GASTROINTESTINAL ASSOCIATES OF ROCKLAND
PATIENT INFORMATION FORM

Patient Name:	**M F Age:**
	Date of Birth:
Street Address	**SS#**
	Home Phone:
City, State, Zip:	**Work Phone:**
Race: **Ethnicity**	
Language:	**Cell Phone:**
	E-mail:

Primary Insurance	
ID# **Group#**	
Policy Holder Name if Different from Above:	**Policy Holder Employer:**
Policy Holder Date of Birth:	**Policy Holder SS#**
Policy Holder Relation to Patient:	**Policy Holder Employer:**
Secondary Insurance:	
ID# **Group#**	**Policy Holder SS#**
Policy Holder Name if Different from Above:	**Policy Holder Date of Birth:**

Responsible Party's Name (Last, First, Middle)	**M F** **Legal Representative Y N**
Responsible Party's Address	**Relationship to Patient?** **Spouse Parent Guardian**
City **State** **Zip**	**Other:**_____
Phone:	
Primary Care Physician:	
Any other physician you would like your reports sent to?	
Preferred Pharmacy:	

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a precentage of the charge. It is your responsibility to pay any deductable amount, coinsurance or any other balance not paid for by your insurance.

If your insurance requires a written referral from your physician and you do not obtain one prior to your visit or procedure, you will be responsible for payment for services rendered.

COPAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED.

If this account is assigned to any attorney of collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and third party plans to the practice named on this form.

I AGREE TO THE ASSIGNMENT AND FINANCIAL RESPONSIBILITIES SHOWN ON THIS PAGE.

Signature of Patient/Responsibility Party **Date**

Type of photo ID presented (if license check)_____. No Photo ID Available_____.