



**Physicians:**  
Harold H. Sullivan, MD, MPH

**Nurse Practitioners:**  
Jaime M. Hare, MS, FNP-C  
Michelle S. True, MS, FNP-C  
Pamela R. Fox, MS, FNP-C

**Casco Bay Gastroenterology, LLC**  
**Casco Bay Endoscopy**

**PATIENT INFORMATION**

Name	Date		
Social Security #	Date of Birth		
Address	City	State	Zip
Primary Phone #	Secondary #	Other #	
Employer Name	Phone #		
Primary Care Provider	Phone #		
Emergency Contact	Phone #		
Please list ANYONE with whom we may discuss your care:			
May we discuss your care with ANYONE listed above? YES / NO			
May we leave a detailed message on your answering machine or with ANYONE listed above? YES / NO			

**INSURANCE INFORMATION**

Primary Insurance	Secondary Insurance
Identification #	Identification #
Group #/Name	Group #/Name
Policy Holder	Policy Holder
Relation to Patient	Relation to Patient

**AUTHORIZATION AND RELEASE**

I understand and agree to the following:

- I have completed all of the above information and certify all information is true and correct.
- I agree to pay my co-pay that is due at the time of my office visit (if applicable).
- It is my responsibility to obtain insurance coverage information from my plan administrator before my visit and to obtain a referral when necessary.
- I am financially responsible for self-pay balances including co-insurance, deductibles, and non-covered services upon receipt of my first statement. A 1% monthly finance charge will be assessed on all accounts over 60 days.
- I authorize release of any necessary information to my insurance carrier to determine liability for claim payment.
- The Providers at Casco Bay Gastroenterology participate with most insurance carriers. We are happy to submit claims on your behalf to both primary and secondary insurance companies.
- I consent to Casco Bay Gastroenterology, LLC's use and disclosure of my protected health information in support of my diagnosis and treatment, payment for the medical services I receive, and the legitimate health care operations of the medical practice.
- I assign the benefits payable to which I am entitled to: Casco Bay Gastroenterology, LLC.
- This assignment will remain in effect until revoked by me in writing.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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**ACKNOWLEDGMENT OF RECEIPT OF  
“NOTICE OF PRIVACY PRACTICES”**

Name \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

- I acknowledge receipt of the “Notice of Privacy Practices” prepared by Casco Bay Gastroenterology, LLC and Casco Bay Endoscopy.
- I acknowledge that I have had the opportunity to ask questions regarding the “Notice of Privacy Practices.”

Signature \_\_\_\_\_ Date \_\_\_\_\_

**OFFICE USE**

If patient refuses to sign “Acknowledgement of Receipt of Privacy Practices,” document date and time patient refused and sign below.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_