DIGESTIVE HEALTH CENTER OF THE FOUR STATES, LLC

Allan P. Weston, M.D., FACG
Phone (620) 783-1650
198 Four States Drive, Suite 6 • Galena, KS 66739

PATIENT INFORMATION: (Please Print) **Today's Date:** _____/_____/_____

NAME:
First: _____ Middle Init: _____ Last: _____

Address: _____ SEX M F MARITAL STATUS Status: S M D W

City/State Zip: _____

Home Phone: _____ Cell Phone: _____ S.S.#: _____-_____-_____ Birth Date_____/_____/_____Age _____

Employer Name: _____ Employer Address: _____

Employer Phone: (_____)-_____-_____ Position (Job Title): _____ How long Employed? _____

RESPONSIBLE PARTY/SUBSCRIBER INFORMATION: (If Minor, Parent or Guardian)

NAME:
First: _____ Middle Init: _____ Last: _____ Relation to Patient _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Cell Phone: _____ S.S.#: _____-_____-_____ D.O.B._____/_____/_____Age: _____

Employer Name: _____ Employer Address: _____

Employer Phone: (_____)-_____-_____ Position (Job Title): _____ How long Employed? _____

SPOUSE INFORMATION:

NAME: _____ S.S. #: _____-_____-_____

ADDRESS: _____ D.O.B. _____/_____/_____

CITY: _____ STATE: _____ ZIP: _____ Cell Phone: ( )-_____-_____-_____

Employer Name: _____ Employer Address: _____

Employer Phone: (_____)-_____-_____ Position (Job Title): _____ How long Employed? _____

PERSON TO NOTIFY IN THE EVENT OF EMERGENCY: (Other than above)

Name: _____ Rel to Patient: _____

Address: _____

Employer Name: _____ Employer Address: _____

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

PRIMARY CARE PHYSICIAN: _____ **REFERRING PHYSICIAN:** _____

Assignment of Benefits: I hereby assign all medical benefits to include major medical benefits to which I am entitled, including private insurance and other health plans to Dr. Allan Weston. Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. The ultimate responsibility for payment lies with your, the patient.

Consent for Health Care: Patient voluntarily consents to such medical care including but not limited to laboratory, diagnostic or medical treatment which may be ordered by patient's physician or assistants, or designees for medical treatment which they may deem necessary and advisable. The agreement and assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I, the undersigned, authorize Dr. Allan Weston to release any information acquired in the course of my examination or treatment to my insurance company(s), or another physician or healthcare professionals or agents for the purpose of business operations, payment for health care services rendered, and continual treatment or coordination of care.

☐ I acknowledge that I have had the opportunity to read and/or receive a copy of Digestive Health Center of the Four States L.L.C., Notice of Privacy Practices A complete copy of the Notice is available at the check in window.

Patient or Guardian's Signature: _____ Date: _____/_____/_____

Form 101 Rev. 10/13 - Litho Printing 417-623-0843

Our Financial Policy

Dr. Allan Weston, M.D., FACG
198 Four States Drive, Suite 6
Galena KS 66739

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, we require you read and sign prior to any treatment.

Copay is due at time of service.
We accept cash, check, MasterCard, Visa, and Discover.

Regarding Insurance:
As a courtesy we will file your insurance for you. Your insurance co-pay is due in full at the time of service. Please remember your insurance policy is a contract between you and your insurance company. We are not a party in that contract unless it is a managed care policy that we have negotiated prior to your visit to this office. In the event we do not accept assignment of benefits the balance is your responsibility. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

We **CANNOT** bill your insurance unless you have provided us with the necessary information. In order for us to bill it we require a copy of all your insurance cards and a copy of your driver's license or state approved photo ID. If you do not provide us with your insurance information, you will be responsible for payment in full.

After 60 days, if your insurance has not paid your claim, this bill will be turned over to your responsibility and we will expect your payment in full. Upon prior approval we can bill this balance to your credit after you provide us the needed information.

Regarding No Insurance:
If you are self-pay and do not have insurance, payment is due **IN FULL** at time of service.

Unusual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients:
Adult patients are responsible for full payment of services.

Minor Patients:
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment of services.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Please sign and date agreeing that "I have read the Financial Policy and I understand and agree to this Financial Policy."

X_____ DATE: _____/_____/_____

Signature of Responsible Party