La Jolla Gastroenterology Medical Group, Inc.

9850 Genesee Ave, Suite 820, La Jolla, CA 92037 (858) 453-5200

My appointment today is with Dr. Lenz

Patient _____ **Birthdate** _____/_____/_____ **Age**_____
(Last Name, First Name, MI)

Address_____ Gender ___M ___F Marital Status _____
(Mailing Address, including apt #)

City _____ **Social Security Number**_____

State _____ Zip Code _____ E-Mail address _____

Home Phone (_____)_____ Cell Phone (_____)_____

Employer _____ Work Phone (_____)_____

Emergency Contact Name _____

Phone Number _____

Insurance Carrier Primary _____

Secondary_____

Referred By _____ **Primary Physician** _____

Authorization to pay benefits to physician: I hereby authorize payment of medical and/or surgical benefits directly to La Jolla Gastroenterology Medical Group, Inc. for services described on the insurance claim forms. I realize that the insurance payment may not represent full payment for services rendered and I will be responsible for the balance due including, but not limited to, deductibles, co-pays, co-insurances, and services not covered under my plan. It is my responsibility to know the coverage of benefits for my insurance policy. I agree to remit payment within 30 days of receipt of a statement and understand that La Jolla Gastroenterology Medical Group charges $5.00 for each past due statement generated for any unpaid balances.

Authorization to release information: I hereby authorize the release of any medical or other information necessary to my insurance company to process claims for services rendered.

HIPAA Policy: I hereby acknowledge receipt of the Notice of Privacy Practices of La Jolla Gastroenterology.

_____ _____
Patient Signature Date