Advanced Pediatric Gastroenterology, PC - New Patient Registration Form

(Please Print)

PATIENT INFORMATION

Patient's last name:	First name:	Middle name:	
Mother's full name (last, first)	Father's full name (last, first)		
Mailing address:	City:	State:	ZIP code:
Home phone no.: ( ) -	Cell phone no.: ( ) -	Work phone no.: ( ) -	
Date of Birth: / /	Patient Age:	Patient Sex: ☐ M ☐ F	
Social Security no.: - -	Employer Name and Address:		
☐ full time ☐ part time ☐ not employed ☐ retired	Student Status: ☐ full time student ☐ part time ☐ not a student		
If patient is a minor, please give parent/guardian names and specify relation to patient:			

IN CASE OF EMERGENCY

Name of emergency contact person:	Relationship to patient:	Home phone no.: ( ) -	Work phone no.: ( ) -
Mailing address:	City:	State:	ZIP code:

RESPONSIBLE PARTY (GUARANTOR)

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip the next section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Guarantor's last name:	Guarantor's first name:	Guarantor's middle name:	
Guarantor's mailing address, if different from patient:	City:	State:	ZIP code:
Guarantor's phone number: ( ) -	Relationship to patient:	Guarantor's date of birth: / /	Guarantor's Social Security No.: - -

INSURANCE INFORMATION

Name of primary insurance:	Policy subscriber's name, if not patient:	Policy subscriber's date of birth: / /
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:		
Name of secondary insurance (if applicable):	Policy subscriber's name, if not patient:	Policy subscriber's date of birth: / /
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:		

OTHER INFORMATION

Pharmacy name:	Pharmacy location:	Pharmacy phone no: ( ) -

Advanced Pediatric Gastroenterology, PC

HOW DID YOU HEAR ABOUT THIS CLINIC, OR WHO REFERRED YOU HERE?		
PRIMARY CARE PROVIDER INFORMATION		
Name:	Office location:	Office phone no: ( ) -
Fax No: ( ) -		

Financial Policy, Assignment Information, and Release of Information

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance or Medicare benefits to be paid directly to Advanced Pediatrics Gastroenterology, PC or its assignees. I am responsible for any non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This acceptance and assignment will be in force for all future services by practitioners from this office.

_____ _____

Signature of Patient or Patient's guardian/representative Date

_____

Printed name of person signing above

Acknowledgement of Notice of Privacy Practices

I understand that as part of my health care, Advanced Pediatrics Gastroenterology originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality.

I understand that Advanced Pediatrics Gastroenterology maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this Notice is displayed in the waiting room area. I understand that Advanced Pediatrics Gastroenterology reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this Notice at any time. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of Advanced Pediatrics Gastroenterology.

_____ _____

Signature of Patient or Patient's guardian/representative Date

_____

Printed name of person signing above