

CENTRAL COAST GASTROENTEROLOGY MEDICAL GROUP
MICK S. MEISELMAN, MD

PATIENT:

Full Legal Name: _____

Male _____ Female _____ Age _____

Mailing Address: _____

Date of Birth _____

City _____ Zip _____

Home Phone#(____) _____

E-mail _____

Cell Phone# (____) _____

Social Security # _____

Marital Status: S _____ M _____ D _____ W _____ DP _____

Primary Care Physician _____

Employer _____

Emergency Contact Person & Phone # _____

Address _____

City _____

Phone# (____) _____

Preferred method of communication ___ Home phone ___ Cell Phone

Occupation: _____

PARENT/SPOUSE:

Name: _____

Date of Birth _____

Employer _____

Phone # (____) _____

Address _____

Social Security # _____

Local Pharmacy: _____
(Any medications prescribed in this office will be available here for your pick up)

Language/Race/Ethnicity Demographic Questions

In order to satisfy the new government requirement for Meaningful Use of Electronic Health Records, we need to ask you about you ethnic origin, race and language preference. Please understand you are under no obligation to answer and you may decline to do so.

Race: ___ White
___ American Indian or Alaska native
___ Asian
___ Black or African American
___ Native Hawaiian or Pacific Islander
___ Other _____
___ Declined to answer

Language: ___ English
___ Arabic
___ Cantonese
___ Hebrew
___ Japanese
___ Korean
___ Mandarin
___ Russian
___ Spanish
___ Other _____

Ethnic Origin: ___ Hispanic or Latino
___ Not Hispanic or Latino
___ Declined to answer

****It is your responsibility to know benefits provided by your insurance company****

FINANCIAL POLICY:

- **Medicare:** This office accepts Medicare assignment. This means Medicare pays 80% of the allowable charges and you pay the remaining 20%. In addition, you are responsible for paying the annual Medicare deductible. Supplemental or secondary plans may cover the 20% Medicare allows but does not pay. This office will bill most of these insurance plans. However, you are responsible for any balance of the 20% your secondary does not cover. If the possibility exists that Medicare will not cover anticipated charges, you will be notified in advance and will be asked to sign an Advance Beneficiary Notice (ABN).
- **PPO, HMO (Contracted Plans):** Know your coverage. All appointments will be scheduled after receiving any required authorization from your insurance company. Co-pay's are due at the time of service. We will submit your claim to your insurance carrier. You will continue to receive statements that reflect any insurance payments received by us and any co-payments or balance that you owe.
- **Other Private Insurance (Non-contracted Plans):** If you are covered by an insurance company that our office does not contract with, payment for an office visit is expected at the time of the visit. Payment for hospital services is expected when you receive our statement. While every effort will be made to assist you with the insurance billing, you, not your insurance company, are responsible for paying our bill.

AGREEMENT: I have read the financial policy and understand my financial obligations. I hereby authorize Central Coast Gastroenterology Medical Group to release my medical records or other information to the insurance carries, to the physician from whom I was referred, or to any physician or facility to which CCGMG may refer me. I also understand that I am financially responsible for all charges whether or not covered by insurance.

Signature

Date