PATIENT REGISTRATION

Account # :_____ Driver's License Verified: ❑ Yes ❑ No

Today's Date : _____

Primary Provider ❑ Kamionkowski ❑ Lissauer ❑ Frankel ❑ Kirsh ❑ Gellis ❑ McNally ❑ Longbons, PA-C

PATIENT INFORMATION

Last Name _____ Social Security # __ __ __ - __ __ - __ __ __ __

First Name _____ Middle Initial _____

Birthdate ____ / ____ / _____ E-mail Address _____

Address _____ Apartment/Suite # _____

City _____ State _____ Zip _____

Home Phone ( ) __ __ __ -- __ __ __ __ ❑ Male ❑ Female Age _____

Cell Phone ( ) __ __ __ -- __ __ __ ____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Employer _____ Occupation _____

Address _____ Work Phone ( ) __ __ __ -- __ __ __ __

City _____ State _____ Zip _____

POLICY HOLDER INFORMATION (IF DIFFERENT THAN PATIENT)

Name _____

Address _____ Apartment/Suite # _____

City _____ State _____ Zip _____

Home Phone ( ) __ __ __ -- __ __ __ __ Relationship_____

Employer _____ Occupation _____

Address _____ Work Phone ( ) __ __ __ -- __ __ __ __

City _____ State _____ Zip _____

Social Security _____ Birthdate: _____/_____/_____

REFERRING or PRIMARY CARE PHYSICIAN

Your Physicians Name _____

How were you referred to the office? ❑ Website ❑ Internet Search ❑ Yellow/White Pages ❑ Family Member ❑ Friend ❑ Physician

EMERGENCY INFORMATION

Emergency Contact _____

Address _____

City _____ State _____ Zip_____

Phone ( ) __ __ __ -- __ __ __ __ Relationship _____

Allergies: _____

Current Medication: _____

Do you take: ❑ Aspirin ❑ Blood Thinner (Lovenox, Heparin, Coumadin, Plavix, Persanthine, Vitamin E)

FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO TREAT

1. AUTHORIZATION OF TREATMENT AND RELEASE OF MEDICAL INFORMATION

A. Permission for Treatment

I, the undersigned patient or patient's legal guardian, acknowledge that the physicians of Gastroenterology Associates of Cleveland, Inc., its employees and other healthcare professionals assigned to patient's care are authorized to administer any treatment as may be deemed necessary or advisable for the diagnosis and treatment of the patient. I understand that this care may include examinations, tests and medical treatment.

B. Release of Medical Information by Gastroenterology Associates of Cleveland, Inc.

The undersigned patient or patient's legal guardian hereby authorizes Gastroenterology Associates of Cleveland, Inc. to release any medical information (including information regarding substance abuse, HIV, and psychiatric treatment) requested by third-party payers, including but not limited to those indicated on the attached photocopy, or their reviewing agencies, to enable payment of insurance proceeds and/or other healthcare benefits for the care rendered by Gastroenterology Associates of Cleveland, Inc. I also authorize the release of such medical information to patient's non-Gastroenterology Associates of Cleveland, Inc. doctors for medical treatment and follow-up. This authorization is subject to written revocation at any time except to the extent that action has been taken in reliance hereon and shall in any event expire one-year following the date hereof. I hereby release Gastroenterology Associates of Cleveland, Inc. from all legal responsibility or liability relating to the release, disclosure and examination of confidential medical

C. Release of Medical Information to Gastroenterology Associates of Cleveland, Inc.

The undersigned patient or patient's legal guardian hereby authorizes the release and disclosure by any healthcare provider or holder of medical information about the patient of any medical information (including information regarding substances abuse, HIV, and psychiatric treatment) pertaining to patient to Gastroenterology Associates of Cleveland, Inc. in connection with patient's medical care and treatment. This authorization is subject to written revocation at any time except to the extent that action has been taken in reliance hereon and shall in any event expire one year following the date hereof.

2. FINANCIAL RESPONSIBILITY FOR HEALTHCARE SERVICES

A. Financial Policy

As the patient or patient's legal guardian, you are reminded that healthcare services rendered to the patient by physicians and/or staff of Gastroenterology Associates of Cleveland, Inc. is charged to the patient and, generally, you are responsible for payment in full for such services. It is your responsibility to understand any health insurance policy or healthcare plan which covers the patient for all or any part of such services.

If under the patient's health insurance policy or healthcare plan, the patient has designated a primary care physician ("PCP"), the patient is required to have prior authorization from such PCP to be seen and treated by a physician of Gastroenterology Associates of Cleveland, Inc. If this authorization is not provided, you will be asked to either reschedule the patient's appointment or pay in full for the visit and treatment at the time such services are rendered.

All co-payment amounts which are the patient's responsibility under the applicable health policy or plan generally are due and payable at the time of service. All other amounts are due within 60 days thereafter, unless other arrangements have been made with and agreed to in writing by Gastroenterology Associates of Cleveland, Inc., which generally does not accept monthly payments unless a written payment agreement is on file in its accounting office. This should allow sufficient time to process coverage under applicable health insurance and healthcare plans and to make payment in full of any remaining balance. Extensions to this policy may be granted for those patients whose primary health insurance carrier is Medicare, a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), which makes payment directly to Gastroenterology Associates of Cleveland, Inc. for its services. Gastroenterology Associates of Cleveland, Inc. will assist you in completing the necessary health insurance or healthcare claims forms to seek appropriate payment with respect to the services performed. In the event of duplicate payments by the insurance carrier or plan administrator, the overpayment will be refunded to you.

B. Assignment of Healthcare Benefits

The undersigned patient or patient's legal guardian hereby assigns to Gastroenterology Associates of Cleveland, Inc., as its interests may appear, all healthcare benefits to which the patient is entitled under the provisions of any and all health insurance policies and/or healthcare plans providing coverage to the patient by virtue of any and all services rendered by physicians and/or staff of Gastroenterology Associates of Cleveland, Inc. during this visit and/or subsequent visits. The undersigned further directs such insurer(s) and/or plan administrators and fiduciaries to pay such benefits on behalf of the patient directly to Gastroenterology Associates of Cleveland, Inc.

Additionally, the undersigned authorizes that payment of any Medicare benefits to which the patient is entitled with respect to services furnished to patient by Gastroenterology Associates of Cleveland, Inc. be made on patient's behalf to Gastroenterology Associates of Cleveland, Inc. and hereby further authorizes any holder of medical information about the patient to release to the Centers for Medicare and Medicaid Services ("CMS") and its agents any information needed to determine such benefits or the benefits payable for related services.

C. Guaranty of Payment

In consideration of all clinical, professional and endoscopic services rendered and/or to be rendered to the patient whose name appears below and at the request of patient or patient's legal guardian, the undersigned, as guarantor (i.e., the personal responsible for payment), unconditionally guarantees payment in full to Gastroenterology Associates of Cleveland, Inc. of any and all of its charges for such services without limitation as to time or amount and acknowledges that all co-payment amounts relating to such services are due and payable at the time of service with any balance due within 90 days thereafter, unless other arrangements have been made with and agreed to in writing by Gastroenterology Associates of Cleveland, Inc. In the event Caresource does not pay due to charges being denied as Workers Compensation, I guarantee payment on those denied charges.

Authorization of Treatment, Release of Medical Information and Assignment of Healthcare Benefits

By signing below, I have reviewed, understand and consent to Sections I, II A & B and C of this form. A copy of my signature is as valid as the original.

Name of Patient _____ Guarantor's Signature _____ Date _____

Witness Name _____ Witness Signature _____ Date _____

Patient Received Copy of Financial Policy on _____ Employee Initials _____