Island Endoscopy Center, LLC

1175 MONTAUK HIGHWAY SUITE 1
WEST ISLIP, NY 11795
PHONE# (631) 376-0001

PATIENT INFORMATION

Name: _____ _____ _____ SS#: _____
Last First M

Address: _____ _____ _____ _____
Street City State Zip

Phone: _____ Work: _____ Cell: _____

Birth Date: _____ Age: _____ Sex: ____ Marital Status: S ☐ M ☐ W ☐ D ☐

Emergency Contact Person: _____ Emergency Contact Phone: _____

Patient's Employer: _____ Occupation: _____

Employers Address: _____ _____ _____ _____
Street City State Zip

PLEASE BE SURE TO BRING YOUR INSURANCE CARD TO THE CENTER THE DAY OF YOUR PROCEDURE

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder: _____ DOB of Policy Holder: _____

Social Security # of Policy Holder: _____

I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Island Endoscopy Center, LLC for any services furnished to me by that third party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

In the event my insurance company pays me directly, I will forward payment immediately to Island Endoscopy Center, LLC along with the explanation of benefits from my insurance company. If my insurance company fails to make payment for my services, I agree to be financially responsible.

I authorize any holder of any medical or other information about me to release to the Social Security Administration and Health Care Administration or its intermediaries or carriers, information needed for this or a related Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 112.86 of the Social Security Act and 31 U.S.C. 3801-3912. provides penalties for withholding this information).

Signature: _____ Date: _____