COASTAL GASTROENTEROLOGY
A Division of Genesis Healthcare
700 Garden View Court
Suite 102
Encinitas, CA 92024

T 760.783.0441 F 760.635.5972

mygenesishealth.com

Robert Goldklang, M.D.
Adrianne LaJoie, M.D.
Steven DiLauro, M.D.

Angelina Collins, A.N.P.
Whitney Woodruff, F.N.P.

NAME_____ BIRTH DATE_____ AGE_____

ADDRESS_____ SEX_____ MARITAL STATUS_____

CITY_____ SOCIAL SECURITY _____

STATE_____ ZIP CODE_____

HOME PHONE _(_____)_____ DAYTIME PHONE __(_____)_____

EMPLOYER_____ SECURED E-MAIL_____

INSURANCE CARRIER: 1)_____ 2)_____

NAME OF INSURED_____ RELATION TO PATIENT_____

EMERGENCY CONTACT (NAME & PHONE)_____

REFERRED BY _____ PRIMARY M.D._____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the above named physician of the surgical and/or medical benefits otherwise payable to me for his services as described on the insurance claim. I realize that the insurance payment may\may not represent the full payment for services rendered and I understand that I am ultimately responsible for the balance due.
Most insurance companies will pay only for services they determine "reasonable and necessary" under section 1862 (a) (1) (A). If your insurance determines that a particular service is not reasonable and necessary for the diagnosis or treatment of illness or injury, they may deny payment. For example, they may deny payment for an office consultation/ visit (to discuss the need for screening colonoscopy). They may not cover **Colon Cancer Screening.**
NO SHOW POLICY: A **$25.00 charge** will be assessed for "no showing" or failing to give 24 hour notice for the need to cancel your office appointment.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Coastal Gastroenterology to release any information in the course of my examination or treatment to my insurance company and to whom I designate.

_____ _____
PATIENT SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge the Notice of Privacy Practices HIPAA and a copy is posted in the office and will be provided to me at my request.

_____ _____
PATIENT SIGNATURE DATE