

RICHMOND GASTROENTEROLOGY ASSOCIATES, INC.
Insurance Information Sheet

FORM MUST BE COMPLETED IN FULL TO PROCESS
PLEASE ATTACH COPIES OF BOTH THE FRONT & BACK OF INSURANCE CARD.

DATE	LOCATION	ACCT #
DOCTOR		REFERRING DOCTOR

LEGAL NAME (LAST) (FIRST) (MIDDLE)			SEX (CIRCLE ONE) M F
BIRTHDATE	AGE	SOCIAL SECURITY #	PATIENT'S STREET ADDRESS
ZIP CODE	CITY	STATE	HOME PHONE
WORK PHONE	CELL/PAGER	PATIENT EMPLOYER	
EMPLOYER'S ADDRESS			OCCUPATION
SPOUSE'S/PARENT'S NAME (LAST) (FIRST) (MIDDLE)			SPOUSE'S SOCIAL SECURITY #
SPOUSE'S EMPLOYER		SPOUSE'S OCCUPATION	SPOUSE'S WORK PHONE
SPOUSE'S BIRTHDATE		SPOUSE'S PHONE	
NEAREST RELATIVE (OTHER THAN SPOUSE)		RELATIONSHIP	RELATIVE'S PHONE

PAYMENT/INSURANCE INFORMATION

TODAY I WILL BE PAYING WITH: Cash Credit Card Check Insurance

PRIMARY

See Card Copy

INSURANCE: _____	PHONE: _____
ADDRESS: _____	
CONTRACT #: _____	EFF. DATE: _____
SUBSCRIBER NAME: _____	RELATIONSHIP TO PATIENT: _____
PRIMARY PHYSICIAN: _____	PHONE: () _____
COVERAGE REQUIRES PRE-ADMISSION CERTIFICATE: YES NO	

SECONDARY

See Card Copy

INSURANCE: _____	PHONE: _____
ADDRESS: _____	
CONTRACT #: _____	EFF. DATE: _____
SUBSCRIBER NAME: _____	RELATIONSHIP TO PATIENT: _____
PRIMARY PHYSICIAN: _____	PHONE: () _____
COVERAGE REQUIRES PRE-ADMISSION CERTIFICATE: YES NO	

MEDICARE

Medicare Number: _____ / Medicare Assignment of Benefits: _____
I request that payment of authorized Medicare benefits be made either to me or on behalf to Richmond Gastroenterology Associates, Inc. for any services furnished me by said Physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents, any information needed to determine these benefits or the benefits payable for related services.
*Lifetime Authorized Signature: _____ Date: _____

Medical Service Contract

I hereby certify that the information I have given is correct and true to the best of my knowledge. I hereby assign Richmond Gastroenterology Associates, Inc. any and all rights and benefits pertaining to their services rendered under any insurance policies, and I authorize said Physicians to release whatever medical information necessary to file said insurance claims and release information necessary for my care and treatment to other professional healthcare providers. I understand that regardless of my insurance status, I am ultimately financially responsible for all charges arising for the treatment of myself (or the above named patient, if applicable). If this contract is referred to a collection agency or attorney for collection, I agree to pay all court costs, including attorneys and collection agency fees in the amount of thirty percent (30%) of all total indebtedness due.

Patient Signature _____ Date _____

Patient's Guardian _____ Witness _____