Central Penn Gastroenterology Asso & Endoscopy Center

Vladimir Petorak, MD Joseph B. Gallagher, MD Georgina Ferriero, PA-C Hillarie Hartzell, PA-C

We are writing to confirm your appointment on _____. Please take a few minutes before your appointment, to fill out the following information on the enclosed forms. Feel free to call our office with any questions or concerns. Also, please bring your insurance cards and any medical information, including prescription cards which would be beneficial to the doctor. We will also need you to bring along your insurance referral if one is required. Payment is expected when services are rendered, unless other arrangements are made in advance. If you are unable to keep this appointment, please call our office to cancel or reschedule. (570)524-2722. Copays are due at time of service

Please Note: This appointment is for a consultation only.
A procedure will NOT be performed on this day.

Name:_____**Religion**:_____

Address:_____**Race**:_____

City:_____**State**:_____**Zip**:_____

Daytime Phone#:_____(**SPECIFY Home, Work or Cell**) **Cell #**_____

DOB:_____**Age**:_____**Maiden Name**_____

Sex:_____**SS#**:_____**Marital Status**:_____

Employer:_____**Occupation**_____

Spouse's Name:_____ **Patient's Email** _____

Insurance Co Name:_____**ID#**_____**GP#**_____

Subscriber:_____**Relationship to Patient:** Self/Spouse/Parent/Other

Subscriber DOB: _____

Referring Physician:_____**Family Physician**:_____

Pharmacy of Choice:_____**Pharmacy Phone Number**:_____

Emergency Contact/Relationship:_____**Phone#**:_____

How did you hear about us?_____

I request that payment of authorized medical benefits, including Medicare benefits, be made either to me on my behalf to Central Penn GI Asso/CPGI Endoscopy Center for any services furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, Social Security Administration, my insurance company or its intermediaries or carriers, this physician's office, my attorney, or other physician's offices any information needed for my medical care.

I permit a copy of this agreement to be used in place of the original. This agreement will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance.

_____ _____

Date Signature of Patient/Guardian/Responsible Party

(05/2015,07/2015,11/04/16)