ECPA

Eastern Connecticut Physician Associates
Dr. Gayethri Narayanswamy
2701 Tamarack Avenue
South Windsor, CT 06074
Phone: 860-375-5141
Fax: 860-896-8190

Patient Name:_____
Last, First, MI

Address:_____
Street Apartment #

_____
City/Town Zip Code

Date of Birth:_____ Email Address:_____

Phone:

Home:	Cell:	Work:

Gender: (Please check one)

Male:	Female:

Race: American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or other Pacific Islander
White
Other

Ethnicity: Hispanic or Latino
Not Hispanic or Latino

Preferred Language:_____ (required by state)

Parents/Guardians Name(s):_____

Emergency Contacts:

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

Local Pharmacy:_____

Pharmacy Address: _____

How did you hear about us? _____

Primary Insurance: _____

Ins. Member ID # Group #

_____

Cardholder's Name Date of Birth

Secondary Insurance: _____

Ins. Member ID # Group #

I request that payment of Authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, Private insurance, and other health insurance to Eastern Connecticut Physician Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance including all reasonable costs and expenses, including attorney's fees incurred in pursuing collections of such charges. I authorize my physician to release any information relating to an illness, injury, care or treatment to my insurance company. I hereby authorize as assignee to all necessary information to secure payment.

_____ _____

Signature Date

_____

Printed Name

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Your insurance policy is a contract between you and your insurance company.
It is your responsibility to understand your coverage and benefits including: waiting period time frames, preventative care limits and maximums, (including immunizations, labs, etc.) deductibles and copays.

All co-payments are due at the time of service.
We accept all forms of payment.

We will work very hard to assist you in receiving the maximum benefits available under your policy.

We will assist you, in your insurance plan requirements, for referral, pre-certification, or authorization to see another doctor or specialist other than your Primary Care Physician (PCP). However, once requested, we require 5-7 business days to fulfill such requests.

Patients with a high deductible health care plan will be required to make a payment of $100 at the time of visit until the yearly deductible has been met.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact the billing department promptly for assistance in the management of your account. If you have not contacted us or paid on your balance for 60-90 days your account will be reviewed for the collection agency process. All accounts sent to collection will incur a flat, one-time $50.00 administrative service fee.

Returned checks will result in a $25.00 fee that will be posted to your account.

Appointments not cancelled 24 hours prior to scheduled appointment will result in a $25.00 fee. 15 minutes late to an appointment is considered a no-show and will result in a $25.00 fee.

Please feel free to discuss any insurance or financial issues or concerns with the billing department at any time. Thank you!

I, the under signed, accept and agree to the above stated terms of the Financial Agreement.

_____ _____

Signature of Parent/Responsible Party Date

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Patient Name: _____ Date of Birth:_____

May we send statements and reminder cards to your home? _____

If not, what address may we use? _____

May we call you at work? _____

May we call you at home? _____

If no to both, what number should we call? _____

May we leave messages (including lab results) on a voicemail? _____

Which number? _____

May we speak to other family members regarding your (or your child's) treatment? _____

Please let us know the person(s) we may speak to:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

May we fax you? _____ Fax number: _____

May we email you? _____ Email: _____

Signature of Responsible Party: _____ Date: _____

Relationship to patient:_____