Gastro Health & Nutrition

PATIENT INFORMATION FORM

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

FINANCIAL AGREEMENT

1. Services rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.
    a. You are responsible for copays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.
    b. For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.
2. It is your responsibility to notify our front desk of any insurance or address change. You will be responsible for any changes that occur if we are not notified.
3. Please inform us, if for any reason you are not able to keep your appointment at least 24 hours in advance. In case of no show without notification, we will charge $50.00 to cover the cost incurred for the preparation of your visit.

PATIENT AUTHORIZATION

I authorize Gastro Health & Nutrition to submit insurance claims using my signature on the file below. I authorize the release of any medical information necessary in order to process this assignment on the claim, I authorize payment of medical benefits to be paid directly to Health and Wellness Solutions, PA: d/b/a GASTRO HEALTH AND NUTRITION.

X_____ _____

Patient Signature (or authorized representative) (Date)

Gastro Health and Nutrition Acknowledgement

At each visit, a distance summary will be provided. This would entail reviewing medications, physician instructions, diagnoses and follow up appointments. Please review and notify us of any discrepancy in a timely manner so that it can be rectified. By signing this agreement, you acknowledge the protocol of the chart summary.

X_____ Date:_____

GENERAL CONSENT FOR TREATMENT

I hereby voluntary consent for treatment to the facility. I permit the facility and its employees, physicians, and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for the treatment and/or test. I consent to examinations, blood tests (including blood test for communicable diseases such as hepatitis and HIV/AIDS when healthcare providers have been exposed to my blood/fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatment rendered by the facility personnel under the instructions, order or direction of such physician(s).

X_____ Date:_____