



ADVANCED ENDOSCOPY & SURGICAL CENTER, LLC

142 Route 35 Suite 101 Eatontown, NJ 07724 Tel: (732) 935-0031 Fax: (732) 935-0032

PATIENT INFORMATION

Name: _____ SS #: _____ - _____ - _____ Birth Date: ____/____/____ Age: _____
Last First MI

Male () Female () Marital Status: Single () Married () Widowed () Divorced ()

Home: (____) _____ Work: (____) _____ Cell: (____) _____

Address: _____
Street City State Zip

Emergency Contact Person: _____
Name Phone Relationship

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

PLEASE BE SURE TO BRING YOUR INSURANCE CARD TO THE CENTER ON THE DAY OF YOUR PROCEDURE.

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 to your primary and secondary insurance. Any remaining balance after receipt of explanation of benefits from your primary and/or secondary insurance carrier will be billed to you.

INSURANCE AUTHORIZATION AND ASSIGNMENT

NAME OF POLICY HOLDER: _____ DATE OF BIRTH _____

I request that payment of authorized Medicare/other insurance company benefits be made either to me on my behalf or to the Advanced Endoscopy & Surgical Center for any services furnished me by that third party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any 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 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 Advanced Endoscopy & Surgical 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.

[] 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