

**PATIENT INFORMATION** CONFIDENTIAL

(PLEASE PRINT)

DATE \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
FIRST MI LAST

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

PATIENT'S OR PARENT'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE OR PARENT'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize direct payment of surgical / medical benefits to Dr. Stern, Dr. Finklestein, Dr. Salomons, Dr. Slye, Dr. Teixeira, Gastrointestinal Specialists or Commonwealth Endoscopy Center (CEC) for services rendered by the Gastrointestinal Specialists Group or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Dr. Stern, Dr. Finklestein, Dr. Salomons, Dr. Slye and Dr. Teixeira to use or disclose my medical or incidental information, which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while this consent is voluntary if I refuse to sign this consent Commonwealth Endoscopy Center can refuse to treat me.

**MEDICARE • MEDICAID**

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

I have received a copy of the Notice of Privacy Standards ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations.

I understand that I may revoke this consent at any time by notifying CEC, in writing, but if I revoke my consent, such revocation will not affect any actions that CEC took before receiving my revocation.

I understand that CEC has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that CEC restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that CEC does not have to agree to such restrictions, but that once such restrictions are agreed to, CEC must adhere to such restrictions.

*A photocopy of these assignments shall be valid as the original.*

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_