DOWNRIVER GASTROENTEROLOGY, P.C.

FRANK SINGH, D.O.
25000 Hall Road • Suite 200 • Woodhaven, MI • 48183 • Ph. (734)692-6566 • Fax (734)692-2517

Patient Name _____ Gender M / F
Last First Middle

Address _____
Street Address City State Zip Code

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Date of Birth _____/_____/_____ SSN _____ - _____ - _____ Marital Status M / S / D / W

Employer _____

Alternate/Emergency Contact _____ Phone Number (____) _____

Primary Physician _____ Referring Physician _____

Email _____

Pharmacy Name _____ Address _____

Insurance Information

Primary Insurance
Name of Insurance _____
Contract/Policy# _____
Group# _____
Policy Holder's
Name _____
SSN _____
DOB _____
Relationship to Patient _____

Secondary Insurance
Name of Insurance _____
Contract/Policy# _____
Group# _____
Policy Holder's
Name _____
SSN _____
DOB _____
Relationship to Patient _____

Assignment and Release

I, the undersigned, have insurance with _____ and assign directly to Dr. Frank Singh, all medical benefits, if any otherwise payable by me for services rendered. I understand I am financially responsible for all collection, attorney or court fees. For such collection efforts, 30% of the debt is added. I hereby authorize the doctor to release necessary information to secure payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Printed name **Signature of Insured/Guardian** **Date**

Medicare Authorization

I request that payment of authorized Medicare benefits be made whether to me or on my behalf to Dr. Frank Singh for any services furnished to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorizes releasing the information to the supplemental insurer. Dr. Frank Singh accepts the charge determination of the Medicare carrier as the full charge. The patient is only responsible for the deductible, co-insurance and non-covered services.

Printed name **Signature of Insured/Guardian** **Date**