The Casella Center for Advanced Gynecology, LLC

Peter J. Casella, MD FACOG

Patient Name: _____ DOB: _____/_____/_____ SS#: _____-_____-_____

Address: _____ City: _____State: _____Zip: _____

Home Phone#: (_____) _____-_____ Cell Phone#: (_____) _____-_____

Email Address: (Please print) _____

Please check appropriate line: _____ Minor _____ Single ____ Separated ____ Married _____ Divorced ____ Widow

Patient or Parents Employer_____ Work Phone# :(____) _____- _____

Business Address _____ City:_____State:_____Zip:_____

Spouse or Parent's Name_____ Contact # :(____) _____- _____

If patient is a student, School Name: _____ City: _____ State: ___

Primary Care Physician (PCP) and/or Referring Physician, address, phone_____

Whom may we thank for referring you? _____

How did you hear about our practice? _____

Emergency Contact Name: _____ Phone#: (____) _____- _____

Insurance Information

Primary Insurance HMO PPO POS OTHER

Insurance Carrier: _____

Policy#_____Group#_____

Policyholder's Name: _____

SS#_____DOB:_____

Relationship to patient: _____

Secondary Insurance HMO PPO POS OTHER

Insurance Carrier: _____

Policy#_____Group#_____

Policyholder's Name: _____

SS#_____DOB_____

Relationship to patient: _____

ASSIGNMENT OF BENEFITS

I authorize my health insurance benefit plan to pay directly to The Casella Center for Advanced Gynecology, LLC the surgical and/or medical benefits, if any, otherwise payable to me for services described on the attached claim, but not to exceed the charges for the service. If my health insurance plan will not direct payment to The Casella Center for Advanced Gynecology, LLC, I agree to forward all health insurance payments I receive for the services rendered by The Casella Center for Advanced Gynecology, LLC upon receipt of such payments.

OFFICE POLICY FOR PAYMENT

If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee. I have read and understand the office policy for payment and agree to the terms as stated.

I intend to pay my expense as follows: _____Cash/Check _____ Credit Card _____Insurance _____Medicare

Patient /Parent Signature_____Date_____

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