIZE THAT PAYMENT BE MADE DIRECTLY TO THE PROVIDER OF SERVICES.

I UNDERSTAND AND AGREE THAT, (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ON BOTH SIDES OF THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES TO THE ABOVE INFORMATION.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## FINANCIAL ARRANGEMENTS AND INSURANCE

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. IF YOU HAVE MEDICAL INSURANCE, WE ARE ANXIOUS TO HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS. IN ORDER TO ACHIEVE THESE GOALS, WE NEED YOUR ASSISTANCE, AND YOUR UNDERSTANDING OF OUR PAYMENT POLICY.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE BY OUR STAFF. (MEDICARE PATIENTS WOULD BE RESPONSIBLE FOR THE 20%, AND THEIR DEDUCTIBLE. MANAGED CARE PLAN PATIENTS ARE RESPONSIBLE FOR THEIR CO-PAYS/DEDUCTIBLES AND NON COVERED SERVICES). WE ACCEPT CASH, CHECKS, MASTERCARD, OR VISA. WE WILL BE HAPPY TO FILE YOUR INSURANCE AS A COURTESY TO YOU FOR YOUR REIMBURSEMENT. IN SPECIAL INSTANCES WE MAY ACCEPT ASSIGNMENT OF INSURANCE BENEFITS.

PLEASE NOTIFY US WITHIN 24 HOURS IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT. YOU MAY BE SUBJECT TO A \$25.00 CHARGE IF YOU DO NOT CANCEL WITHIN 24 HOURS.

RETURNED CHECKS WILL BE SUBJECT TO AN ADDITIONAL FEE OF \$45.00.

YOU MUST REALIZE, HOWEVER, THAT:

1. YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT.
2. OUR FEES ARE GENERALLY CONSIDERED TO FALL WITHIN THE ACCEPTABLE RANGE BY MOST COMPANIES, AND THEREFORE ARE COVERED UP TO MAXIMUM ALLOWANCE DETERMINED BY EACH CARRIER. THIS APPLIES ONLY TO COMPANIES WHO PAY A PERCENTAGE (SUCH AS 50%, OR 80%) OF "U.C.R.". "U.C.R." IS DEFINED AS USUAL, CUSTOMARY AND REASONABLE FEES FOR THIS REGION. THUS, OUR FEES ARE CONSIDERED USUAL, CUSTOMARY AND REASONABLE BY MOST COMPANIES.
3. NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL CONTRACTS. SOME INSURANCE COMPANIES ARBITRARILY SELECT CERTAIN SERVICES THEY WILL NOT COVER.

WE MUST EMPHASIZE THAT AS MEDICAL PROVIDERS, OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY (EXCEPT THE MANAGED HEALTH CARE PLANS). WHILE THE FILING OF INSURANCE CLAIMS IS A COURTESY THAT WE EXTEND TO OUR PATIENTS, ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE THE SERVICES ARE RENDERED. WE REALIZE THAT TEMPORARY FINANCIAL PROBLEMS MAY AFFECT TIMELY PAYMENT OF YOUR ACCOUNT. IF SUCH PROBLEMS DO ARISE, WE ENCOURAGE YOU TO CONTACT US PROMPTLY FOR ASSISTANCE IN THE MANAGEMENT OF YOUR ACCOUNT.

IF YOU HAVE ANY QUESTIONS ABOUT THE ABOVE INFORMATION OR ANY UNCERTAINTY REGARDING INSURANCE COVERAGE, PLEASE DON'T HESITATE TO ASK US. WE ARE HERE TO HELP YOU.