ASHEVILLE GASTROENTEROLOGY ASSOCIATES
A Division of Digestive Health Partners, P.A.
191 Biltmore Avenue, Asheville, North Carolina 28801
828.254.0881 FAX 828.258.1614

PATIENT INFORMATION FORM

☐ **New Patient** ☐ **Name Change** ☐ **Address Change** ☐ **Insurance Change**

Patient's Full Name: Last ______________________________ First ______________________________ M.I.______

Gender: ___Male ___Female Date of Birth ________ Marital Status: ___Married ___Single ___Widowed ___Divorced

Patient's Street Address ____

City ____ State________________________ Zip_________________

Patient's Home Phone (_____) _________________ Work Phone (_____) ____________________

Patient's Cell Phone (_____) _________________ E-Mail Address ____

Patient's Employer____ Occupation______________________

Employer's Address____

In Case of Emergency Contact (Not living with you)____________________________Relationship____________________

Contact Address____ Telephone_________________________

Primary Insurance ____

Policy Number____________________ Group number______________ Effective Date_______________

Subscriber's Name _____________________________________ Date of Birth _____________________

Secondary Insurance ____

Policy Number____________________ Group number______________ Effective Date_______________

Subscriber's Name _____________________________________ Date of Birth _____________________

INSURANCE AUTHORIZATION

I authorize any holder of medical or other information about me to release to my provided insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signature: ____ Date: ____________

FINANCIAL POLICY

PAYMENT AT THE TIME OF SERVICE

As a courtesy, we will bill your insurance for all billable services; however, you will be expected to pay any portion of your cost not covered by your insurance due to deductible, co-insurance, or co-payments on the day of service.

SUBMISSION OF CLAIMS

Your health insurance plan is a contract between you and your insurer. It is the patient's responsibility to understand their insurance policy limitations. In the event your health insurance determines that they will not cover a service that you have received, you will be responsible for payment. Our business office can provide additional information and support for disputes and appeals. Please note – patient diagnosis cannot be changed on, added to, or deleted from a claim in order to facilitate better insurance coverage.

OUTSTANDING BALANCES

We urge you to keep your account current with our office. When an account balance becomes more than 90 days past due, it may be referred to an outside collection agency. At that time, any additional fees incurred on the account will be the responsibility of the patient. If you need to make special payment arrangements, it is your responsibility to contact our business office before your account is sent to an agency. Minimum monthly payment arrangements may be made for no less than $50 per month, depending upon the balance incurred.

PAYMENT PLANS

Only an approved, official, and signed payment plan document will stand as an acceptable payment agreement. Incremental payments made apart from an official payment plan will not be recognized as a payment arrangement between a patient and Asheville Gastroenterology Associates.

OVERPAYMENTS

In the event of an overpayment, our office will work to refund any applicable credits, minus any balances, as quickly as possible.

RETURNED CHECKS, NSF, CLOSED ACCOUNTS

Payments made to Asheville Gastroenterology Associates that are not honored by the bank will incur a returned check fee of $35.00.

Guarantor Signature: ________________________________ **Date** ________________

By signing above, you agree to all the terms and conditions contained herein.