Today's Date:	PCP:	Account #:

Last Name:	First Name:	M.I.	Social Security Number:	Birth Date: / /

Sex: ☐M ☐F	Preferred Language: ☐English ☐Spanish ☐Other	Race: ☐American Indian/ Alaskan Native ☐Black/African American ☐White ☐Asian/Pacific Islander ☐More than 1 Race ☐Other
Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino	Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Other	Preferred Contact Method: ☐Home ☐Cell ☐Work
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

Street Address:

City:	State:	Zip Code:	Email Address:

PATIENT EMPLOYMENT INFORMATION

☐Employed ☐Retired ☐Unemployed ☐Other

Employer's Name:	Occupation:

GRANT ACCESS TO YOUR MEDICAL INFORMATION

You may discuss my health information with the following people (caregivers, family members, etc.)

May we leave a message at your home, answering machine or third party? YES or NO

Name	Phone Number	Relationship to Patient
	( )	
	( )	

PATIENT'S INSURANCE INFORMATION

PLEASE PROVIDE INSURANCE CARD(S) AND PHOTO ID TO RECEPTIONIST

Please fill out the following section completely. Your insurance company will not pay if we do not have the correct information.

Person Responsible for Bill:	Birth Date: / /	Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other	Phone Number: ( )

Street Address (if different):	City:	State:	Zip Code:

Primary Insurance Company:		Secondary Insurance Company:	
Subscriber's Name	Birth Date: / /	Subscriber's Name	Birth Date: / /
Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other	Subscriber's SSN:	Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other	Subscriber's SSN:
Policy ID Number:		Policy ID Number:	
Group Number:		Group Number:	

______________________________ ______________________

Patient's Signature Date

REV. 6/18

PATIENT PAYMENT POLICY
NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Patient Responsibility:

* You are responsible for all charges resulting from treatment provided by WestGlen Gastrointestinal Consultants. We bill most insurance carriers. However, primary responsibility for the accounts is yours. Your co-payment is always due at the time of service; any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a delinquent balance, we may ask you to make a payment at the time of your next visit with us.
* See patient credit card form.
* Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Insurance Billings:

* It is your responsibility, (or that of the financially responsible party) to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.
* **Medicare:** We participate with Medicare.
* **Medicaid:** Please bring your current medical card with you to each appointment.

Private Pay:

*You will be responsible for payment at time of service and prior to any procedures that are scheduled.

Check Returned:

*It is our office policy to charge a **$35 fee** for checks that are returned.

Authorization to Release Information:

* In obtaining payment for services, I authorize WestGlen Gastrointestinal Consultants to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance companies and their representatives and my employer or union if they are involved in processing the claim. For further information regarding disclosure of health information please refer to the Notice of Privacy Information.
* If I have been referred by, or am being referred to another healthcare provider, I authorize WestGlen Gastrointestinal Consultants to release my medical information to this provider for continuing care.
* I hereby authorize payments of benefits to WestGlen Gastrointestinal Consultants. I understand I am financially responsible for all charges incurred in the course of my treatment by WestGlen Gastrointestinal Consultants.

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.
I CAN REQUEST A COPY OF THIS POLICY AT ANY TIME.

_______________________________ _______________________________ ____________
Patient Name (Please Print) Patient's Signature or Patient's Representative Date

Sign Below if Disclosure of Information is NOT Authorized:

Therefore, I agree to pay for costs of all treatment and services personally.

_______________________________ ____________
Signature of Patient or Representative Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _______________________________ have been offered and or received a copy of the Notice of Privacy Practices.

_______________________________ ____________
Signature of Patient or Representative Date