CENTRAL TEXAS GASTROENTEROLOGY CONSULTANTS

PATIENT REGISTRATION FORM

ACCOUNT # _____

DATE: _____

DOCTOR OF RECORD:_____

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	DATE OF BIRTH:

ADDRESS:	CITY:	STATE:	ZIP:

CELL PHONE #:	HOME PHONE #:	SOCIAL SECURITY #:	GENDER [ ] M [ ] F

EMAIL:	RACE/ETHNICITY:	MARITAL STATUS: [ ] S [ ] M [ ] W [ ] D

PREFERRED METHOD OF CONTACT:
CELLPHONE [ ] HOME PHONE [ ] EMAIL [ ] TEXT MESSAGE [ ] MAILING ADDRESS [ ]

PRIMARY DOCTOR:	REFERRING DOCTOR:

PHARMACY:	LOCATION:

SPOUSE/RESPONSIBLE PARTY INFORMATION

NAME:	RELATION: [ ] SPOUSE [ ] PARENT [ ] LEGAL GUARDIAN	PHONE#:

EMPLOYMENT STATUS: [ ] EMPLOYED [ ] UNEMPLOYED [ ] RETIRED	EMPLOYER:	WORK #:

IN ORDER TO PROTECT YOUR PRIVACY, PLEASE INDICATE WITH WHOM WE MAY DISCUSS YOUR MEDICAL INFORMATION, INCLUDING BUT NOT LIMITED TO, SCHEDULED APPOINTMENTS/TESTS AND RESULTS:

[ ] SPOUSE [ ] CHILDREN [ ] PARENT(S) [ ] OTHER_____[ ] RESTRICTIONS _____

NOTIFY OUR OFFICE IN WRITING OF ANY CHANGES

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:	MEMBER #:	GROUP #:

SUBSCRIBER NAME:	DATE OF BIRTH:	SOCIAL SECURITY #:

SECONDARY INSURANCE COMPANY:	MEMBER #:	GROUP #:

SUBSCRIBER NAME:	DATE OF BIRTH:	SOCIAL SECURITY #:

EMERGENCY CONTACT INFORMATION

NAME:	RELATION:	PHONE #:

ADDRESS:	CITY:	STATE:	ZIP:

PATIENT ACCOUNT # _____

CENTRAL TEXAS DIGESTIVE DISEASE

PRACTICE FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

FINANCIAL AGREEMENT: I understand that I am responsible for deductibles, co-pays, noncovered services, coinsurance and items considered "not medically necessary" by my insurance company. I agreed to pay copayments and coinsurance as services are rendered. I understand my insurance is a contract between myself and my insurance company and Central Texas Digestive Disease will bill my insurance as a courtesy to me. The remaining balance will be taken care of within 30 days of notice from the insurance company. Although my insurance company may estimate what they may pay, it is the insurance company that makes the final determination. I agree to pay any portion of the charges not covered by insurance. If a referral and/or preauthorization are required by my insurance, I will assist Central Texas Digestive Disease in obtaining a referral and/or preauthorization. I understand that I am ultimately responsible for any balance on my account.

ASSIGNMENT OF BENEFITS: I hereby assign to Central Texas Digestive disease such insurance benefits to which are entitled under my insurance plan(s).

RELEASE OF INFORMATION: I hereby allow Central Texas Digestive Disease to furnish any information pertaining to my medical treatment to my insurance carrier, worker's compensation representative, attorney or other providers of service as necessary to obtain payment for services and proved additional care.

CONSENT FOR TREATMENT: I hereby authorize Central Texas Digestive Disease to examine, treat and perform diagnostic tests and office procedures that the provider deems necessary.

PRIVACY PRACTICES: Central Texas Digestive Disease is required by law to maintain the privacy of a patient's protected health information. In addition, we are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. You must list any restrictions on the release of your protected health information here. _____

PHYSICIAN DISCLOSURE OF OWNERSHIP: I, Dr. Chang/Derbes/Gray/Pham/Moore/Case, MD, may and/or have recommended that you receive medical treatment and/or services from the Central Texas Endoscopy Center, LLC and hereby inform you that I have ownership interest in this facility. You should be aware that alternative health care facilities may be available to you. Please sign below to acknowledge your receipt and understanding of this disclosure and that you have had an opportunity to ask and receive answers to any questions you may have about this disclosure, including your options, if any, for treatment at other facilities.

I have read and agree to Financial Agreement, Assignment of Benefits, Release of Information, Consent for Treatment, and Physician Disclosure of Ownership as listed above. My signature below indicates that I have also received a copy of Central Texas Digestive Disease Notice of Privacy Practices and I have indicated any restrictions on my protected health information above. Scanned signatures suffice as originals.

Patient or Responsible Party Signature	Printed Patient Name	Date

Person Signing on Behalf of Patient (Print Name)	Relationship to Patient	Date