WELCOME TO

GASTROENTEROLOGY SPECIALISTS OF FREDERICK, P. A.

www.frederickgi.com

Patient's name: ______________________________ Today's date: ____________

Address: ____

City: ____________________ **State:** __________ **Zip Code:** ____________

Mailing address if different from physical address:______________________________

Phone #'s: Home: ________________Work: ________________Cell: ________________

E-mail address: ____

Last 4 digits of SS# __________Date of Birth: ______________ Age: _______

Please CIRCLE: Male/Female /Other Married/Single/Divorced/Separated/Widowed

Patient's occupation: ____________________ Employer: ______________________________

Employer's address: ______________________________ Emp phone: ______________

Your Primary Care Physician: ________________ Other important physicians: ________________

Who Referred You? ______________________________

IN CASE OF EMERGENCY, PLEASE NOTIFY: ______________________________

Relationship: ____________________Address:______________________________

Home/Work/Cell phone: ______________________________

Other close relative/friend who does not live with you (Name, Address, Phone) ______________________________

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If patient has a Power of Attorney, please notify the doctor.

If you do not have insurance, please be prepared to discuss payment options.

OVER **OVER** **OVER**

AUTHORIZATION

This is an authorization for Providers at Gastroenterology Specialists Of Frederick (GSOF) to apply for benefits on my behalf. I request that any payments for services rendered to me under any insurance plan, Medicare, Medical Assistance, etc. be made directly to Gastroenterology Specialists of Frederick, P.A. until such time that I revoke this authorization in writing. I further authorize the release of any medical information for any claim to my insurance carrier that may be transmitted electronically.

I authorize Providers of Gastroenterology Specialists Of Frederick (GSOF) to send a letter to my referring physician or healthcare provider summarizing his/ her findings, treatment, and recommendations. I further authorize any and all communication between GSOF and my health care providers to facilitate optimal patient care when felt to be in my best interest. I understand that I need to complete a formal "Release of Information" form for my chart to be copied and forwarded to another health care provider. A charge may apply for copying of records. I may be contacted with appointment reminders, replies to inquiries, messages regarding test results or treatment, via answering machine or voicemail messages, letters, or email.

**If my family (spouse, parents, siblings, adult children) should inquire about my medical care, treatment issues, etc., I authorize such communication if providers at GSOF feel such to be in my best interest. WRITE BELOW NAME OR PERSONS, IF ANY, THAT YOU WISH INFORMATION <u>WITHHELD</u> FROM.

I acknowledge that I am responsible for payment of the total bill incurred. I promise to pay my bill in a timely manner as determined by Gastroenterology Specialists of Frederick, P.A. and/our office policy. We require ALL COPAYS OR DEDUCTIBLES be paid at the time of service. I acknowledge and accept financial responsibility for any and all expenses, direct and indirect, related to collection of my financial obligation, including court costs, attorney fees, collection agency fees, rebilling and administrative fees, loss of wages/salary, etc. **I may be held financially responsible for office appointments not canceled with at least <u>2 full business days</u> notice ($50) and procedure appointments not canceled with at least <u>5 full business days</u> notice ($100). I understand that my insurance company will not pay this fee.**

I understand that Providers at GSOF may recommend further testing, procedures, future appointments, consultations with other healthcare providers, treatments, etc. I accept full and complete responsibility if I fail to obtain such recommended testing, procedure(s), consultations, follow-up evaluations, etc., or fail to follow recommendations and advice from Providers at GSOF. I release Providers at GSOF and their staff from any consequences that may result.

I understand I should not take any medication if there is any possibility that I may be or could become pregnant without discussing with Providers at GSOF as such could seriously harm my unborn child. Likewise, if there is any possibility that I could be pregnant at the time of an X-ray examination or any other examination, test, or procedure, I need to inform Providers at GSOF. I accept any and all responsibility if I fail to take appropriate precautions or so fail to inform Providers at GSOF. **Prescriptions will be refilled during regular business hours; please allow 48-hours notice.**

I understand it is the policy of Providers at GSOF's to generally acknowledge all testing and lab results, pathology reports, etc. If I should not receive such an acknowledgment within a reasonable amount of time, generally 14 days, I understand that it is my responsibility to contact the office to verify that results were received.

I understand and agree to the above, which shall remain in effect until revoked in writing. I may request a copy of this Authorization.

Signature of patient/responsible party: ____

Date: ____