GastroIntestinal Healthcare (GIH)
PATIENT REGISTRATION (please print)

Today's Date: ____/____/____ Birthdate:____/____/____ S.S.# _____/____/_____

Patient Name:_____Age:_____Sex:_____
Last First Middle

Address:_____
Street Apt# City State Zip

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

Can we leave your medical information on your voice mail? Yes No

Emergency contact: ( )_____ Name:_____ Relationship:_____

Primary Insurance Co:_____ Secondary Insurance Co:_____

Employer:_____

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

PRIVACY POLICIES NOTICE ACKNOWLEDGEMENT, IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) and ACKNOWLEDGEMENT OF RECEIPT OF A COPY OF OUR PATIENTS RIGHTS AND PATIENT RESPONSIBILITIES POLICIES.

I acknowledge that a copy of GastroIntestinal Healthcare's Privacy Policies Notice has been made available to me in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I FURTHER Acknowledge that I have received a copy of GIH's Patient Rights and Patient Responsibility Policies.

Signed:_____ **Dated:** _____

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

Patient signature:_____ Date:_____

Guardian signature (if applicable):_____ Date:_____