Treasure Coast GI
Scott Altschuler, MD
1701 SE Hillmoor Dr Suite 4
Port St Lucie, Fl 34952
Ph: 772-777-2575 Fax: 772-777-2587

Patient Information Sheet

Name:____**Date of Birth**:________/_____/______
First Middle Last

Address: ____
Street City State Zip

Please Check One: ☐ Male ☐ Female **Social Security Number**: _____-____-_______

Telephone#:_________________________________ **May we leave a message on this number** ☐ Yes ☐ No

Cell#:_____________________________________ **May we leave a message on this number** ☐ Yes ☐ No

Work #:____________________________________ **E-Mail Address**:____

Emergency Contact:___________________________**Phone#**_________________________**Relationship**:______________________

Name of Family Physician: ____

Primary Insurance:_______________________________________**Policy#**________________________________**Group#**______________________

Policyholder's Full Name (The person who holds the policy)____

Policyholder's Date of Birth:_______________/________/_________**Relationship to Patient**:____

Secondary Insurance:___________________________________**Policy#**___________________________________**Group#**________________________

PLEASE INITIAL:

_____I authorize any holder of medical or other information about me to release same to the social security administration and center for Medicare and Medicaid services (CMS, formerly chufa) or its intermediaries or carrier, the minimum necessary information needed for this or a related insurance or Medicare 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. Regulations pertaining to insurance or Medicare assignment of benefits apply.

_____I attest that the insurance information that I have provided is true and accurate. If this information is found to be false, I will be responsible for payment of all services rendered.

_____I also authorize the transfer of my protected health information (phi) to others for the purposed of "treatment" to be "electronically" transmitted in my behalf, including but not limited to fax, mail, e-mail, or via computer database.

_____If you must cancel an appointment with our office, we ask that you notify us 24-48 hours in advance. There is a $50.00 fee for "no shows" on a routine visit and $100.00 fee for "no shows" for procedure. These fees are due prior to scheduling your next appointment.

______ I have received and/or reviewed this office's notice of privacy practices, as well as the patient responsibility and accountability contract.

______ I further acknowledge that I am responsible to uphold all TCGI policies and agree not to sue Dr. Altschuler, or the professional corporation of TGGI for any reason. This signed receipt will become part of my permanent medical records.

______ The doctor-patient relationship is based on trust and open communication. In order for your physician to make valid diagnosis and render beneficial care, the information you provide to him/her must be complete and true.

***Your doctor is not allowed to release information to anyone but the patient. If you would like our office to be able to discuss results with anyone besides yourself, please indicate this below**:*

- ☐ Only to myself
- ☐ Name:____Relationship:_____________________________
- ☐ Name:____Relationship:_____________________________

By signing below, I acknowledge that I have read and understand the above information.

Signature:____**Date:**_________/________/_______

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Insurance Benefits

As a patient, it is in your best interest to know if your insurance plan is contracted with Treasure Coast Gastroenterology, and to understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Your may have different deductibles, co-insurance, or co-payment amounts, depending on the contracted status of your insurance company.

If the physician is not listed as a contracted provider and/or not in is not in your insurance company's network, we are still happy to file your insurance and provide you with services. If your policy has out-of-pocket benefits, your insurance plan may still cover services provided to you at Treasure Coast Gastroenterology, however, you may be responsible to pay a higher amount out of pocket than if you receive services from an in-network provider. Your insurance company's customer service representative can help you verify your benefits and out-of-pocket costs.

A listing in an insurance handbook or online is NOT a guarantee that we are providers. Not all services are covered in all insurance contacts. If your insurance plan benefits do not cover a service or procedure, you will be held personally responsible for payments of these charges. To find out what your insurance plan benefit covers, and an estimate of financial obligation may be, you must call the customer or member services department of your insurance company. You can find this phone number on the back of your insurance identification card. Your employer's human resources department may also be a source of information or assistance.

Print Name of Patient/Responsible Party: ___________________________________ Date: ____________________

Sign Name of Patient/Responsible Party: ___________________________________ Date: ____________________

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Patient Responsibility & Accountability Contract

At Treasure Coast Gastroenterology (TCGI), in order to meet the basic requirements necessary to maintain doctor-patient relationships, we must hold our patients accountable. Please read the following policies carefully, and initial on each line to verify that you have read and understand your responsibilities as a patient. Failure to uphold any portion of this contract may result in immediate termination from care at TCGI.

I, (Print name) ______________________________DOB____________, hereby consent to be examined by the medical staff at TCGI and to tested and treated as deemed necessary and appropriate by them.

