

PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC
PALM BEACH SURGERY CENTER, LLC
1157 SOUTH STATE ROAD 7
WELLINGTON, FL 33414
PHONE (561) 795-3330 / FAX (561) 795-1030

PATIENT ACCOUNT # _____ **Date:** _____

How did you hear about us?

Drive by Friend/Family Television
 Newspaper / Magazine Web Other _____

Referring Physician: _____ Is this your PCP? Yes / No
If No, who is your PCP? _____

Patient Name: (Last) _____ (First) _____

E-mail Address: _____

Language(s) Spoken: _____

If other than English, do you understand English? (Circle one) yes / no

SS#: _____ DOB: _____ SEX: (Circle) Male / Female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Insurance Name: _____ Policy Holder: _____

Policy #: _____ Group Number: _____

Insurance Phone #: _____ Claims Address: _____

I authorize the release of my medical information necessary for treatment or to process claims. I also authorize for the release of my medical records to any physician, hospital or ancillary care center participating in my care and treatment. Only medically necessary information will be released when requested. I understand that this information will be faxed or mailed to the party requesting the information.

I hereby assign all medical benefits to include major medical benefits to which I am entitled to Palm Beach Gastroenterology /Palm Beach Surgery Center. This assignment will remain effect until revoked by me in writing. I further agree to be solely responsible for any balances that my insurance does not pay. I understand that I am responsible for any collection and/or legal fees incurred as a result of non-payment on my account.

A credit card is required to be on file in order to pay any delinquent balances left unpaid by patient after 35 days of being billed. All co-pays are due when service is rendered. No statements will be mailed for co-payments, the patient's credit card on file will be charged.

A PHOTOCOPY OF THESE AUTHORIZATIONS ARE TO BE CONSIDERED LEGALLY VALID AS ARE THE ORIGINALS.

Patient Signature: _____ **Date:** _____