*Your Good Health Medical Group, P.A.*
*Dr. David L. Vastola, D.O.*
*Internal Medicine and Gastroenterology*

**PATIENT REGISTRATION INFORMATION**
(PLEASE Print Legibly-All information is Strictly Confidential)

Date_____ Name_____
(Last Name) (First Name) (Middle Initial)

Address_____City_____ State_____ Zip_____

Phone_____ Cell Phone_____ Work_____

Sex ☐M ☐F Age_____ Birth date_____ ☐Married ☐Single ☐Divorced ☐Widow

Social Security_____ Employer_____

Occupation_____ Email Address_____

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Attached Insurance Card: _____ Cash Pay: _____

Person Responsible for Account_____ Relation to Patient_____ Phone #_____

Emergency Contact_____ Phone_____

How did you hear about us? ☐Insurance ☐Phone Book ☐Newspaper ☐Other

☐Friend/Family_____ ☐Doctor_____

Military Service: Active ☐ Retired ☐ Not Applicable ☐

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## 24 HOUR APPOINTMENT CANCELLATION POLICY

Our office has a 24 hour cancellation/rescheduling policy. If you miss your appointment, cancel or change your appointment within less than 24 hour notice, you will be charged $25.

This policy is in place out of respect for our patients and office staff. Cancellations with less than 24 hour notice are difficult to fill. By giving last minute notice or no notice at all, you have prevented someone from being scheduled in that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for the office of Your Good Health Medical Group, PA

## ASSIGNMENT AND RELEASE

I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to Your Good Health Medical Group, P.A. for the services rendered by any of its employees. I further authorize the release of any medical information required by my insurance company. I understand that I am financially responsible for charges not paid by my insurance company. If the amount owed is not fully satisfied by the due date, then a fee of 35% of the outstanding balance, as calculated on the due date, will be charged, and sent to our collection agency.

PATIENT SIGNATURE_____ DATE _____
(Signature of Patient, Parent, Guardian or Personal Representative)