GASTROENTEROLOGY GROUP, INC.

M. SHILL, M.D. S. FULTON, M.D. R. GACAD, M.D. J. GELLIS, D.O. DANA GOODYEAR, APRN-CNP

Patient Information

Last Name_____ First Name_____ Middle Initial_____

Address_____ City, State, Zip_____

Birth Date____/____/____ Sex____ Marital Status_____ Social Security #_____

Email_____

Home Phone #_____ Work Phone #_____ Cell Phone#_____

Circle best number to reach you at

Primary and/or Referring Physician_____ Pharmacy/Location_____

Occupation_____ Employer_____

Do you have a Living Will? Y / N Do you have a Power of Attorney? Y / N

If you have either, please provide us a copy. If you need a blank form, let us know.

Insurance Information

Primary Insurance Company_____

Secondary Insurance Company_____

Authorization for Treatment, Assignment of Benefits and Information Release:

I hereby request and consent to treatment and services reasonable and proper by today's standards provided by Gastroenterology Group, Inc. and authorize payment directly to the physician of medical benefits, if any, otherwise payable to me by Medicare or other insurance companies for his/her services and I assume responsibility for any unpaid balance including non-covered services except as limited by law. I also hereby authorize the physician to release any information to the Health Care Financing Agency or its agent, to third party payers and anyone assisting the provider in obtaining payment including billing, coding and collection agents, provider's attorney, consultants, and to my insurance company as required in the course of my examination or treatment. This authorization will remain in effect until revoked by me in writing. I reviewed and accept the authorization, assignment and information release.

Signed (Patient or Representative) _____ Date_____

TGG 10.23.19