PATIENT REGISTRATION AND CONSENT FORM

Welcome to our office! If you should need assistance in completing this form, please ask a staff member for help.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name (if applicable):_____ Status: ☐Child ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Street Address: _____ Apt# _____ City:_____ State: ____ Zip:_____

Date of Birth: _____ Sex: ☐Male ☐Female Social Security # _____

Race: ☐American Indian /Native Alaskan ☐Asian ☐Black /African American ☐Hispanic /Latino ☐Native Hawaiian /Pacific Islander ☐White ☐Other

Cellphone :(_____)_____ Home Phone: (_____)_____ Work Phone :(_____)_____

Email Address: _____ Emergency Contact: _____Contact Number _____

Referring Doctor: _____ Primary Care Doctor: _____Employer (or School if student):_____

How were you referred to us? ☐Family/Friend ☐Physician ☐Internet ☐Insurance ☐Newspaper ☐Phone Book ☐Walk-In ☐Other

GUARANTOR INFORMATION (If patient is a Minor or Dependent)

Last Name: _____First Name: _____Middle Initial: _____

Street Address: _____Apt# _____City:_____State: ____Zip:_____

Date of Birth: _____ Sex: ☐Male ☐Female Social Security # _____

Cellphone :(_____)_____ Home Phone: (_____)_____ Work Phone :(_____)_____

Relationship to Patient: _____ **Email Address:** _____
_____

HIPAA COMMUNICATION PREFERENCE

In order for our office to better communicate with you, please indicate your preferences below:

What is your primary phone contact? ☐Cell Phone ☐Home Phone ☐Work Phone

May we send you text messages? ☐Yes ☐No May we communicate with you by email? ☐Yes ☐ No May we leave you a voice mail? ☐Yes ☐ No

May we communicate with anyone on your behalf? ☐Yes ☐ No Contact Name: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. We are required by law to maintain the privacy of your health information and make every effort to inform you of your rights. The Notice contains a section describing your rights under the law related to your personal health information. By signing below, I acknowledge that I have reviewed or had explained to me the Notice of Privacy Practices and agree to continue my care with Gastroenterology Consultants, PA under said terms.

_____ _____

Patient or Guarantor Signature **Date**

INSURANCE AUTHORIZATION AND FINANCIAL RESPONSIBILITY DISCLOSURE

My signature below authorizes Gastroenterology Consultants, PA to release any medical information necessary to process my or my dependent's insurance claim. I authorize any benefits due be paid directly to Gastroenterology Consultants, PA.

Your insurance company only provides our office an "estimate" of covered benefits prior to receiving any services or materials from us. This "estimate" is not a guarantee of benefits. I understand that I may be required to pay a deductible, co-pay, co-insurance, or any balance not covered by my insurance plan. In the event that my insurance does not fully pay for services and/or materials rendered to me, I agree to be responsible for payment of all balances on my or my dependent's behalf.

I understand that all fees for professional services shall be paid at time of service. Unsettled balances may be referred to an outside collection agency and the credit bureau. Returned checks will be subject to additional fees.

I certify that I have read and understand the above information to the best of my knowledge.

_____ _____

Patient or Guarantor Signature **Date**