PATIENT INFORMATION PLEASE FILL FORM COMPLETELY

Race and Ethnicity questions are required to be asked to the patient by the Federal Government

Patient Name: _____ Date of Birth _____

Age: _____ Sex: F ____ M ____ Marital Status: M ____ S ____ D ____ W ____ Other _____

Employed _____ Retired _____ Unemployed _____ Student _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ Other Race ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to answer

Primary Language: _____

Primary Address: _____ City and State: _____

Patient's Phone (Primary) ( ) _____ Patient's Phone (Cell) ( ) _____

Email Address: _____

Please check your preference on how to contact you: ☐ Primary Phone ☐ Cell Phone

Can we leave test results on your phone? ☐ Yes ☐ No Who can we leave results with? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician: _____

Is this visit related to a Work Accident: _____ Auto Accident: _____

or Other Accident _____

Pharmacy Name: _____ Phone: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

Subscriber's Name: _____ Relationship to Patient: _____

Date of Birth: _____ ID#: _____ Group#: _____

Secondary Insurance Company: _____

Subscriber's Name: _____ Relationship to Patient: _____

Date of Birth: _____ ID#: _____ Group#: _____

I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to George Georgakakis, M.D., PA. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles, co-pays and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

Signature: _____ Date: _____

FINANCIAL & TREATMENT CONSENT

I hereby authorize said assignee to release all information necessary to secure payment. I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services or authorize such physician to submit a claim to the above insurance company for payment to me. **I understand that I am financially responsible for all charges whether paid by my insurance, including any deductibles and co-pays, and that payments are due at the time services are rendered. I understand and agree that in the event that I fail to make payments for services rendered to me, my name and account may be turned over to an attorney or a collection agency, and I agree to pay collection agency fees of 30% plus patient account balance, court costs, and/or reasonable attorney's fees that may be incurred in the collection of any outstanding balance.**

I hereby voluntarily consent to outpatient care at George Georgakakis, M.D., P.A., encompassing routine diagnostic procedures (scopes), examination and medical treatment.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including audiologists, medical assistants or their designees as is necessary in the physician's judgment.

Patient Signature: _____ Date: _____

MEDICARE CONSENT

I certify that the information given by me in applying for payment under Title SVIII and /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Patient Signature: _____ Date: _____