

Gastroenterology Atlanta LLC

5669 Peachtree Dunwoody Rd. Suite 240 Atlanta, GA 30342 (404)257-0000

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Gender: Male Female SSN: _____ Marital Status: _____

Address: _____

Phone Numbers Cell#: _____ Home#: _____ Work#: _____

Email: _____ Preferred Method Of Contact: _____

Emergency Contact: Name: _____ Relationship: _____

Phone#: _____

Insurance Primary

Carrier: _____ Policy#: _____ Group# _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Patient: _____ Employer: _____

Insurance Secondary

Carrier: _____ Policy#: _____ Group# _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Patient: _____ Employer: _____

Were you referred to our practice by another physician? ___ NO ___ YES

If yes, please provide the following information:

Provider Name: _____ Phone#: _____

Address: _____

Other Healthcare Providers:

Please provide any other healthcare providers that you would like to include in your treatment:

Provider Name: _____ Phone#: _____

Address: _____

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Financial Policy

Insurance Plans and Policies

- We participate with most insurance plans.
- It is your responsibility to check with your insurance plan prior to your visit to make sure we are in network and a participating provider.
- If you have an insurance that requires a referral, it is your responsibility to contact your PCP (Primary Care Physician) prior to being seen. If we do not have a referral on file, the bill is your responsibility.
- Knowing your insurance benefits is your responsibility.
- As a courtesy, Gastroenterology Atlanta LLC will verify your insurance and take care of any precertification that may be needed prior to any endoscopy procedures.

Proof of Insurance

- A copy of a valid insurance card will be needed on the day of your appointment.
- It is your responsibility to provide our office with this information. If you do not have a copy of your card, you will be considered a self-pay patient.

Copayments and Billing Statements

- Copayments are due at the time of your visit.
- All copayments and deductibles are based upon Primary Insurance coverage. .
- Please remember that we are contractually obligated by your insurance company to collect copayments and deductibles.
- We will file your charges with your insurance company. You will be responsible for payment of any remaining balance.
- If any deposit or copays are due at the time of your endoscopy procedure, our office will let you know ahead of time so you can make appropriate arrangements.
- If you cannot pay your balance in full, our office will be happy to set up payment arrangements. It will be your responsibility to contact our billing department and arrange payment plan.

We accept Cash, Check, or Credit Cards (Visa or Mastercard or American Express)

- Returned checks are subject to a \$30.00 fee.

Failure to receive your statement does not relieve you from your financial obligation. It is the patient's responsibility to notify our office with any address or contact changes.

Patient Name (Print)

Date of Birth

Signature of Patient/Guarantor

Today's Date