



Associates in Gastroenterology, P.C.
Patient Registration

Form with multiple fields for patient registration including: Last Name, First Name & M.I., Date of Birth, Sex, Address, City/State/Zip, Home Phone, Cell Phone, Work Phone, Social Security Number, Email, Employer, Employer Address, Insurance Carrier, Insurance ID #, Insurance Group #, Insurance Subscriber's Name, Relationship to Patient, Insurance Subscriber's Social Security Number, Insurance Subscriber's Employer, Insurance Carrier Address, Emergency Contact's Name, Relationship to Patient, Home Phone, Cell Phone, Work Phone.

Authorization to Pay Benefits to Physician: I hereby authorize payment directly to Associates in Gastroenterology, P.C., otherwise payable to me for services rendered, realizing I am responsible to pay non-covered services. I also realize that I am responsible for any other cost incurred while collecting my outstanding balance(s).

Authorization to Release Information: I hereby authorize Associates in Gastroenterology, P.C., to release any information acquired in the course of my treatment necessary to process insurance claims.

No Show Policy: I understand that Associates in Gastroenterology, P.C. may charge a \$30 fee to me if I fail to present for a scheduled appointment. If I need to reschedule or cancel, I will coordinate with the office staff at least 24 hours prior to the scheduled appointment.

Signature

Date

Waiver: I, _____, agree to be seen by Associates in Gastroenterology, P.C., on this date. I acknowledge that I did not bring a referral as required by my insurance company and/or I do not have my insurance card. I am electing to be seen today and agree to pay for services rendered without a valid referral or insurance card.

Signature

Date