G.I. Associates of West Alabama, P.C.

Patient Information Physician ______________________ Date ____________

Social Security Number ______________________ (Required) Referring Physician ______________

Sex ☐ Male ☐ Female

Name ____
Last First MI

Street Address ____

City ______________________ State ____________ Zip ____________

Mailing Address ____
(include only if different from street address)

Date of Birth ______/______/________ (MM/DD/YYYY)

Home Phone ______________ Work Phone ______________ Cell Phone ______________

E-mail Address ____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer ______________________ Address ______________________

Spouse ______________________ Spouse's Date of Birth _____/_____/_______ (MM/DD/YYYY)

Spouse Employer ______________________ Spouse Work Phone ______________

If the patient is a minor, please list responsible party ______________________

Relationship ______________ Date of Birth ____/____/______ Phone ______________

Address ____

AUTHORIZATION FOR TREATMENT/PAYMENT – I authorize G.I. Associates of West Alabama, P.C. to provide medical treatment and hereby agree to pay any outstanding balance whether paid for or denied by my insurance company or third party payer.

AUTHORIZATION TO RELEASE INFORMATION – I authorize the Physician to release any information required, in the course of my exam or treatment, to my insurance company or any third party with whom I have coverage. Furthermore, I authorize any holder of medical information about me to release said medical information to a physician or other medical professional who may be a part of my care.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN – If I have Insurance, Medicare, Medicaid, or Workman's Compensation, I authorize payment directly to the physician for medical services rendered. I understand that G.I. Associates of West Alabama, P.C. will file insurance claims to my primary and/or secondary insurance carrier. G.I. Associates of West Alabama, P.C. does not currently file with a third payer.

COPAYS, DEDUCTIBLES, AND NON-COVERED CHARGES – I understand that I am responsible for any unpaid balance, co-pays, deductibles, and non-covered charges relating to my care, and that **co-pays and deductibles are due at the time of the service. I acknowledge that any co-pays and/or deductibles must be paid before any procedure can be scheduled.** Accounts having a balance over 30 days old are considered delinquent, and I understand if my bill goes to collection, that in addition to the account balance, I will also be liable for any court costs and/or attorney fees involved in collecting the delinquent bill.

APPOINTMENT CANCELLATION – Except in the case of verifiable emergencies, failure to give a 24 hour notice of cancellation of an appointment will result in a "no show" charge of $50 to my account, and failure to give a 48 hour notice of cancellation for outpatient procedures may result in a $100 charge to my account. These charges cannot be billed to my insurance company and are my responsibility. Failure to pay fees will be treated according to policy as a unpaid balance. While care will not be withheld for medical emergencies, three consecutive "no show" occurrences can result in discharge from the practice.

______________________________________ ______________________
PATIENT SIGNATURE **DATE**