

PATIENT INFORMATION FORM

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

FINANCIAL AGREEMENT

- 1. Services rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.
 - a. You are responsible for copays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.
 - b. For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.
- 2. It is your responsibility to notify our front desk of any insurance or address change. You will be responsible for any changes that occur if we are not notified.
- 3. Please inform us, if for any reason you are not able to keep your appointment at least 24 hours in advance. In case of no show without notification, we will charge \$50.00 to cover the cost incurred for the preparation of your visit.

PATIENT AUTHORIZATION

I authorize Gastro Health & Nutrition to submit insurance claims using my signature on the file below. I authorize the release of any medical information necessary in order to process this assignment on the claim, I authorize payment of medical benefits to be paid directly to Health and Wellness Solutions, PA: d/b/a GASTRO HEALTH AND NUTRITION.

X		
Patient Signature (or aut	horized representative)	(Date)

Gastro Health and Nutrition Acknowledgement

diagnoses and follow up	summary will be provided. This would entail reviewing medications, physician instructions, appointments. Please review and notify us of any discrepancy in a timely manner so that gning this agreement, you acknowledge the protocol of the chart summary.
x	Date:
	GENERAL CONSENT FOR TREATMENT
others involved in my ca to ask questions and to for the treatment and/o diseases such as hepati laboratory and imaging	ent for treatment to the facility. I permit the facility and its employees, physicians, and are to treat me in ways they judge to be beneficial to me. I understand that I have the right receive information about my care and treatment, and the right to withdraw my consent or test. I consent to examinations, blood tests (including blood test for communicable its and HIV/AIDS when healthcare providers have been exposed to my blood/fluids), procedures, medications, infusions, nursing care and other services or treatment rendered under the instructions, order or direction of such physician(s).
X	Date: