Patient's Name

Last :_____

First: _____

Date: _____

7 Hill Gastroenterology, PA
3256 S. Pine Avenue Ocala FL. 34471
Office: (352) 401-1919
Fax: (352) 401-1870

MEDICARE/INSURANCE INFORMATION

DO YOU HAVE MEDICARE/MEDICAID INSURANCE? (CIRCLE ONE) YES NO

IF YES, WHAT IS YOUR MEDICARE/MEDICAID NUMBER? _____

IF NO, DO YOU HAVE ANOTHER INSURANCE CARRIER? (CIRCLE ONE) YES NO

NAME OF YOUR INSURANCE CARRIER _____

INSURANCE CARRIER ADDRESS _____

GROUP # _____ **ID#** _____

SUBSCRIBER'S NAME: _____ **DOB:**_____ **SSN:** _____-_____-_____

DO YOU HAVE A SECONDARY INSURANCE CARRIER?_____

INSURANCE CARRIER ADDRESS _____

GROUP # _____ **ID#** _____

SUBSCRIBER'S NAME: _____ **DOB:**_____ **SSN:** _____-_____-_____

DOES YOU INSURANCE REQUIRE PRE-ADMISSION CERTIFICATION? (CIRCLE ONE) YES NO

IF YES, PLEASE PROVIDE US WITH THE TELEPHONE NUMBER (_____**)** _____- _____

Medicare Law requires that we determine if your medical services might be covered by another insurer. In order to assist us in correct billing procedures, please answer the following questions:

1. **Is your illness due to:**
   - **A. A work-related accident/condition? YES NO**
   - **B. An automobile accident? YES NO**
   - **C. The fault of another party? YES NO**
2. **Are you eligible for coverage under the Veterans Administration? YES NO**
3. **Are you a student: YES NO If yes, are you a Full-Time Student? YES NO**
4. **Are you employed? YES NO**
   - **If "Yes", provide employer's name** _____
   - **Employers address** _____
   - **Employer's phone:** _____
   - **If "No", please provide date of retirement if applicable:** _____

Patient's Name

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MEDICARE/INSURANCE INFORMATION (CON'T)

5. **Is your spouse employed? YES NO**

If "Yes", please provide us with your spouse's name: _____

Spouse's Employer's Name: _____

Spouse's Employer's Address: _____

If "No", please provide date of retirement if applicable: _____

***PLEASE READ CAREFULLY In consideration for services rendered by 7 Hill Gastroenterology, P.A., I hereby agree to release the information requested, as needed, by my Insurance company and assign insurance benefits to 7 Hill Gastroenterology, P.A.. I further agree to be solely responsible for any balances my insurance carrier does not pay.**

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT.

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

I request that payment of authorized Medicaid benefits be made on my behalf to 7 Hill Gastroenterology, P.A. for any services rendered by 7 Hill Gastroenterology, P.A.

SIGNATURE: _____ **DATE:** _____

PROTECTING YOUR MEDICAL HEALTH INFORMATION: **Please list the names of family members, and/or friends with whom we may share your medical information and/or lab results. DUE TO PRIVACY LAWS, WE WILL NOT GIVE ANY INFORMATION TO ANYONE WHO IS NOT ON THIS LIST!**

PLEASE LIST THE PEOPLE WE MAY CALL WITH YOUR MEDICAL INFORMATION:

NAME:_____ **PHONE:(____)**_____

NAME:_____ **PHONE:(____)**_____

NAME:_____ **PHONE:(____)**_____

MAY WE MAIL INFORMATION TO YOU? YES NO **MAY WE LEAVE A MESSAGE ON YOUR PHONE?** YES NO

NOTIFICATION OF TEST RESULTS: **Pleas call our office if you have not been notified of a test result by 14 days from date of having test performed.**

YOUR SIGNATURE: _____ **DATE:**_____