CENTER FOR DIGESTIVE& LIVER DISORDERS

James S. Amontree, MD

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet your healthcare needs, please fill out this form completely in ink or on-line. If you have any questions, please ask us - we will be happy to help.

1. Personal Information

Date Birth Date Social Security #

Name Male Female

Minor Single Married Divorced Widowed Separated

Local Mailing Address

City State Zip

Other Address

Employer Occupation

Referred by: Dr. Yellow Pages

Newspaper Insurance

Friend

2. Telephone

Home # Work # Cell #

Email Address

Where do you prefer to receive calls? Home Work Cell

When is the best time to reach you? Time Days

In the event of an emergency, who should we contact?

Name Relationship

Home # Work #

3. Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent, if minor Date

List below the names of relatives that are authorized to receive your personal health information:

4. Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Please note that we request you to pay your portion of the estimated payment at the time of visit.

Cash Personal Check Credit Card (Visa or MC) I wish to discuss

Late charges: If I do not pay the entire balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances.

5. Notice to Patients

If you need a procedure that is appropriate for an out-patient surgical facility, that procedure may be performed at the Charlotte Surgery Center, and I call the attention to that fact that I have an ownership interest in that center.

Signature of patient or parent, if minor Date

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Thank your for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.