Eisenman & Eisenman M.D.
ADVANCED GASTRO CONSULTANTS
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PATIENT CONSENT FOR TREATMENT

I, _____, understand that as part of my health care, Eisenman & Eisenman, M.D., Advanced Gastro Consultants LLC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for the future care or treatment.

TREATMENT CONSENT: I hereby give consent to Eisenman & Eisenman, M.D., Advanced Gastro Consultants, to examine, treat and perform diagnostic tests and office procedures that the provider deems necessary. I authorize you to view my prescription history from external sources in order to facilitate appropriate medication orders and reconciliation. In understand that communication between interdisciplinary healthcare providers is a necessity for quality of care and information may be requested from other providers that I have seen.

REASON OF RESPONSIBILITY: I understand that if I leave the practice without the consent of the physician and/or fail to carry out instructions for follow-up care: I do so at my own responsibility. I further understand that any injury or harm I may suffer while away from Eisenman & Eisenman, M.D., Advanced Gastro Consultants, will be my responsibility.

Initial: _____

PATIENT FINANCIAL POLICY

The following is a statement of our financial policy. Please read and sign this document prior to your treatment. In addition, we kindly ask that you complete our Patient Registration form, including insurance billing information, before you are seen.

1. New patients who have insurance are expected to pay their coinsurance or co-pay responsibility the date they are seen. If their deductible has not been met, they are expected to pay in full up to the amount of their deductible at the time of service.

2. If you are a member of an HMO or PPO with which we participate, your co-pay or coinsurance is payable at time of treatment. If you belong to an HMO, you must have a referral before we can provide any services to you. It is your responsibility to obtain that referral from your Primary Care Physician. If you do not have a valid referral at the time of your appointment, you will have to be rescheduled.

3. Established patients with outstanding balances are expected to pay their balance in full before they are seen or treated for any routine services. No elective diagnostic or treatment procedure will be done for patients whose balance exceeds $100.00. In the event of financial hardship, we are able to make special payment arrangements with you.

4. Patients who were originally seen by one of our physicians in the hospital, and who came to our office for follow-up services are expected to provide accurate insurance information, and are responsible for referrals, co-payments, and coinsurance at the time of your appointment.

5. Patients may pay by: cash, check, MasterCard, American Express, Visa or Discover. Patients whose checks are returned to us for non-sufficient funds will be fined a $25 returned check fee and will have to pay the balance due by cash, credit card, or money order.

6. Patients who do not pay their balance or establish a pattern of steady payments within 90 days of the date they were first billed, or after the receipt of 3 statements from our office, may be sent to a collection agency on our behalf.

7. Patients whose accounts have been sent to a collection agency will be discharged from our practice and will no longer be able to be seen. Exceptions will only be made if collection balance is paid.

8. Co-pays and/or coinsurance will apply to your follow up appointments

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS.

_____ _____

PATIENT'S SIGNATURE DATE

_____

PRINTED NAME OF PATIENT

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