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