



Naugatuck
Valley
Gastroenterology
Consultants, LLC.

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► **PATIENT INFORMATION FORM**

Patient's Name (Last, First and MI)
 Street City State Zip
 Date of Birth Home Phone Sex Marital Status
 Referred By Primary Doctor
 Patient SS# Patient's Employer Phone
 Street City State Zip

Spouse's Name Spouse's Employer Phone
 Street City State Zip

Responsible Party Name (Last, First, MI) Relationship
 Street City State Zip
 Phone Responsible Party SS#

Responsible Party Employer
 Street City State Zip
 Phone

► **INSURANCE INFORMATION**

1. Insurance #1 Name
 Insurance #1 Street City State Zip Phone
 Policy Holder Name (Last, First and MI) Relationship
 ID# Group#

2. Insurance #2 Name Does insurance require preauthorization? (Y/N)
 Insurance #2 Street City State Zip Phone
 Policy Holder Name (Last, First, MI) Relationship
 ID# Group# Member#

In case of emergency contact: Name Work Phone
 Nearest sibling relative/friend not living with you Phone

► **SIGNATURE**

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay the deductible amount, co-insurance, or any other balance not paid by your insurance. **In order to control the cost of billings, we request that charges for office visits be paid at the conclusion of each visit.** If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original. I understand that i am financially responsible to pay for all charges whether or not paid by insurance.

Authorization to pay benefits to physician: I hereby authorize payment directly to the physician of any benefits, otherwise payable to me for his services realizing I am responsible to pay noncovered services.

Authorization to release information: I hereby authorize my physician to release any information acquired in the course of my treatment to process insurance claims.

I agree to the assignments and financial responsibilities as indicated on this form.

SIGNATURE DATE

[The corporation reserves the right to designate the individual to perform the service on its behalf.]