Charlottesville Gastroenterology Associates

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PATIENT E-MAIL ADDRESS

☐ PERMISSION TO USE EMAIL FOR APPOINTMENT REMINDER

PATIENT INFORMATION

SOCIAL SECURITY NUMBER	FIRST NAME	MIDDLE NAME	LAST NAME

ADDRESS	☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

CITY	STATE	ZIP	HOME PHONE

WORK PHONE	CELL PHONE	EMPLOYER	RACE	BIRTH DATE	AGE	SEX ☐ M ☐ F

IN CASE OF EMERGENCY PLEASE NOTIFY

NAME					
ADDRESS					
CITY	STATE	ZIP	WORK PHONE	HOME PHONE	EXT.

PLEASE ALLOW RECEPTIONIST TO MAKE A COPY OF YOUR INSURANCE CARD(S)

HIPAA (PRIVACY PRACTICE)

REFERRED BY: _____ FAMILY DOCTOR: _____

Please list anyone who our office can release your healthcare information to other than your family physician. You may change this at any time. In order to protect your privacy, we feel it is important to know with whom we have permission to discuss your healthcare.

NAME	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION

PRIMARY		SECONDARY	
	INSURANCE CARRIER		INSURANCE CARRIER
	NAME OF POLICY HOLDER		NAME OF POLICY HOLDER
	INSURANCE ID NUMBER		INSURANCE ID NUMBER

Please list your email address at the top left corner. This will assure you will be connected to our patient portal system, which will allow you to retrieve test results and to connect with your doctor through a safe, secure and convenient environment.

PATIENT'S RESPONSIBILITY / MEDICAL RELEASE / ASSIGNMENT OF BENEFITS

I hereby acknowledge responsibility for any professional fees incurred and for obtaining any referral needed.

I authorize the release of medical information necessary to process my insurance claim.

I request that payment of authorized benefits be made to Gastroenterology Associates of Charlottesville for any services furnished me by them.

Should this account become delinquent and collection becomes necessary, the undersigned agrees to be responsible for attorney's fees of 33 1/3% and any and all applicable court costs.

☐ I acknowledge and agree that a copy of the CGA Notice of Privacy Practice is available upon request.

SIGNATURE	RELATIONSHIP TO PATIENT	DATE