Associated Gastroenterologists of Central New York, P.C.

FOR OFFICE USE ONLY:
Account Number

(Please Print)

PLEASE FILL IN "ALL" INFORMATION

Date:

Patient's Name:			Social Security #	
Local Address Street:		City:		Zip:
Date of Birth:	Age:	Phone:	Work:	Mobile:
Sex: ☐M ☐F	Marital Status: ☐S ☐M ☐Div. ☐Wid.	If patient is under "21", give name of parent or guardian and address:		
Employer of patient:		Address:		Phone:
Spouse's Name:		Spouse's Employer:		Phone:
Emergency Phone Number:		Name:		
Referring Physician:				

Please list your insurance in the order it should be billed	Subscriber's Name & Subscriber's Employer	Social Security #	Birth Date
Insurance:			
ID #:			
Insurance:			
ID #:			
Insurance:			
ID #:			

☐ I have already completed an advance directive in the form of the following: (check all that apply)
☐ health care proxy ☐ living will ☐ Do Not Resuscitate order (DNR)

☐ I am interested and would like to discuss the issue.

☐ I am not interested in talking about advance directives at this time.

Signature _____ Date _____

STATEMENT TO AUTHORIZE PAYMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Associated Gastroenterologists of CNY, PC of the health benefits, if any, otherwise payable to me by insurance companies and any others who are financially liable for my medical care.

I also hereby authorize Associated Gastroenterologists of CNY, PC having treated me, to release all information needed for utilization management to governmental agencies, insurance carriers, others who are financially liable for my medical care and any third party administrator(s) working on behalf of same. Further, I hereby permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Insured or Authorized Person's Signature _____ Date _____

STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claims.

I request that payment under the medical insurance program be made to Associated Gastroenterologists of Central New York, P.C. for services provided to me during the period of my treatment or lifetime.

Medicare Beneficiary Signature _____ Date _____

Health Insurance Claim Number _____