GastroCare of El Paso

PATIENT REGISTRATION FORM

Date____/____/_____ Patient Number_____

PATIENT INFORMATION (Required data)

Please provide your Driver's License card to the Receptionist to copy.

What is the name of the GastroCare of El Paso Physician you are seeing?_____

Social Security#_____

First Name _____Middle_____

Last Name_____Suffix_____

Gender_____Date of Birth_____/_____/_____

Patient Primary Language _____

☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed ☐ Domsestic Partner
☐ Employed ☐ Retired ☐ F/T Student
☐ Black ☐ Caucasian ☐ Hispanic
☐ Asian ☐ American Indian/Na- ☐ Pacific Islander
☐ Asian Pacific Amer. ☐ tive Alaskan ☐ Other Race

Home Address_____

Apt._____City/State_____Zip_____

Secondary Address_____

Apt._____City/State_____Zip_____

E-mail_____

Home Phone (_____)_____

Work Phone (_____)_____

Cell Phone (_____)_____

Employer_____

Employer Address_____

Ste_____City/State _____Zip_____

Employer Phone (_____)_____

How Did You Hear About Us?

☐ Emergency ☐ Magazine ☐ Office Staff
☐ Established Patient ☐ Newspaper ☐ Telephone
☐ Friend/Family ☐ Radio ☐ Television
☐ Hospital ☐ Provider Book ☐ Walk-In
☐ Insurance Company ☐ Research Patient ☐ Yellow Pages
☐ Internet ☐ Referring Provider ☐ Other

Referring Physician_____ Phone (_____)_____

PHARMACY INFORMATION

Pharmacy Name _____Pharmacy Phone (_____)_____

Pharmacy Address _____City/State _____ Zip_____

INSURANCE INFORMATION (Required Data)

Please provide your Insurance card to the Receptionist to copy.

Insurance Company_____Policy#_____Group#_____

Plan Name_____

Please indicate your Plan type:

☐ Individual/Exchange	☐ Employer/Group	☐ Medicare
☐ Medicare Replacement	☐ Medicare Supplement	☐ Medicaid Replacement

Insured (if other than Patient)_____Relationship_____

Insured's Date of Birth_____/_____/_____Insured's SS#_____Phone (_____)_____

Employer_____City/State_____Employer Phone (_____)_____

2nd Insurance Company_____Policy #_____Group #_____

Plan Name_____

Please indicate your Plan type:

☐ Individual/Exchange	☐ Employer/Group	☐ Medicare
☐ Medicare Replacement	☐ Medicare Supplement	☐ Medicaid Replacement

Insured (if other than Patient)_____Relationship_____

Insured's Date of Birth_____/_____/_____Insured's SS#_____Phone (_____)_____

Employer_____City/State_____Employer Phone (_____)_____

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Date____/____/_____ Patient Number_____

I have an *Advanced Directive* or *Health Care Directive.* ☐Yes ☐No

EMERGENCY CONTACT

Relationshop to Patient_____Gender_____Home Phone (_____)_____

First Name_____Last Name_____Work Phone (_____)_____

I authorize GastroCare of El Paso to discuss with the above-named Emergency Contact the following issues related to my care: Medical Financial **Patinet Initials**_____

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encom passing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician, his assistants or designees.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatment or examinations performed.

This form has been fully explained to me and I certify that I understand and accept its contents.

All the above will be discussed with me, by the attending physician prior to any proposed testing or any type of surgical procedures to be scheduled.

SIGNATURE (Patient or Parent if Minor)_____**Date:**_____/_____/_____

FINANCIAL POLICY

INSURANCE INFORMATION

Your health insurance is a contract between you and your insurer. Any charges not paid by your insurer for any reason are your responsibility. It is your responsibility to understand your insurance benefits, including plan limitations, the difference between screening or preventative care benefits versus diagnostic procedure benefits and need for referrals or pre-certifications. We will make every effort to verify your benefits, identify your financial liabilities and obtain any necessary pre-certifications prior to your appointment on your behalf; however, this is not a guarantee of payment.

OPEN BALANCES

It is our policy to collect payment in full at the time of service. If you need to make special payment arrangements, it is your responsibility to initiate this effort with our offices. As a last resort, patients who fail to adhere to our financial policies may be sent to collections, occur additional costs and be terminated from our practice. Identified balances on account may be refunded only during the final week of the month.

MISCELLANEOUS FEES

We will charge $30 for returned checks for any reason. Failure to remedy the returned check may result in legal action. Missed appointments or appointments cancelled with less than 24 hours notice for office visits and 48 hours for procedures will result in a fee of $25 (office) and $100 (procedure). Our fee for completing forms is $25.

PATIENT'S REASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand and accept the financial policies of GastroCare of El Paso, and its subsidiary locations. I authorize payment of any insurance coverage and benefits to GastroCare of El Paso and authorize them to release any medical information necessary to process claims. I give GastroCare of El Paso permission to apply payments received to balances among its locations, including application to oldest balances first. I understand that I am ultimately financially responsible for the services I receive from GastroCare of El Paso and its subsidiaries. Should I neglect to meet my financial responsibility, I understand that I may be charged additional fees incurred in the collection process, including from third party collection agencies.

SIGNATURE (Patient or Parent if Minor)_____**Date:**_____/_____/_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly **to the Physician of the Surgical and/ or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.**

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the Physician to release any information information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE (Patient or Parent if Minor)_____
Date:_____/_____/_____

SIGNATURE (Patient or Parent if Minor)_____
Date:_____/_____/_____