JENNIFER KAUFMAN, ARNP PLLC
LARSEN GASTROENTEROLOGY PLLC
LIVER AND DIGESTIVE DISEASES

Last Name: First Name: Middle Initial:

DOB: Marital Status: M S D W Other SSN:

Patient's Address:

City: State: Zip:

Landline: Cell: Preferred Phone: Landline Cell

Ok to leave a Message? Yes No Text Reminders? Yes No Email:

ONLINE BILL PAY IS AVAILABLE

Employer: Job Type:

Primary Care Physician: Pharmacy:

Referring Physician: (if different)

Gender : Male Female Trans M to F Trans F to M Other: (Nondiscriminatory, For Medical Information Only)

Emergency Contact: Relationship: Phone Number:

Do you have an Advance Care Directive? No Yes Where is this on file?

Surrogate Decision Maker? No Yes Name Phone Number:

Primary Insurance Name:

Policy ID/Enrollee #: Group #

Primary Insured Name: Insured DOB:

Secondary Insurance Name:

Policy ID/Enrollee #: Group #

Secondary Insured Name: Insured DOB:

• **Consent for Treatment -** I hereby authorize necessary medical care to be rendered to the patient registered herein. • **Financial Responsibility -** I hereby acknowledge and accept financial responsibility for charges incurred by the above named patient while under the care of Jennifer Kaufman ARNP PLLC or Larsen Gastroenterology PLLC. • **Release of Information -** I hereby authorize Jennifer Kaufman ARNP PLLC or Larsen Gastroenterology PLLC to provide information gained through history physical, progress notes, and lab findings etc., that may become necessary to aid in processing any future insurance claims. • **For Medicare Patients -** I release payment of authorized Medicare benefits to me, or on my behalf, for any service furnished to me by Jennifer Kaufman ARNP PLLC or Larsen Gastroenterology PLLC. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits for related services. Signature effective until revoked by the beneficiary. • **For Public Assistance Patients -** It has been explained to me that Public Health Services may not pay for the services provided if they are not medically necessary. All services, in addition to being medically necessary, must meet certain criteria before payment can be authorized. If payment for this visit is denied, I agree to be financially responsible for this billing. • **Notice of Privacy Practices -** I acknowledge that I have received and understand Jennifer Kaufman ARNP PLLC and Larsen Gastroenterology PLLC Notice of Privacy Practices for Health Information.

Signature:_____ Date:_____