Modesto Gastroenterology Medical Corp.

2336 Sylvan Ave., Ste. A
Modesto, CA 95355

Phone: 209-338-0292
Fax: 209-338-0298

*Please **print** all information in the spaces provided. Be sure to sign and date the bottom of the form.*

Last Name_____ First Name_____ M.I._____

Social Security Number_____ M / F Date of Birth _____

Home Address_____City_____Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer Name and Address_____

Emergency Contact/Relation_____Phone:_____

Referring Physician_____Pharmacy Name/Location_____

Primary Insurance

Company Name and Phone Number_____

Billing Address_____

Name of Insured and Relation to Patient_____

Insured's ID Number_____ Group Number_____

Secondary Insurance

Company Name and Phone Number_____

Billing Address_____

Name of Insured and Relation to Patient_____

Insured's ID Number_____ Group Number_____

I hereby authorize payment of medical benefits billed to my insurance to **Modesto Gastroenterology Medical Corporation.** I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I agree to pay all co-payments at the time the service is rendered.

_____ _____

Signature of Patient or Guardian *Date*

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize **Modesto Gastroenterology Medical Corporation** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, then your Medical Care Provider can refuse to treat me.

I have been informed that **Modesto Gastroenterology Medical Corporation** has prepared a notice ("Notice Of Privacy Practices"), 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 have the right to review such notice prior to signing this consent.

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

I understand that **Modesto Gastroenterology Medical Corporation** has reserved the right to change its privacy practices and that I can obtain such changed notice upon request.

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

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____

Printed name of patient or patient's representative

_____

Relationship to the patient