Treasure Coast Gastroenterology

Scott Altschuler, MD

I authorize Treasure Coast GI to release my protected health information to the following people on my behalf.

Name	Relationship	Phone Number

Please provide insurance cards and driver's license to the receptionist so that we can scan them into our computer system for future reference.

I authorize any holder of medical or other information about me to release same to the Social Security Administration and Center for Medicare and Medicaid Services (CMS, formerly HCFA) or its intermediaries or carrier, the minimum necessary information needed for this or a related insurance or Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to insurance or Medicare assignment of benefits apply. I attest that the insurance information that I am providing is true and accurate. If this information is found to be false, I will be responsible for payment of all services rendered.

I also authorize the transfer of my Protected Health Information (PHI) to others for the purposes of "treatment" to be "electronically" transmitted on my behalf, including but not limited to fax, mail, e-mail, or via computer database.

If you must cancel an appointment with our office, we ask that you notify us 24-48 hours in advance. There is a $50.00 fee for "No Shows' on a Routine visit and a $100.00 fee for a 'No Show' for Procedures. These fees are due prior to scheduling your next appointment.

I also acknowledge that I have been provided the Notice of Privacy Practices, as well as the Patient Responsibility and Accountability Contract. I further acknowledge that I am responsible to uphold all TCGI policies. This signed receipt will become a permanent part of my medical record.

The doctor-patient relationship is based on trust and open communication. In order for your physician to make valid diagnosis and render beneficial care, the information you provide to him/her must be complete and true.

Signature:_____ Date:_____

Treasure Coast Gastroenterology
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