HAMPSHIRE GASTROENTEROLOGY ASSOCIATES, LLC
10 MAIN STREET, FLORENCE, MASSACHUSETTS 01062
(413) 586-8910 FAX (413) 584-7270

PATIENT INFORMATION SHEET

Name: _____ Acct # _____

Address: _____City:_____ State:_____Zip Code:_____

Telephone: (Home) _____(Work)_____Social Sec #:_____-_____-_____

Date of Birth: _____ M____ F____ Primary Care Provider: _____

Employer: _____ Address: _____

Primary Insurance Co: _____ Ins. Co. Address: _____

Subscriber's Name: _____Subsciber's Date of Birth: _____

Subscriber's Relationship to you: _____

Insurance Policy #_____ Group or Plan #:_____

Secondary Insurance Co: _____ Ins. Co. Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Relationship to you: _____

Insurance Policy #:_____ Group or Plan #:_____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

Telephone #:_____ Relationship: _____

CONSENT FOR TREATMENT

I authorize **HAMPSHIRE GASTROENTEROLOGY ASSOCIATES, LLC** and/or their designee to examine, treat and perform any diagnostic testing or certain procedures on me in the office which he deems necessary to properly evaluate my condition.

_____ _____/_____/_____
Patient or Authorized Representative Date

ASSIGNMENT OF BENEFITS

I authorize the release of medical information necessary to process my insurance claims for services rendered to me by the office of **HAMPSHIRE GASTROENTEROLOGY ASSOCIATES, LLC.** This assignment shall remain in effect until revoked by me in writing.

I authorize payment of my insurance to be made on behalf to **HAMPSHIRE GASTROENTEROLOGY ASSOCIATES, LLC.** I understand that I am financially responsible for all charges that are deemed not medically necessary by my insurance. I understand that it is my responsibility to obtain referrals for my visits, or I will be held liable for charges that result from that visit. I have read this information and understand its content.

_____ _____/_____/_____
Patient or Authorized Representative Date