GASTROINTESTINAL DISEASES, INC.

PATIENT REGISTRATION FORM

Please complete form using your legal name as it appears on your social security card.

Date: _____ Email Address: _____ Cell #: (____) _____

Patient's Name: _____ Date of Birth: _____

Marital 5tatus: ____Single ____ Married ____ Divorced ____ Widowed SSN: _____

Street Address:_____Apt# _____ Phone: _____

City: _____ State: _____ Zip: _____

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Retired ❑ Unemployed ❑ Disabled ❑ Self Employed

Employer Name: _____ Phone: (____) _____

Street Address: _____ City: _____State: ___ Zip: _____

Husband's Name: _____ Date of Birth: _____

Husband's SSN: _____ Husband's Employer:_____ Phone: (____) _____

Emergency Contact: _____Relationship: _____ Phone: (____) _____

Family Physician: _____ Referred By: ❑ Physician ❑ Friend ❑ Other

Insurance: Please allow us to make a copy of your insurance card(s) and provide us with all pertinent information regarding your insurance coverage.

Primary insurance Company: _____ Group #: _____

Insured's Name: _____ ID #: _____

Insured's Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance Company: _____ Group #: _____

Insured's Name: _____ ID #: _____

Insured's Date of Birth:_____ Relationship to Patient: _____

If it is necessary for me to bring my child at the time of my visit, I understand that it is my responsibility to watch out for the safety and well being of my child.

Patient's Signature: _____ Date: _____

Gastrointestinal Diseases, Inc.

PATIENT INFORMATION AND HISTORY AUTHORIZATIONS

I hereby authorize Gastrointestinal Diseases, Inc. to submit a sample of my blood to test for HIV or any potentially life threatening condition should a staff member encounter exposure.

_____ _____
Signature of Authorized Representative Date

_____ _____
Witness Date

I authorize the release to Medicare and/or my commercial insurance carrier of any medical or other information necessary to process claims for medical services.

I request payment of medicare and /or commercial insurance medical benefits to be paid directly to Gastrointestinal Diseases, Inc.

I understand that payment of my account is ultimately my responsibility and not my insurance carrier's. I hereby agree that if my account becomes delinquent and collection action by an outside agency becomes necessary that I will be responsible for the 30% collection fee charged by the agency. I understand that if I have not secured appropriate authorizations or otherwise complied with the terms of my benefit plan that there may be decrease in my insurance coverage or no coverage at all for some or all of the services which I may receive or be referred for by my primary care physician. I understand that I will be financially responsible for any non-covered services.

I acknowledge that in consideration of other patients, a 24 hour notice of cancellation is required by this office and failure to do so could result in a $30.00 charge that is not covered by insurance and would be payable from myself or my authorized representative.

I am aware that any checks returned from the bank with no payment will result in a $20.00 fee added to my account I also acknowledge if the returned check fee, as well as the original amount of the returned check, are not paid with in 10 business days after notification, my account will be sent to an outside agency for collective action and I will be responsible for the charges incurred for that as well.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Witness Date

Gastrointestinal Diseases, Inc.

One Time Authorization Form

PATIENT'S NAME _____ DATE _____

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named facility all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, I understand that all bills are payable upon receipt and that 1, and not the insurance company, am responsible for the payment of all services.

INITIAL: _____

Responsibility for copay amounts: I agree to be fully responsible for paying co-pays of set amounts at the time of physician's visit. Further, I understand that if my copay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received, once insurance has paid, will be due upon receipt.

INITIAL: _____

Assumption of referrals: I understand that if I have insurance coverage, which requires a referral from a Primary Care Physician, it must be received in order to receive the maximum benefits from the insurance company, I further understand that it is my responsibility to obtain a hard copy referral from my Primary Care Physician, I have been given the opportunity by the above said provider to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

INITIAL: _____

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits, including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of as third party or organization, and so forth, payable to or for the above said patient until account is paid in full.

INITIAL: _____

SIGNATURE _____ DATE _____

Acknowledgement of Receipt of Privacy Notice.- I acknowledge receiving today a copy of the provider's notice of privacy Policies- I consent to the provider's use of protected health information as described in the notice for treatment, payment, of health care operations- I understand that I must provide a separate authorization before any other disclosures may be made.

INITIAL: _____

Rem Reminder / notification: We may call you to remind you of your appointment or notify you of test results. I agree, if I have an answering machine, to allow the doctor or staff members to identify themselves, as well as myself and to notify me of my appointment or tell me that test results are back. We will not leave test results on your answering machine.

INITIAL: _____

SIGNATURE _____ DATE _____

Request for restrictions: I request that my protected health information be disclosed to the following persons or facility (please list): _____

SIGNATURE _____ DATE _____