

**Tri-State Gastroenterology Associates, Inc.**

**PATIENT INFORMATION**

PATIENT NAME: . ACCOUNT:  
ADDRESS: DATE OF BIRTH:  
CITY: STATE: ZIP: HOME PHONE:  
EMPLOYER: WORK #  
REFERRING PHYSICIAN: PHONE: (859) 428-1610  
PHARMACY: PHARMACY PHONE:

**EMERGENCY CONTACT:**

NAME: RELATIONSHIP: PHONE:

**INSURANCE INFORMATION**

**~~~ PLEASE HAVE YOUR INSURANCE CARDS READY FOR PHOTOCOPYING ~~~**

PRIMARY INS: NAME OF INSURED: #  
POLICY # GROUP #  
COPAY: \$  
SECONDARY INS: NAME OF INSURED:  
POLICY # GROUP # DOB:  
CO-PAY: \$

\*\*\*\* IF YOUR INSURANCE REQUIRES A REFERRAL FOR YOU TO SEE Dr. . MD, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE REFERRAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT - DUE TO NO REFERRAL - YOU THE PATIENT AGREE TO PAY Dr. MD IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT.

PATIENT SIGNATURE: DATE:

**INSURANCE RELEASE INFORMATION**

I HEREBY AUTHORIZE THE OFFICE OF Tri-State Gastroenterology Associates, Inc. TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO DR. MD. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. IN THE CASE THAT THIS ACCOUNT IS REFERRED TO AN OUTSIDE COLLECTION AGENCY I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ALL ASSOCIATED COLLECTION FEES.

PATIENT SIGNATURE: DATE: