

N.B. Edgerton, Jr. M.D.
2706 W M.L.King Jr. Blvd
Tampa, FL 33607
813-875-8650

Patient Information

Name _____ Date _____
(last) (first) (middle init)

Address _____

City, State, Zip _____ Phone _____

Date of Birth _____ Age _____ SS# _____ Sex M or F
(home) (office or cell)
(circle one)

Email Address _____

Primary Dr. _____ Referring Dr. _____

Employer/School _____ Occupation _____

In case of Emergency notify _____ Phone _____

Primary Insurance

Name and type of Insurance _____

Subscriber's Name and Date of Birth _____

Secondary Insurance

Name and type of Insurance _____

Subscriber's Name and Date of Birth _____

****PLEASE LET US MAKE A COPY OF YOUR INSURANCE CARD(S).****

Assignment and Release

I request that payment of authorized benefits be made payable to Dr. Edgerton for any services furnished to me. I further authorize Dr. Edgerton to release my medical information to my insurance company(ies), in order to determine these benefits or the benefits payable for related services.

I agree to comply with the terms of my insurance, including the payment of my co-payment at the time of the office visit. I understand that co-insurance, and deductible amounts are payable in full, upon receipt of the bill, unless other arrangements have been made with the office.

Finally, I understand that the filing of secondary insurances is a courtesy, and will be done if amounts due are over \$50 for any one date of service. (These amounts are non cumulative.)

Signature _____ Date _____

Please bring all PAPER WORK, PHOTO ID and INSURANCE card (s) on the day of your appointment along with your co-pay. Please also bring all previous lab work, CAT scans, Ultrasounds, Colonoscopies, Endoscopies and any pertinent information related to your visit. Also bring your calendar to schedule any testing Dr. Edgerton might order. Please do NOT mail your paper work or co-pay. Date all of your paper work for the day of your appointment.

**Thank you,
Dr. Edgerton's Office Staff**

AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT

Notice to all patients regarding payment for office visits and procedures.

This note is written to help you understand the meaning of authorization. Each time we get an authorization the above phrase is added to the approval-"this authorization is not a guarantee of payment". This statement is given by the authorization department, and has nothing to do with the **payment** of your office visits and procedures. It means various things from - we will pay if you do not have a deductible, or - we will pay if you do not have a pre-existing condition, or we will pay if you are using an "In-Network" Physician.

PAYMENT FOR SCREENING AND/OR POSSIBLE POLYP REMOVAL

If you have any concerns about how much your insurance company will be paying for your **screening** colonoscopy and/or possible polyp removal or biopsy, please call your insurance company for information. All insurance companies do not pay the same for different procedures performed.

Please understand that we will not be calling your insurance company for this information. It is your responsibility.

Thank you.