

MID-CENTRAL ILLINOIS GASTROENTEROLOGY, LTD

PATIENT INFORMATION (Please Print)

Name: _____
(LAST) (FIRST) (MI)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT EMPLOYER: _____ SPOUSE EMPLOYER: _____

HOME PHONE: _____ MARITAL STATUS: _____

WORK PHONE: _____

BIRTHDATE: ___/___/___ SSN: ___:___" AGE: _____ SEX: M/F

IF PATIENT IS A MINOR, PLEASE LIST THE RESPONSIBLE PERSON WITH WHOM THE PATIENT LIVES

NAME: _____ RELATIONSHIP: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____

**PLEASE PROVIDE COPIES OF YOUR
INSURANCE CARDS**

THIS SECTION MUST BE COMPLETED FOR INSURANCE PURPOSES

ASSIGNMENT: I UNDERSTAND THAT PAYMENT IS DUE WHEN SERVICES ARE RENDERED (UNLESS I HAVE MADE OTHER ARRANGEMENTS) AND THAT I WILL BE RESPONSIBLE FOR PAYMENT AT THAT TIME. I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MID-CENTRAL ILLINOIS GASTROENTEROLOGY, LTD. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY INSURANCE. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR A FINANCE CHARGE OF 1.5% MONTHLY ON ALL BALANCES OUTSTANDING OVER 60 DAYS, AND ANY COSTS OF COLLECTION (IF NECESSARY) SUCH AS COLLECTION FEES, ATTORNEY FEES, AND COURT COSTS. ALL NON-FINANCIAL DISPUTES WILL BE RESOLVED BY ARBITRATION. IF INFORMATION IS REQUIRED FROM MY INSURANCE COMPANY, PHYSICIAN, OR LABORATORY, I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NEEDED.

A COPY OF THIS SIGNATURE IS A VALID AS THE ORIGINAL.

SIGNATURE: _____

DATE: _____