BHS-Digestive Disease Associates

(PLEASE PRINT)

Patient Information/Informacion del Paciente

Last Name: _____ First Name: _____

Address _____ City _____ State Zip _____

Your Contact phone # _____ Your EMAIL Address _____

Referring Doctor _____ Social Security # _____

Birthdate _____ Marital Status S M W D

Race A=Asian---P=Native Hawaiian---O=Other Polynesian---B=Black---N=Native American---W=White---3=More than one Race---U=Unknown

Ethnicity Y=Hispanic N=Non Hispanic X=All Others U= declind to specify

Employer _____ Work Phone # _____

Address _____ City, State Zip _____

Pharmacy Name_____ Pharmacy Phone #_____

Pharmacy Address_____ City,State,Zip_____

Insurance responsible person/Persona responsible

Name _____ Relationship to Patient_____

DOB _____ Social Security # _____

Consent for Treatment/Consentimiento para tratamiento

I authorize BHS physicians, their nurses and staff under their direction, to conduct examinations, administer treatment and/or medication as they deemed necessary or advisable.

Yo autorizo BHS doctors,las enfermeras y personal que este bajo su direccion, a examinar, administrar tratmiento y/o medicamento segun sea necesario y recomendable.

Signature/Firma X _____ Date _____

Payment Policy-Assignment of Benefits/Poliza de Pago-Autorizacion de Beneficios

I the undersigned hereby authorize the release of any information relating to all claims for benefits submitted on my behalf. I further agree and acknowledge that my signature on this document authorizes BHS to submit claims for benefits on my behalf without obtaining my signature on each and every claims submitted for myself and that I will bound by this signature as though the undersigned had personally signed the particular claim. I also understand that verification of benefits is not a guarantee of payment and that I accept liability for services not paid for by my insurance company for whatever reason.

Yo, el abajo firmante y por este medio, autorizo se disponga de cualquier informacion en relacion con los cobros sometidos en mi nombre. Admito que mi firma en este documento autoriza a BHS en me nombre a someter cargos por servicios prestados sin necesidad de obtener mi firma para cada uno de los cobros o cargos sometidos. Por medio de mi firma se hace valida cualquier peticion adicional como si yo la hubiera firmado personalmente.
Ademas somprendo que la verificacion de beneficios no es garantia de pago y acepto la responsabilidad de cobros o servicios que no sean cubiertos por mi compania de seguro.

Signature/Firma X _____ Date _____