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The state-of-the-art procedure center supporting several regional clinics.

The Center for Digestive Wellness | 10461 Wallace Alley Dr. | Kingsport TN 37663 | ph 423.279.1400 | fx 423.279.1410

Please fill out completely:

Name: _____ Male Female
(Last) (First) (Middle Name)

Date of Birth: _____ Social Security Number: _____

Address: _____
(Street Name) (City) (State) (Zip Code)

Phone Number: Home _____ Cell Phone _____

Employer Name and Phone Number: _____

Emergency Contact (Other than home phone): _____
(Name) (Number)

Family Physician: _____ Referring Physician: _____

Spouse Information: (Or Guardian if patient is a minor):

Name: _____ Birthdate: _____

Social Security Number: _____ Employer/Retired: _____

Insurance filed through: Self Spouse Parent/Guardian: _____ Insurance Co.: _____

I certify that the information given by me in applying for payment under TITLE XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the SS Administration and/or the Medicare program of its information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

SIGNATURE: _____ DATE: _____

I authorize the signed physician to release any information necessary to process my insurance claim in the course to my examination or treatment and permit payment directly to him, any benefits due me for his services rendered. I recognize and accept personal responsibility for any balance remaining after payment of such benefits.

SIGNATURE: _____ DATE: _____

**COPAYS ARE DUE AT TIME OF SERVICE.
IF COPAYS ARE NOT PAID AT TIME OF SERVICE, PATIENT WILL BE BILLED A \$5.00 SERVICE CHARGE.**

Acknowledgement of Receipt of Notice of Privacy Practices

Tri-Cities Gastroenterology reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Tri-Cities Gastroenterology.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative (required if patient is minor or adult unable to sign this form)

Relationship of Patient Representative to Patient

Providing you with the quality care we expect for our own family.