# North Valley Gastroenterology Medical Group, Inc. and The Endoscopy Center, Inc.

Patient Id: _____ Provider:_____ _____ Referring Provider:_____ Today's Date: July 14, 2021

**Patient Information:**
Last Name:_____First Name:_____Middle Initial:___
House Address:_____ _____ _____
Mailing Address (If different):_____
Primary Tel#:_____ Secondary Tel #:_____ Email:_____
Gender:__ Marital Status:_____ Birth Date:_____ SSN:_____ _____ _____
Ethnicity/Race:_____ Preferred Language:_____

**Responsible Party: Guarantor Info** (parent info for Minors)
Guarantor's Last Name: _____ Guarantor's First Name: _____
Guarantor's DOB: _____Guarantor's SSN: _____ Guarantor ph. #_____

**Spouse Information:**
Last Name: _____First Name: _____ Middle Initial:__ Suffix:___
Birth Date: _____ Social Security Number: _____ Gender: _____
Can we release the following information to your spouse: Medical information: Y or N Financial Information: Y or N

**Emergency Information:**
Last Name:Anderson _____ First Name:Victoria_____
Address:_____ _____
Relationship to patient:_____ Telephone: _____
Can we release the following info to your emergency contact: Medical information: Y or N Financial Information: Y or N

**RELEASE OF INFORMATION:** (other than spouse and emergency contacts)

In compliance with HIPAA I give North Valley GI Medical Group and The Endoscopy Center permission to discuss my MEDICAL and/or FINANCIAL information with: (circle choice)
Name: _____ Relationship: _____ Medical Yes No Financial Yes No
Name: _____ Relationship: _____ Medical Yes No Financial Yes No

**Insurance Information:** (All fields are required, for billing purposes)
Primary Carrier:_____ Subscriber'sDOB:_____
Subscriber's Name:_____ _____ Subscriber's SSN:_____
Policy Number: _____ Group#: _____
Patient's relationship to subscriber: Self Spouse Child Other _____

Secondary Carrier:_____ Subscriber'sDOB:_____
Subscriber's Name:_____ Subscriber's SSN:_____
Policy Number:_____ Group#:_____
Patient's relationship to subscriber: Self Spouse Child Other _____



office use only: Form received and reviewed by:_____

## North Valley Gastroenterology Medical Group, Inc. and The Endoscopy Center, Inc.

**INSURANCE POLICY:**

I request that payment of authorized Medicare or any other health insurance benefits be made to North Valley Gastroenterology Medical Group and/or The Endoscopy Center for any services furnished by these physicians. In addition, I agree that I am financially responsible for all services rendered. I authorize NVGI and/or The Endoscopy Center to release the information to my health insurance provider and its agents to determine benefits.

Filing insurance claims is a service provided without charge and in no way relieves you of your financial responsibility. It is your responsibility to assure in advance that your proposed treatment/procedure is covered under your insurance plan. We will attempt to obtain the authorization for you if you need our assistance.

**I have read and understand the Insurance Information _____ Initials**

**FINANCIAL POLICY:**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

**All patients must complete our information form before seeing the physician.**

**Full payment is due at the time of service, we accept Cash, Checks or Credit Cards (Master Card and Visa)**

**Adult Patients:** are responsible for full payment at the time of service.

**Minor Patients:** The parent or guardian of the minor is responsible for full payment. For an unaccompanied minor, non-emergency, treatment will be denied.

**Insufficient Funds:** A **$50.00** fee will be charged for any payment returned for insufficient funds.
**Co-pays:** Co-pays must be collected at time of service.

**Insurance Cards**: Insurance cards must be provided at time of check-in, if not insurance cards must be presented within 48 hours to avoid responsibility of claim balances.

**Cancellation Policy:** North *Valley Gastroenterology Medical Group Inc.*: Unless canceled, at least **2 business days in advance**, our policy is to charge **$50.00** for missed appointments. *The Endoscopy Center Inc.:* Unless canceled, at least **3 business days in advance**, our policy is to charge **$200.00** for missed appointments.
**This charge is patient responsibility; insurance companies will not pay this charge.**

I understand if I have an unpaid balance to North Valley Gastroenterology Medical Group, Inc. and The Endoscopy Center, Inc. and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collectioning my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for North Valley Gastroenterology Medical Group, Inc. and The Endoscopy Center, Inc. or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that North Valley Gastroenterology Medical Group, Inc. and The Endoscopy Center, Inc. and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and /or use of an automatic dialing device, as applicable.

**I have read and understand the Financial Policy**

Signature _____ (Services will be refused if you refuse to sign this acknowledgment).



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## Acknowledgment of Receipt of Notice of Privacy Practices (HIPAA)

A copy of this office's Notice of Privacy Practices is posted in the waiting room. (copies provided upon request)

Signature _____ (Service will not be refused if you refuse to sign this acknowledgment).

## Acknowledgment of Receipt of Patient Rights and Responsibilities

A copy of this office's Patient Rights and Responsibilities is posted in the waiting room. (copies provided upon request)

Signature _____ (Service will not be refused if you refuse to sign this acknowledgment).

**I have completed to the best of my ability and knowledge and I understand the patient information form of North Valley Gastroenterology Medical Group Inc. and The Endoscopy Center Inc. I have initialed and agree to the Insurance Information and the Financial Policy contained in this form.**

**Signature** _____ **Date Signed** _____



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