Endoscopy Center of Arkansas, LLC

(Please complete all items. Please Print.)

Patient's Name_____Age____Sex____Todays Date_____

Address_____City_____State_____Zip_____

County_____Race_____

Home Phone_____Cell Phone_____Date of Birth_____

SS#_____Marital Status_____Occupation_____

Employer_____Emp. Phone_____Address_____

Referring Physician_____Primary Care Physician_____

Nearest Relative(not at your address)_____Phone_____

In case of emergency contact_____

Primary Insurance:_____

Policy Holder_____Relationship_____DOB_____SS#_____

Ins ID_____Group_____

Secondary Insurance:_____

Policy Holder_____Relationship_____DOB_____SS#_____

Ins ID_____Group_____

Medicare Secondary Payer Questionnaire

1. Are you entitled to Medicare based on:_____AGE?_____DISABILITY?_____ESRD?
2. Are you currently employed?_____YES_____NO_____Date of retirement

   Employer_____

Agreement for Payment of Balance Due: I hereby authorize payment directly to Endoscopy Center of Arkansas, LLC, 1024 North University Ave., Little Rock, AR 72207, for services provided to me on this date and otherwise payable to me. I understand that any estimated amount collected today is only an estimate and does not constitute payment in full. I agree that I will be responsible for any allowed charges not paid by my insurance. I agree that I will be held liable for any collection, legal or court costs should it become necessary for Endoscopy Center of Arkansas, LLC to pursue these avenues to collect a balance due. **Screening Procedures Only:** I understand that in the event my screening procedure requires additional diagnostics/therapeutic procedures, my insurance plan benefits will apply.

Patient Signature:_____Date:_____

Responsible Party Signature:_____Date:_____