Gastroenterology Care Center

160 N. Eagle Creek Drive, Suite 202 Lexington, KY 40509
Phone 859-263-0022 Fax 859-263-4666

Dr. Laurie S. Haas Dr. Kathleen Martin

Patient's Name: ____ Date of Birth: _______________ Age: _________

Street Address: ______________________________ City: __________________ State: ________ Zip: _________

Home #: (______) __________________ Work #: (______) __________________ Cell #: (______) __________________

Social Security #: ____________________ *Circle Sex*: M F Marital Status: _____________ Race: ______________

Patient's Employer: ___________________________________ Occupation: ___________________________________

Contact In Case of Emergency: _____________________________ Phone #: ________________________________

Family Doctor: __________________________________ Referring Doctor: __________________________________

Pharmacy: ____ Phone #: ______________________________

<u>Authorization For Release Of Information</u>

I hereby authorize the release of certain information that may or may not contain psychiatric information, the the GI Care Center. Information Requested:
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<u>Release of Information, Benefit Assignment, Payment Authorization, Full Disclosure Statement, Payment Agreement, and Permission to Treat</u> (Financial Policy)

I hereby authorize Gastroenterology Care Center to release any information necessary to process my insurance/ Medicare claim, acquire in the course of my examination or treatment; to allow a photocopy of my signature to be used to process my insurance/Medicare claim for the period of LIFETIME. I claim any insurance benefits due me for services rendered by Gastroenterology Care Center and authorize and direct my carrier to issue payment check(s) directly to Gastroenterology Care Center. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full. Permission for treatment is granted for such medical and surgical treatment as deemed necessary.

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

I have reviewed and understand the **HIPAA Policy** ____________ (initial here)
I have reviewed and understand the **Release of Information** ____________ (initial here)
I have reviewed and understand the **Financial Policy** ____________ (initial here)
(copies of these policies are available upon request)

Patient
Signature ____ Date: _____________________
(if patient is a minor, responsible party must sign)