Digestive Care & Management

2013 PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME: ______________________________ BIRTHDATE: ______________ ☐MALE ☐FEMALE
SOCIAL SECURITY #: ____________ HOME PHONE: ____________ CELL PHONE: ____________ WORK PHONE: ____________
MAILING ADDRESS: ______________________________ CITY, STATE, ZIP: ____________________
EMAIL ADDRESS: ______________________________ (For appointment reminders & lab results only)
OCCUPATION: ____________________ EMPLOYER: ______________________________

May we leave lab/test results, scheduled procedure dates and appointment reminders on the following?
Home phone ☐YES ☐NO / Cell phone ☐YES ☐NO / Email ☐YES ☐NO

SPOUSE INFORMATION

NAME: ______________________________ BIRTHDATE: ____________ EMPLOYER: ______________
CELL PHONE: ____________ WORK PHONE: ____________

EMERGENCY CONTACT INFORMATION

NAME: ______________________________ RELATIONSHIP TO PATIENT: ______________
HOME PHONE: ____________ CELL PHONE: ____________

INSURANCE INFORMATION

PRIMARY INSURANCE: ______________ SUBSCRIBER NAME: ______________ BIRTHDATE: __________
SUBSCRIBER ID#: ____________________ SUBSCRIBER SOCIAL SECURITY #: ____________________
SECONDARY INSURANCE: ______________ SUBSCRIBER NAME: ______________ BIRTHDATE: __________
SUBSCRIBER ID#: ____________________ SUBSCRIBER SOCIAL SECURITY #: ____________________
PLEASE NOTE, WE WILL NEED COPIES OF ALL INSURANCE CARDS IN ORDER TO FILE YOUR CLAIMS

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I grant permission for the person(s) listed below to have access to any and all of my medical information that pertains to my care from Digestive Care & Management. This includes, but is not limited to, appointment times, lab results, plans for health care, etc. I agree to notify Digestive Care & Management, in writing, if there are any changes in the person(s) authorized.

NAME: ______________________ RELATIONSHIP TO PATIENT: ____________________
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AUTHORIZATION

I authorize Digestive Care & Management to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Administration, Third Party Administrator's and/or Worker's Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize Digestive Care & Management to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records.
I grant permission to Digestive Care & Management to release all or part of my medical records to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities.
I request that payment of Medicare, Medigap, Medicaid, Traveler's Railroad Retirement, Managed Care Organization, Third Party Administrator's, Commercial Insurance, Worker's Compensation, Liability, and/or any other insurance benefits be made on my behalf to Digestive Care & Management for services furnished to me or on behalf to my provider.
I understand that I am financially responsible for co-payments, deductible amounts, co-insurance amounts, non-covered charges and any balances not covered under a contractual write-off agreement between Digestive Care & Management and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

______________________________________ ____________________
SIGNATURE OF PATIENT OR RESPONSIBLE/INSURED PARTY DATE