GASTROENTEROLOGY & HEPATOLOGY ASSOCIATES, PLLC.

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Updated Patient Registration

Patient Name: ________________________________ Date of Birth: ___________ SS# ________________

Street Address: ____
City: _____________________________________ State:________________ Zip Code: ________________

Confidential email: ____

Telephone: (check preferred number) ☐Home ____________ ☐ Work: _____________ ☐ Cell:______________
Marital Status (circle one): S M W Separated or D Name of Spouse: _______________________________
Spouse Employer: _________________________________Spouse Phone Number: _____________________

Emergency Contact Name: ______________________________ Relationship to patient:_________________
Emergency Contact Phone Number: _________________ Cell:________________
Emergency Contact Address:____
Primary Care Physician: ____________________Pharmacy Name/Location/Number: ____________________

PATIENT EMPLOYER INFORMATION:
Employer Name: ____ Telephone: _________________
Patient's Occupation: ____ (Please Circle) Full Part time

POLICY HOLDER'S INFORMATION:
Name: _______________________________ Date of Birth:____________ Social Security #_______________
Telephone:___________________ Name of Insurance:________________________________
Subscriber ID#___________________ Group#_________ Relationship to Patient: __________________

I hereby authorize: **A)**The release of any medical information, including protected health information, necessary to process this claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. **B)** Any rendering provider of Gastroenterology and Hepatology Associates PLLC to apply for benefits on my behalf. I request that payment from my insurance company be made directly to Gastroenterology and Hepatology Associates, PLLC. (or to the party that accepts assignment.) **C)** That the information I have reported with regard to my Insurance coverage is correct. I recognize that I will be responsible for all charges, whether covered or not by my insurance company. **D)** Gastroenterology and Hepatology Associates, PLLC to obtain records from other sources as may be necessary in the diagnosis or treatment.

Signature:**X** ______________________________________ Date: _________________________

RELEASE OF INFORMATION: I authorize Gastroenterology and Hepatology Associates, PLLC to release any medical information from my medical record to any insurance carrier or person employed by such carrier for the purpose of collecting Insurance benefits so long as I am listed on this account as having coverage with such carrier. This authorization includes release of this discharge diagnosis to employers for group insurance coverage, workers compensation carriers and welfare agencies, if applicable to my claim for treatment. I hereby release Gastroenterology and Hepatology Associates, PLLC from any and all responsibility relative to the release of such information. I understand that if my records contain information relating to venereal disease, hepatitis, HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I have the right to revoke this authorization by written notification to the health care provider to which this authorization is submitted. The provider must comply except to the extent that the provider has already acted in reliance upon this authorization.

Person(s) I allow my information to be given to: ____

Patient Signature: X __________________________________ Date: ______________________