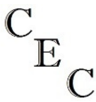

COASTAL ENDOSCOPY CENTER, LLC

175 Gunning River Road | Building A | Unit 4 | Barnegat, NJ 08005-1436
Tel: (609) 698-0700 Fax: (609) 698-0777

PATIENT INFORMATION (*Please be sure to fill out* ***entirely***)

Name:____**SS#**_____-___-______ **Birthdate**:___/____/____ **Age**:_________
Last **First** **MI**
Sex: [ ] Male [ ] Female **Marital Status:** [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Phone: (____)___________________ **Work Phone:** (____)_____________ **Cell Phone:** (____)______________

Address:____
Street City State Zip

Emergency Contact Person:____
Name **Phone** **Relationship**
Patient's Employer:____**Occupation**:_____________________

Employer's Address:____
Street **City** **State** **Zip**
All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit this information to your primary and secondary insurance carrier. Any remaining balance after receipt of explanation of benefits from your insurance carrier will be billed to you.

INSURANCE AUTHORIZATION AND ASSIGNMENT (*Please be sure to fill out* ***entirely***)

NAME OF PRIMARY INSURANCE HOLDER: ______________________________________**DATE OF BIRTH**______________

RELATIONSHIP: [ ] Self [ ] Spouse [ ] Parent [ ] Other

PRIMARY INSURANCE POLICY: _________________________________ **POLICY ID #:** _______________________________________

SECONDARY POLICY (if applicable):__________________________________ **POLICY ID#.**____________________________________

RELATIONSHIP: [ ] Self [ ] Spouse [ ] Parent [ ] Other

I request that payment of authorized Medicare/other insurance company benefits be made either to me on my behalf or to the Coastal Endoscopy Center for any services furnished me by that third part who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.
I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and information needed for this or a related Medicare claim/other Insurance company 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 to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

____ ________________________
Signature of Patient or Responsible Party Date

LABORATORY TESTING

During the course of your procedure it may be necessary for your physician to obtain and send tissue samples, blood samples, or request other laboratory testing. The State of New Jersey now requires clinical laboratories to directly bill patients for their testing services. In other words, they may not present a bill for its services to any person other than the person who is the recipient of the services, or that person's legal representative. Therefore, it is necessary for the Coastal Endoscopy Center to receive authorization from the patient in order for us to allow the laboratory to bill your insurance company for you. If you do not want the laboratory to bill your insurance company, then billing for the services will go directly to you as the patient.

Please complete and sign below so that we may direct this issue in the proper manner.

Thank you for your cooperation with this matter.

Lab Corp *Only*
Quest Lab *Only*

[ ] Yes, I am giving the laboratory permission to bill my insurance company

[ ] No, I do not give the laboratory permission to bill my insurance company. I am aware that I am responsible for payment of services directly to the laboratory

____ ______________________
Signature of Patient or Responsible Party Date

REGISTRATION

9/11/2014