

PATIENT INFORMATION – PLEASE PRINT

NEW PATIENT
 ANNUAL UPDATE
 ADDRESS CHANGE
 NAME CHANGE

DONALD K. BRYAN, MD
 CHRISTOPHER M. COPELAND, MD
 DAVID C. BELL, MD
 CAROL J. GRECO, MD
 SANGEETA J. CROUSER, MD
 STEPHANIE W. COSTA, MD
 JASON V. MELILLO, MD
 KIMBERLY R. SHEPHERD, MD
 JASON G. SAYAT, MD

DATE _____

NAME _____
 LAST FIRST MI MAIDEN RELIGION

ADDRESS _____
 STREET CITY STATE ZIP CODE

() () ()
 HOME PHONE WORK PHONE CELL PHONE

SSN BIRTHDATE / AGE RACE

MARITAL STATUS (CIRCLE ONE) S M D W E-MAIL ADDRESS _____

PATIENT'S EMPLOYER _____
 OCCUPATION FT/PT

EMPLOYER'S ADDRESS _____
 STREET CITY STATE ZIP PHONE

PRIMARY CARE OR REFERRING PHYSICIAN _____

PERSON FINANCIALLY RESPONSIBLE _____

PRIMARY INSURANCE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY _____

NAME OF INUSRANCE COMPANY _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S BIRTHDATE POLICY HOLDER'S SS# _____

POLICY HOLDER'S BIRTHDATE POLICY HOLDER'S SS# _____

POLICY # GROUP # _____

POLICY # GROUP # _____

SPOUSE NAME _____
 LAST FIRST MI SSN BIRTHDATE/AGE

SPOUSE EMPLOYER _____
 OCCUPATION WORK PHONE FT/PT

EMERGENCY CONTACT _____
 LAST NAME FIRST NAME RELATIONSHIP TO PATIENT

ADDRESS _____
 STREET CITY STATE ZIP

() ()
 HOME PHONE WORK PHONE EMPLOYER

PLEASE PRESENT YOUR CURRENT INSURANCE CARD(S) TO THE RECEPTIONIST
PLEASE COMPLETE OTHER SIDE

NOTIFICATION TO ALL PATIENTS

The rigid regulations of the insurance industry require us to have you sign the following release.

PLEASE READ CAREFULLY

NON-COVERED SERVICE WAIVER

Medicare, Medicaid and private insurers or payers have limited coverage on the procedures listed below. Medicare does not question the value of the test but the program is required by statute to “specifically exclude services that are screening in nature” and to pay only for services that are “medically necessary . . . (for) the treatment and diagnosis of disease” as determined under Section 1862(a)(1)(A) of the Social Security Act. Your physician has determined that these tests are useful and consequently has ordered one or more of these tests to provide you with the degree of medical care he or she believes is necessary to protect your health. KGA will bill your insurance carrier for these procedures. If the service is denied, the billing will be forwarded to you, the patient, for payment. **Medicare and many insurers do not cover routine/annual health diagnostic testing for payment** without corresponding medical diagnosis or conditions as designated by them. This means payment may or may not be made for the following procedure/tests:

- _____ 1. Annual or routine health checks
- _____ 2. DEXA (bone) scans
- _____ 3. Blood occult: slides
- _____ 4. Mammograms
- _____ 5. Routine Lab work
- _____ 6. Pap smears
- _____ 7: Other

- _____ *Medicare usually does not pay for this service for the provided diagnosis
- _____ *Medicare does not pay for tests that do not have FDA approval
- _____ *Medicare usually does not pay for routine exams/lab work
- _____ *Medicare may not pay for this test frequently

By signing this form below you are agreeing to be fully responsible for payment of any services that are deemed medically unnecessary or they are not covered under your healthcare contract by your insurance carrier.

It is your responsibility, as a patient, to understand your health insurance and its limits. Read your policy and understand the benefits regarding your physician and selected hospital. It is a requirement of your insurance carrier that you present your insurance card at every visit. If you have any questions about your policy, please contact your agent or employer.

I have read and understand the above information and I agree to be personally and fully responsible as indicated if my insurance carrier or payer denies payment.

Insurance release: I authorize Kingsdale Gynecologic Associates, Inc. to release to my insurance company(s) and information relative to my treatment.

Signature: _____ (OR PARENT IF MINOR)

Date: _____

PLEASE COMPLETE OTHER SIDE