

Michiana Endoscopy Center- Initial Patient Information

Last Name _____ First Name _____ M.I. _____

Home Address _____ City _____ Zipcode _____

Home Phone _____ Work Phone _____ Marital Status: M D S W

Employer Name and Address _____

Social Security Number _____ Date of Birth _____ Sex _____ (M/F)

Have you ever seen: Dr. O'Dea ___ Dr Mathis ___ Dr Mark ___ Dr Gilliam ___ Dr Manbeck ___ Dr Patel ___

Referring Doctor _____ Reason for Visit _____

Primary Insurance

Company Name and Phone Number _____

Billing Address _____

Name of Insured and Relation to Patient _____ Insured Date of Birth _____

Insured's ID Number _____ Group Number _____ Employer _____

Secondary Insurance

Company Name and Phone Number _____

Billing Address _____

Name of Insured and Relation to Patient _____ Insured Date of Birth _____

Insured's ID Number _____ Group Number _____ Employer _____

Name and Phone Number of person to

Contact in the case of an emergency _____ Relationship _____

You are responsible for obtaining precertification from your insurance company. **PLEASE NOTE:** We will bill your Medicare/Insurance for today's facility charge. We will also forward your insurance information so they can bill for the physician's charge. You will be receiving two (2) bills (facility and physician) for this procedure.

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.

I will pay by (check one) cash check credit card.

Signature of Patient or Guardian

Date

Please turn page over

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize Michiana Endoscopy Center to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. Michiana Endoscopy Center may also obtain any information about me, which is needed to treat me, from other persons or healthcare facilities that have provided medical care to me. I understand that while this consent is voluntary, if I refuse to sign this consent, Michiana Endoscopy Center can refuse to treat me.

I have been informed that Michiana Endoscopy Center has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying The Privacy Officer of Michiana Endoscopy Center, in writing, but if I revoke my consent, such revocation will not affect any actions that Michiana Endoscopy Center took before receiving my revocation.

I understand that Michiana Endoscopy Center has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Michiana Endoscopy Center restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Michiana Endoscopy Center does not have to agree to such restrictions, but that once such restrictions are agreed to, Michiana Endoscopy Center must adhere to such restrictions.

Consent for Testing: I consent to have my blood tested for Hepatitis B and HIV (Aids Virus) in those instances where a health care worker has an accidental exposure to my blood and/or body fluids. The test results will be noted in my medical record. I understand that I will not be charged for these tests. I will be informed of any positive results and offered counseling. I understand that the results of these tests are confidential and will not be shared with anyone, except my physician and others, as specified by law, without my written consent.

Assignment of Insurance Benefits: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Michiana Endoscopy Center, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature authorizes release of medical information necessary to pay the HCFA-1500 form, or elsewhere, my signature authorizes releasing of assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare Carrier. A copy of this signature should be as valid as the original.

_____ Initial

I authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Michiana Endoscopy Center, LLC. I understand I am financially responsible for any balance owed at any time. I also agree that if Michiana Endoscopy Center, LLC employs an attorney or collection agent to assist in the collection of any sum due from me for services rendered, that I will pay the reasonable fees of such attorney or agent and all court costs and expenses related thereto to the extent permitted by law. A copy of this signature shall be as valid as the original.

**Signature of patient or patient's representative
(Form MUST be completed before signing.)**

Date

Printed name of patient or patient's representative

Relationship to the patient