MONMOUTH GASTROENTEROLOGY L.L.C.

A Division of Allied Digestive Health

Patient Information Form

Please PRINT all information in the space provided. Be sure to complete and sign the statement on the back of this form.

Appointment Date:_____**EMAIL ADDRESS:**:**(MUST PROVIDE!)** _____

Last Name:_____First Name: _____M.I._____

Address:_____City:_____State_____Zip_____

Cell phone:_____Home phone:_____

Social Security Number:_____Date of Birth:_____

Race:_____Ethnicity_____Language:_____

Male/Female:_____ Martial Status: **(circle one)** Single Married Divorce Widow Other-

Emergency Contact: _____Phone Number:_____

Employer Name:_____Work phone:_____

Primary Care Physician Name and Address:_____

Cardiologist Physician Name and Address: _____

Who referred you to our office:_____

Pharmacy Name and Address:_____Pharmacy phone:_____

PRIMARY INSURANCE : This information **MUST BE COMPLETED**, in addition to a copy of your insurance card.
Company Name and Phone Number: _____

Insured's ID Number:_____Group Number:_____

Name of Policy Holder:_____Policy Holder's DOB:_____

Patient's relationship to Policy Holder:_____Policy holder phone #:_____

Policy holder address: _____

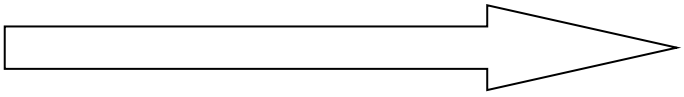
SECONDARY INSURANCE:
Company Name and Phone Number: _____

Insured's ID Number:_____Group Number:_____

Name of Policy Holder:_____Policy Holder's DOB:_____

Patient's relationship to Policy Holder:_____

Please review and sign reverse side



MONMOUTH GASTROENTEROLOGY, LLC

A DIVISION OF ALLIED DIGESTIVE HEALTH, LLC.

TIN #46-3915494 - NPI #1265831259

DOCTORS BAIG, BELITSIS, FIEST, GORCEY, MERIKHI AND UPPAL

Patient Financial Responsibility Statement

We are pleased that you have chosen our practice for your healthcare needs. It is our goal to provide you with the highest quality healthcare services possible. In exchange for providing these services, we ask that you take the time to understand your financial responsibilities to ensure timely and acceptable payment for our services.

1. I am responsible for knowing the details of my insurance coverage(s) including my responsibility for co-payments, deductibles, co-insurances, and referrals. I will call my insurance company to obtain this information.

2. I authorize payment of my insurance benefits to Allied Digestive Health for the medical services received.

3. I accept responsibility for payment of any amounts (co-payments, deductibles, and co-insurance) that are not covered by my insurance(s).

4. I will provide all current insurance information (we require both sides of your insurance cards) at the time of service, including a photo ID.

5. I agree to have a current and active insurance referral (if applicable) issued by my PCP (primary care physician). Otherwise my appointment may be canceled, rescheduled or I will pay for the full fee for my appointment. A doctor's prescription is not a valid insurance referral.

6. If I have an endoscopy procedure, I may be responsible for the following fees:

- **a) Gastroenterologist's Fee;**
- **b) Facility Fee for the Endoscopy Center;**
- **c) Pathology Fee for any tissue biopsy/ testing;**
- **d) Anesthesiologist's Fee.**

7. Colonoscopies are not always screening colonoscopies and may not be covered in full by my insurance. I understand I am responsible for any balance left unpaid by insurance. *Allied Digestive Health will not/cannot change the diagnosis. (See attached "Screening Colonoscopy vs Diagnostic")*

***8.* If I am without insurance coverage, Allied Digestive Health expects to be paid at the time services are rendered.**

9. I understand that after three (3) attempts to collect any patient balance, my account will be turned over to a collection agency. I will also be responsible for any and all fees and service charges incurred as a result of a collection agency's involvement.

10. I understand I will be charged a $35.00 fee if my personal check is returned by my bank.

I have read the above statements and fully understand and agree to these terms.

X_____ _____ _____ X_____

Print Patient Name **Responsible Party/Guardian**

X_____ X_____

Patient Signature **Date**