GastroIntestinal Healthcare (GIH)
PATIENT REGISTRATION (please print)

Today's Date: ____/____/____ Birthdate:____/____/____

Patient
Name:_____Age:_____Sex:_____
Last First Middle

Address:_____
Street Apt# City State
Zip

Home Phone: ( )_____ Business Phone: ( )_____ Cell:
( )_____

Primary Insurance Co:_____ Secondary Insurance Co:_____

Employer:_____

How did you hear about our office? _____ Referring Physician: _____

I authorize the attending physicians to administer medical care as necessary. GIH will file all insurance claims as a courtesy to you, our patient. Given that we contract with your insurance company, we **are required** to collect all co-pays, deductibles and co-insurance due associated with your procedure. If you have any questions regarding your outstanding deductible and/or procedure co-pays and/or co-insurance, please consult your insurance company prior to procedure. I hereby authorize payment directly to GastroIntestinal Healthcare for all medical services provided to me, for benefits otherwise payable to me. This is to include major medical insurance and payment of surgical or medical benefits. I understand that I am financially responsible to the physicians and their associates for charges not covered by assignment. I understand that should it become necessary to pursue collections through an outside agency for unpaid medical services, I will be responsible for all reasonable collection and attorney fees.

All deductibles, co-insurance and co-pays are due at the time of service. If you have no insurance, payment in full is expected at time of service. We accept cash, checks, or all credit cards.

I authorize the release of all records by GastroIntestinal Healthcare for the purpose of processing medical claims. I authorize the release of all medical information in the possession of this medical office to any consultants or medical personnel for the purpose of rendering treatment to myself, and/or to continue my care. I understand I can revoke this authorization at any time by notification in writing.

I agree that GastroIntestinal Healthcare and affiliated agencies to contact the numbers listed above, including wireless telephone numbers, which may result in charges to me. I also authorize to be contacted via text messages and/or emails to the telephone number and email address I provided above. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device as applicable. By signing this document I agree to have read the above disclosure and agree that GastroIntestinal Healthcare and affiliated agencies may contact me.

I certify that I understand and agree to the above releases and assignment of benefits.

Patient signature:_____ Date:_____

Guardian signature (if applicable):_____ Date:_____