ISLAND
GASTROENTEROLOGY
CONSULTANTS, P.C.

1111 Montauk Highway, Floor 3, Suite 1
West Islip, New York 11795
PH (631) 669-1171
FX (631) 669-1912
www.islandgastro.com

PATIENT DEMOGRAPHICS

Last Name First M SSN# - -

Address City State Zip Code

Home Phone Cell Work

E-mail Address

Date of Birth / / Age Sex Marital Status: □ Single □ Married □ Widowed □ Divorced

Primary Language Spoken Ethnicity/Race

Emergency Contact Person Phone Relationship

Patient's Employer Occupation

Employer's Address City State Zip Code

Primary Care Physician Phone

ALLERGIES

INSURANCE INFORMATION

Please be advised that we will submit claims to your primary and secondary insurance carriers. Any remaining balances after receipt of explanation of benefits from your primary and/or secondary insurance carrier will be billed to you.

Primary Insurance Phone

Identification Number Group Number

Name of Policy Holder Policy Holder's Date of Birth

Policy Holder's Relationship to Patient: □ Self □ Spouse □ Child

Secondary Insurance Policy Holder

Identification Number Policy Holder's Date of Birth

I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to Island Gastroenterology Consultants, P.C. for any services furnished to me by that third party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
In the event my insurance company pays me directly, I will forward payment immediately to Island Gastroenterology Consultants, P.C. along with the explanation of benefits from my insurance company. If my insurance company fails to make payment for my services, I agree to be financially responsible.
I authorize any holder of any medical and/or other information about me to release to the Social Security Administration and Healthcare Administration or its intermediaries or carriers, information needed for this or a related Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-2912 provides penalties for withholding this information).

Signature Date

ISLAND
GASTROENTEROLOGY
CONSULTANTS, P.C.

1111 Montauk Highway, Floor 3, Suite 1
West Islip, New York 11795
PH (631) 669-1171
FX (631) 669-1912
www.islandgastro.com

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

As the provider of healthcare services, Island Gastroenterology Consultants, P.C. is authorized to release any protected health information required for medical treatment, payment of services rendered or for other healthcare operations of the office, or the operations of contracted medical provider, if applicable. Before information is released to parties other than for treatment, payment of your account or for healthcare operations, the office will require specific authorization from you.

With my consent, Island Gastroenterology Consultants, P.C. may call my home, or other designated location, and leave a message or may mail to my home, or other designated location, in reference to any items that assist the office in carrying out healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including results, among others.

I have the right to request Island Gastroenterology Consultants, P.C. restrict how it uses or discloses my protected health information; however, the office is not required to agree to all request restrictions, but if it does, is bound by this agreement.

By signing below, I acknowledge that the Notice of Privacy Practices has been made available to me. I have the right to restrict uses and disclosures of health information as it pertains to my treatment, payment and healthcare operations.

I authorize the staff to leave medical information pertaining to my care by the following methods:

HOME VOICE MESSAGING: □ Yes □ No CELLULAR VOICE MESSAGING: □ Yes □ No

Please list the names of authorized people we may leave messages with:

NAME/RELATIONSHIP _____ NAME/RELATIONSHIP _____

NAME/RELATIONSHIP _____ NAME/RELATIONSHIP _____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosure of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Name of Patient: Date of Birth:

Insurance Carrier: Physician:

Signature: Date of Notice:

Relationship to Patient (if signed by a personal relative or legal guardian of the patient):