West Lafayette
Internal Medicine
A UNITY HEALTHCARE PARTNER

Carlos Gambirazio, M.D.

REGISTRATION

Date _____ Home Phone _____

Date of Birth _____ Cell Phone _____

Patient Name _____
Last First Middle

Street Address _____ City _____ State_____ Zip _____

Social Security # _____ Marital Status _____

Email address _____

Sex □ Male □ Female **Gender Identity** Male Female Both Neither Race _____

Ethnicity □ Hispanic/Latino □ Not Hispanic / Latino

Emergency Contact _____ Relationship _____ Phone _____

How did you learn of our practice?_____

Patient Employed By _____ Occupation _____

Business Address _____ Phone _____

May we contact you at work □ yes □ no

Do you have medical insurance? □ Yes □ No If yes, Name of Primary Insurer _____

What is your co-pay, if any? _____

Name of Secondary insurer (if any) _____

Spouse's Name (or responsible party if minor) _____

Please complete the following questions if your insurance is through your spouse.

Spouse's Social Security # _____ Spouse's Date of Birth _____

Spouse's Occupation _____ Business Phone _____

Spouse's Employer _____ Address _____

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Patient Name _____ Date of Birth _____

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

_____
Initials

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

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FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account of future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $200.00, whichever is greater.

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Initials

TELEPHONE CONTACTS: I authorize Unity Healthcare, LLC and its affiliates and agents to contact me at the phone numbers I have provided (whether such is my cell phone or land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me.

_____
Initials

FINANCIAL DISCLOSURE: I acknowledge that Unity Healthcare, LLC holds an interest in certain tax-exempt bonds used in financing the St. Elizabeth East Hospital, which is owned and will be operated by the Sisters of St. Francis Health Services, Inc. I understand that I am free to determine which facility to utilize for health care services and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a non-SSFHS facility.

_____
Initials

MEDICARE CERTIFICATION: I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to my treating physician on my behalf.

_____
Initials

Patient Signature: _____ Date _____

Parent/Guardian Signature:_____