

<b>Patient Information</b>	Name (Last, First, MI)					Today's Date	
	Street Address						
	City		State	Zip	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth
	Social Security #		Daytime Phone ( )		Evening Phone ( )		
	Cell Phone ( )		Email Address:				
	Occupation	Employer		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			
<b>Emergency Contact</b>	Name				Relationship to Patient		
	Daytime Phone ( )			Evening Phone ( )			
<b>Referral Info</b>	Referring Physician's Name (if applicable)				Physician Phone/Fax (if known) ( ) /		
	Physician Address (if known)						
	How did you hear about Trinity Centre?						
<b>Insurance Information</b>	Primary Insurance Company		Policy #		Group #		
	Claims Address		City	State	Zip	Phone	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)			
	Subscriber's Social Security #			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
	Secondary Insurance Company		Policy #		Group #		
	Claims Address		City	State	Zip	Phone	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if Other Than Patient)			
	Subscriber's Social Security #			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
<b>Assignment and Release</b>	<p><b>Please read the following and sign below</b></p> <p><u>Assignment of Benefits and Release of Information</u> I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.</p> <p><u>Medicare Patients</u> I authorize any holder of medical or other information about me to release to the Centers for Medicare &amp; Medicaid Services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.</p> <p><u>Notice of Privacy Practices Acknowledgment</u> By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.</p> <p><u>Financial and Cancellation Policy Acknowledgment</u> By signing below, I acknowledge that I agree to the financial and cancellation policy described on the back of this form.</p>						
	Signature: _____				Date: ____ / ____ / ____		

**Financial Policy**

The Physicians at NYU Gastroenterology Associates participate with a variety of insurance programs that are popular in the tri-state area. However, please be aware not all physicians participate in the same plans. We will do our best to assist you; however the responsibility for payment of fees for services is the direct responsibility of the patient. You should be knowledgeable of your plan's specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, limits on outpatient charges, or specific physicians to use.

**\*Payment Policy:**

- |                                    |  |
|------------------------------------|--|
| • Co-payments                      | Full payment is due at time of service |
| • Deductible and coinsurance       | Full payment is due at time of service |
| • Non-covered service              | Full payment is due at time of service |
| • Non-participating insurance plan | Full payment is due at time of service |
| • Past due balances                | Full payment is due at time of service |

**Referral/Insurance Waiver**

I understand that payment of fees for services is my responsibility. I am responsible for obtaining the necessary requirements my insurance plan requires. If I do not provide the referrals/documents required or if my insurance is no longer valid, I am responsible for paying for the services I am requesting.

**Fairness and Cancellation Policy**

In order to be fair to other patients who are waiting for appointments as well as to be fair to NYU Gastroenterology Associates, please be advised that the following policy is in effect regarding cancellation of appointments:

- |                        |   |
|------------------------|---|
| Missed Appointment Fee | The office requires at least 24 hours notice when canceling an appointment. Failure to provide this notice will result in a \$75.00 charge to your account. |
| GI Procedure           | A \$150.00 fee will be charged to your account if you cancel your procedure with less than 48 hours notice.   |
| Returned Check Fee     | \$25.00   |
| Medical Records        | A fee of \$.75 per page due prior to receipt of records.  |

\* subject to change at any time

We realize that medical care can often become very expensive. If you have concerns about your ability to pay for service, we recommend that you contact us for assistance in the management of your account.

Should you have any questions with regard to our financial policy we encourage you to ask. It is our goal, not only to provide the best quality of medical care, but to help you by answering any questions you might have.