_____ I agree to pay my co-payment, based on my insurance plan, at the time of each appointment.

_____ I agree to update my Patient Information Form and insurance documentation as required by TCGI.

_____ I understand that any three (3) missed appointments within a 12-month period may disqualify me for services at TCGI. I agree to call at least 24 hours in advance if I need to cancel or reschedule an appointment.

_____ I understand that it is my responsibility to arrive on time (standard procedure is to arrive 15 minutes early) for all appointments. I understand my appointment may be rescheduled if I arrive late. (At the discretion of the provider.)

_____ I agree to contact my local pharmacy when I have five (5) days of medication remaining. This allows your provider to process your refill in a timely manner.

Signature of Responsible Party: ____________________________ Date: ________________

TCGI Representative: ______________________________ Date: ________________

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Our Financial Policy

1. Why is this policy now in writing?
   - This is the financial policy of Treasure Coast Gastroenterology (TCGI). The purpose of this document is to communicate our expectations.
2. Why do patients need to update personal information?
   - On an annual basis, we ask that patients update your personal information. This helps us to keep current with any changes in your medical history, demographic data, or insurance information that may be pertinent.
3. Initial office visit- What payment is required?
   - Prior to your first visit with our office, we will verify your insurance to assure that we are a member of the plan under which you are covered. We will then communicate to you regarding your responsibility.
4. Allowable forms of payment include:
   - Personal checks, Debit cards, Visa, Mastercard, Discovery, and American Express.
5. Appointment cancellation policy and charges:
   - We request at least 24-hour cancellation notice prior to appointment. This allows another patient who may be ill to take your time slot. Cancellations that continue to occur may results in you being charged for that appointment.
6. Patient is responsible for appropriate charges.
   - We do not look to a third party for payment. Co-pays must be paid at the time of the visit. Deductibles and your co-insurance must be paid immediately upon notice from your insurance company.
7. Maximum number of payments allowed.
   - Special payment arrangements for patients who do not have insurance may be made prior to him/her having diagnostic testing or seeing a provider. Patients without insurance will be expected to pau for his/her entire visit at time of service
8. Collection Policy
   - Any account turned over to collections will have a $25.00 collection fee added to the outstanding balance. To discuss any aspect of our financial policy, you may contact our Billing Manager or Practice Administrator with any questions/concerns at any time.

Insurance Information
Your health insurance is a contact between you and your insurer. Any charges not paid by your insurance for any reason if your responsibility. It is your responsibility to understand your insurance benefits, including plan limitations and the difference between screening or preventative care benefits versus diagnostic procedure benefits and the need for referrals or pre-authorizations. Note- We will make every effort in verifying your benefits and complete prior authorizations on your behalf; however, this is not a guarantee of payment. We will bill your insurance for all services we provide; however, we require you to pay any portion of your financial liability for care, copays, deductibles, or co-insurance, prior to service.

Signature of Responsible Party: ____________________________ Date: ________________

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Release of Medical Records

I, the undersigned patient, or legal representative, hereby authorizes Treasure Coast Gastroenterology to request any health information, including the diagnosis and records of any treatment or examination rendered to me.

PLEASE PRINT CLEARLY

Patient Name: ___________________________
Date of Birth: ____________________________

OFFICE USE ONLY:

This information may be disclosed to and used by the following:
Name: **Treasure Coast Gastroenterology**
Address: 1701 SE Hillmoor Drive Suite 4, Port St. Lucie, Florida 34952
Phone Number: 772-777-2575 Fax Number:772-777-2587

The dates of service and the type(s) of information to be used or disclosed are as follows:
DATE(S) OF SERVICE:____________________________________
RECORDS REQUESTED:___________________________________
Hospital or Facility: ______________________________________
DOCTOR('s) ____

This request is for the purpose of treatment, payment, and/or Health Care operations. This authorization will be valid while I am a current patient with Treasure Coast Gastroenterology. I understand that I may revoke this authorization at any time by notifying Treasure Coast Gastroenterology in writing, but if I do it will not have any effect on actions that Treasure Coast Gastroenterology took before it received the revocation. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that I may inspect or copy the information to be used or disclosed.

Date: ____

Patient Address: __________________________________

Signature of Patient or Legal Representative:

____

If signed by a Legal Representative, indicate your relationship to the patient below and provide appropriate documentation to verify your authority:

□ Parent □ Guardian □ Conservator □ Executor of Estate □ Power of Attorney □ Other