Coastal Gastroenterology, APC

Robert Goldklang, M.D.
Adrianne LaJoie, M.D.
Steven DiLauro, M.D.
Ahmad Masood Mansour, M.D.

Angelina Collins, A.N.P.
Whitney Woodruff,F.N.P.
Jenessy Elshire, F.N.P.

NAME________________________________ BIRTH DATE__________________ AGE_________

ADDRESS_____________________________ SEX_____________ MARITAL STATUS___________

CITY________________________________ SOCIAL SECURITY ___________________________

STATE_____________ ZIP CODE__________

HOME PHONE _(_______)________________ DAYTIME PHONE __(________)_________________

EMPLOYER____________________________ SECURED E-MAIL____________________________

INSURANCE CARRIER: 1)_________________________ 2)________________________________

NAME OF INSURED_____________________ RELATION TO PATIENT_______________________

EMERGENCY CONTACT (NAME & PHONE)____

REFERRED BY ___________________________ PRIMARY M.D.______________________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the above named physician of the surgical and/or medical benefits otherwise payable to me for his services as described on the insurance claim. I realize that the insurance payment may\may not represent the full payment for services rendered and I understand that I am ultimately responsible for the balance due.

Most insurance companies will pay only for services they determine "reasonable and necessary" under section 1862 (a) (1) (A). If your insurance determines that a particular service is not reasonable and necessary for the diagnosis or treatment of illness or injury, they may deny payment. For example, they may deny payment for an office consultation/ visit (to discuss the need for screening colonoscopy). They may not cover **Colon Cancer Screening.**

NO SHOW POLICY: A $**25.00 charge** will be assessed for "no showing" or failing to give 24 hour notice for the need to cancel your office appointment.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Coastal Gastroenterology to release any information in the course of my examination or treatment to my insurance company and to whom I designate.

____ ______________________________________

PATIENT SIGNATURE DATE

The Endoscopy Center Financial Policy: In the event of scheduling a procedure at The Endoscopy Center, I hereby agree to the financial policy and understand I may obtain a copy of the policy upon request.

____ ______________________________________

PATIENT SIGNATURE DATE

Notice of Privacy Practices: I hereby acknowledge the Notice of Privacy Practices HIPAA and a copy is posted in the office and will be provided to me at my request.

____ ______________________________________

PATIENT SIGNATURE DATE