***THE CENTER FOR GASTROINTESTINAL DISORDERS***
***1150 N. 35th Ave, Suite 445, Hollywood, FL 33021***

## *PATIENT INFORMATION*

***DATE:_____***

***PATIENT NO._____ ALLERGIES:_____***

***PATIENT'S NAME:_____ PHONE:_____***

***ADDRESS:_____***

***CITY:_____ STATE:_____ ZIP:_____***

***SOCIAL SECURITY NO._____ DATE OF BIRTH:_____ AGE:_____***

***SEX: F ( ) M ( ) MARITAL STATUS: Single ( ) Married ( ) Divorced ( ) Widowed ( )***

***EMPLOYER:_____ WORK PHONE:_____***

***EMERGENCY CONTACT (or Spouse's Name):_____***

***REFERRED BY:_____ TELEPHONE:_____***

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## *INSURANCE INFORMATION*

***PRIMARY INSURANCE:_____TELEPHONE:_____***

***BILLING ADDRESS:_____***

***Policy Number:_____ Group Name or No._____***

***HMO_____ PPO_____ OTHER:_____ Effective Date:_____***

***Co-Pay: Office:_____ Procedure:_____ OV Referral/Auth:_____ Contracted Labs:_____***

******PRE-CERTIFICATION: Colonoscopy, Upper Endoscopy, Flexible Sigmoidoscopy, CT Scan******

***Phone #_____ Office:_____ Out patient:_____ In Patient:_____***

***Out of Network Cov: Yes_____ No_____% Covered_____ Deductible_____ Met: Yes____ No____***

***Spoke to:_____ Verified by:_____ Date:_____***

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***SECONDARY INSURANCE:_____ PHONE NO._____***

***Billing Address:_____***

***Policy Number:_____ Group Name or No._____***

## *PHYSICIANS' RELEASE OF ASSIGNMENT*

***I Hereby authorize payment directly to MARK LAMET, M.D.. P.A. of benefits due to me from my insurance company payable to me. I further authorize the release fo medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information and the Health Care Finance Administration or it intermediaries or carriers any information needed for this or a related medical claims. I request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization, for any amount not covered by my insurance, and/or for any deductible pending at time of service.***

***PATIENT'S SIGNATURE:_____ DATE:_____***