LONG ISLAND GASTROENTEROLOGY SPECIALISTS

Michael C. Barth, M.D., F.A.C.G.
Jordan M. Rush, M.D.
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PATIENT INFORMATION

Date: _____

Name: _____ Gender: ❑ Male ❑ Female
Last First Middle Initial

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Spouse's Name (if applicable): _____

Address _____
Street City State Zip Code

Phone #s: Home (_____)_____ Cell (_____)_____ Work (_____)_____ Primary #: ❑ Home ❑ Cell ❑ Work

Email Address: _____

Ethnicity: ❑ Hispanic or Latino ❑ Non-Hispanic or Latino **Primary Language**: ❑ English ❑ Spanish ❑ Other

Race: ❑ White ❑ Black/African American ❑ Asian ❑ Hispanic ❑ American Indian ❑ Other

Preferred Pharmacy: _____ Phone #: _____

Patient's Employer / Occupation: _____

Address _____
Street City State Zip Code

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone #: (_____)_____ Alternative Number: (_____)_____

CONTACT INFORMATION

If unable to contact me with medical information such as test results, I give your office permission to leave information on my answering machine/voice mail: ❑ Yes ❑ No This option can be changed at any time at my discretion.
If unable to contact me with medical information, the information may be left with my (include first & last name):

❑ Spouse ❑ Parent ❑ Other: _____
If you answer NO or do not provide a name, we will leave a message for you to contact the office.

I approve of the above **Signature**: _____

RESPONSIBLE PARTY/SPOUSE'S INFORMATION

Name of Person to Bill: _____ Relationship: _____

Street Address: _____

Date of Birth: _____/_____/_____ SS #: _____-_____-_____ Home #: (____)_____

Name of His/Her Employer: _____ Work #: (____)_____

Street Address: _____

REFERRING PHYSICIAN/ PCP

Primary Care Physician: _____ Phone #: (____)_____

Referring Physician: _____ Phone #: (____)_____

INSURANCE INFORMATION

Primary Insurance: _____ Policy ID#: _____

Group #: _____ Address _____

Policy Holder Name: _____ Type of Coverage: _____

Secondary Insurance: _____ Policy ID#: _____

Group #: _____ Address _____

Policy Holder Name: _____ Type of Coverage: _____

I certify that all of the above information is correct.
Signature: _____ **Date:**_____

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OFFICE POLICY

We appreciate your confidence in choosing this practice. Please note our office financial policy:

CO-PAYMENTS: Co-payments are required by your carrier each time you are seen in this office. This must be paid prior to being seen by a doctor. We accept cash, checks and major credit cards (MasterCard, Visa, American Express). If you are not prepared to pay at the time of service, there will be a $20 service charge imposed.

CANCELLATIONS: Cancellations within 24 hours of a scheduled appointment will be imposed a $50 charge.

REFERRALS: If you are required by your insurance carrier to have a referral, you must have it at the time of service. If not, you will be financially responsible for the fees involved.

It is the responsibility of the patient to be familiar with their insurance policy. It is impossible to get any guarantee of payment until a claim is submitted. Therefore, the patient is liable for any charges that are not covered under their contract.

MEDICAL RECORDS: All requests for medical records must be in writing. Upon receipt of such request, records will be available in 1-2 weeks.

PRESCRIPTIONS: All requests for prescription renewals should be left on the office's prescription renewal line, which can be accessed through the main office number. All prescriptions will be processed within 48 - 72 hours. If your prescription is with a mail away company, it is the patient's responsibility to mail the written prescription.

Please sign below. I have read the above and understand my obligations.

Signature of Patient Date

PRESCRIPTION HISTORY CONSENT

I, _____, whose signature appears below, authorize Long Island Gastroenterology Specialists and its affiliated providers to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers.

My signature certifies that I have read and understood the scope of my consent and that I authorize the access.

Signature of Patient Date

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize the release of any medical information necessary to process insurance claims or any medical information that is needed for any utilization or quality insurance review.

Signature of Patient Date