Center for Pediatric Adolescent Gynecology
Lawrence Amesse, MD, PA

INSURANCE INFORMATION/PATIENT AGREEMENT

Patient Name: _____Date of Birth: _____ SS#: _____
Last name, First Name
Address: _____ Email: _____
Street, City, State, Zip
Home Phone: _____ Cell: _____ Work: _____

Other Guarantor: _____ Address: _____
(Husband/Wife/Other) Last Name, First Name

Home Phone: _____Cell: _____ Work: _____

Insurance Company: _____ID#: _____ Group#: _____

Insurance Phone: _____ Driver's License #: _____

I authorize Dr. Amesse and staff to provide medical treatment to me. I also authorize any physician, hospital, or medical facilities to provide information on my medical history. I understand that the practice of medicine is not an exact science and expected or desirable outcomes cannot be guaranteed. Treatments have risks and they may result in complications with short term and /or long-term consequences.

Signature: _____ Date: _____ Signature: _____ Date: _____
Patient Other Guarantor

In order for Dr. Lawrence S. Amesse to provide medical treatment, it will be necessary for him to be reimbursed for his services.

Prior to your visit we will attempt to verify your insurance coverage. If the services provided by Dr. Amesse are covered by your insurance policy, the insurance company will be billed directly. Payment from you insurance company will then go directly to Dr. Amesse MD, PA. In the event the insurance company does not pay for those services or you do not have insurance, you will be financially responsible. All charges are due in full within 30 days from the date the amount was billed to you.

Signature: _____ Date: _____ Signature: _____ Date: _____
Patient Other Guarantor