ENDOSCOPY CENTER
of the North Shore, LLC

Appt Date: _____Time: _____ **Office: 1732 Central St, Evanston IL 60201**

CONFIDENTIAL PATIENT INFORMATION – PLEASE USE THE PORTAL FOR MORE SECURE TRANSMITTAL OF PRIVILEGED INFORMATION

NAME (LAST, FIRST)	**SOCIAL SECURITY #**	**DATE OF BIRTH**	**SEX** M F	**AGE**	**EMAIL**		
STREET ADDRESS	**CITY**	**STATE**	**ZIP**	**CELL PHONE**	**HOME PHONE**		
PATIENT EMPLOYER	**EMPLOYER'S ADDRESS**				**BUSINESS PHONE**		
PRIMARY INSURANCE NAME:	☐ PPO ☐ HMO	**ID:**		**GROUP:**	**PRIMARY INS PHONE:**		
SUBSCRIBERS NAME (IF NOT PATIENT)	**SOCIAL SECURITY #**	**RELATIONSHIP**	**SEX** M F	**DATE OF BIRTH**			
SECONDARY INSURANCE NAME:	☐ PPO ☐ HMO	**ID:**		**GROUP:**	**SECONDARY INS PHONE:**		
SUBSCRIBERS NAME (IF NOT PATIENT)	**SOCIAL SECURITY #**	**RELATIONSHIP**	**SEX** M F	**DATE OF BIRTH**			
PRIMARY CARE DOCTOR	**PHONE:**	**FAX:**					
ADDRESS	**CITY**	**STATE**	**ZIP**	**REFFERED BY:**			
PHARMACY NAME & ADDRESS:	**SPOUSE/SIGNIFICANT OTHER:**	**LEAVE MSG?** YES NO	**OK TO DISCUSS YOU CASE WITH (PLEASE NAME):**				

AUTHORIZATION AND ASSIGNMENT

1) All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance payments. However, the patient is ultimately responsible for all fees, regardless of insurance coverage. For patients without insurance, it is necessary to make arrangements in advance with our Office Administrator.
2) The patient authorizes and requests the insurance company to pay directly to The Endoscopy Center of the North Shore any insurance benefits otherwise payable to them.
3) The patient authorizes the release of any information including the diagnosis and the records of any treatment or examination rendered to them during the period of such care to third party payors and/or other health care practitioners.
4) I hereby authorize the release of records to and from The Endoscopy Center of the North Shore, covering providers, and my primary doctor, including the diagnosis and records of any treatment or examination rendered to me.

MEDICARE PATIENT ACKNOWLEDGEMENT

If the patient receives notification that Medicare denied payment for services ordered by the physician according to section 1862(a)(1) of the Medicare Law, he or she agrees to be personally and fully responsible for the payment. The patient understands that if any part of the claim is denied, he or she will receive a bill from The Endoscopy Center. You may receive a check directly from Medicare for services we are owed. You are responsible for then paying this fee to us. Additional fees not covered by Medicare may apply.

I acknowledge that I have been given an opportunity to review a copy of Endoscopy Center of the North Shore's patient's privacy policy and the bill of patient's rights and responsibilities. A written copy is available upon request.

Patient Signature	**Date**