GASTROENTEROLOGY ASSOCIATES

Patient Registration (PLEASE PRINT CLEARLY!)

Patient's Name:_____ SS #:_____
First Name MI Last Name

Date of Birth:_____ Male Female _Single _Married _Widowed Divorced _Separated

Mailing Address:_____

City/State/Zip Code:_____ Home Phone w/Area Code:_____

Cell phone w/ area code:_____ Email:_____

Spouse's Name:_____

Spouse's Employer:_____ Spouse's Work Phone#:_____

Patient's Employer:_____ Work Phone w/Area Code:_____

Credit: (Circle) MC Visa # Exp__/__/__ Name on card_____

Responsible Party: Relationship: _Self _Spouse _Parent _Other:_____

In case of emergency, please contact_____

Contact number:_____ Relationship:_____

Is this work-related? _Yes _No **We do not participate in Workers Compensation**

Primary Care Physician's Name & Phone Number:_____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR SCANNING INTO YOUR MEDICAL RECORD

If you do not have insurance, have you applied for Medicaid? __Yes _No

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I hereby authorize the payment of medical benefits to Gastroenterology Associates for services rendered. I understand that Iam financially responsible for any services not covered by my insurance carrier.

I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.

I hereby authorize Gastroenterology Associates to release any medical information necessary to complete and process my insurance claims.

I authorize Gastroenterology Associates to treat me and use my personal health information for healthcare operations.

Patient/Guarantor Signature_____ Date_____

GASTROENTEROLOGY ASSOCIATES
Billing Policy

The following sets forth the general billing policy of Gastroenterology Associates. Please review this information and sign where indicated.

•• I understand that it is my responsibility to provide the office of Gastroenterology Associates with current, accurate billing information at the time of check in and to notify office of any changes in this information.

•• **I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered.** I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

•• I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, money order, cashier's check, or credit card.

•• I understand that there is a $20 fee to complete disability paperwork, Aflac or any other types of forms that require physician review and signature. I **understand that the $20 fee prior to completion.**

•• I understand the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further runderstand that **THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.**

•• I understand that I will be balance billed for any remaining fees after my insurance has processed the claim and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

•• I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

•• I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to cancelling your appointment. Failure to do so may result in a $25 fee per occurrence. I understand that if I no show for 2 consecutive appointments or no show for a total of 3 appointments, not only will I be charges a $25.00 no show fee, I may be discharged from care. You will be notified in writing via certified mail if you are discharged from care.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to the physicians of Gastroenterology Associates.

_____ _____

Patient Name Date

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Patient Signature