

GASTROENTEROLOGY, LTD

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|---|---|--|---|---------------------|
| Today's Date | Appointment Time | Arrival Time | Account No. | Staff Initials |
| PATIENT INFORMATION: Please print all registration information. Thank you. | | | | |
| Patient Name (last, first, middle) | | | Home Phone | Cell Phone |
| Patient Address | | | DOB | Social Security No. |
| City, State, Zip Code | Marital Status M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> | | Gender M <input type="checkbox"/> F <input type="checkbox"/> | E-mail Address |
| Race <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black Non-Hispanic <input type="checkbox"/> White Non-Hispanic <input type="checkbox"/> I decline completing this information <input type="checkbox"/> Two or more races <input type="checkbox"/> Other Race | | | Ethnicity <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Other <input type="checkbox"/> I decline completing this information | |
| Employer's Name and Address | | Work Phone | Occupation | |
| <i>Note: Please do not list a number if you do not wish us to call or leave messages.</i> | | | | |
| Name of Primary Care Physician Last Name First Name | | Name of Referring Physician Last Name First Name | | |
| PHARMACY INFORMATION | | | | |
| Pharmacy Name | | Name of Street | | |
| PERSON FINANCIALLY RESPONSIBLE | | | | |
| Name and Address | | Patient's Relationship to Guarantor Self/Spouse/Dependent Child/Other | | |
| Employer's Name and Address | | Guarantor's Home Phone | Guarantor's Work Phone | |
| INSURANCE INFORMATION: Please allow us to make a copy of your card. | | | | |
| PRIMARY INSURANCE INFORMATION | | | | |
| Insurance Company Name: | | | Policy Holder Name: | |
| Policy Holder Relationship to Patient: | Policy Holder DOB: | Policy Holder Social Security No. | | |
| Policy No.: | Group No.: | Effective Date: | | |
| SECONDARY INSURANCE INFORMATION | | | | |
| Insurance Company Name: | | | Policy Holder Name: | |
| Policy Holder Relationship to Patient: | Policy Holder DOB: | Policy Holder Social Security No. | | |
| Policy No.: | Group No.: | Effective Date: | | |

(PLEASE COMPLETE OTHER SIDE)

Patient Name _____ Date of Birth _____ Acct. # _____

I HEREBY CONSENT TO TREATMENT by Gastroenterology, Ltd. physicians, their associates and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include lab work, injections and/or such other procedures as deemed necessary. Initial: _____

I understand that Advance Directives will not be honored while in any of our medical facilities, including the physician office and endoscopy suite. Initial: _____

I would like to receive information regarding Patient Rights and Responsibilities. Yes: _____ No: _____

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood was tested for HIV antibodies pursuant to this provision. The testing would be explained and you would be given the opportunity to ask any questions you might have. Initial: _____

Acknowledgement of Receipt of Notice of Privacy Practices: I have received a copy of the notice of privacy practices for Gastroenterology Ltd.

Yes: _____ Declined: _____

We participate and accept assignment of payment with most major insurance plans in the area. If you provide us with your correct insurance policy information and any needed referral forms, we will file the insurance claim forms. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Gastroenterology, Ltd. for payment of any fees not covered by insurance. I understand that payment (or co-payment) is expected at the time of service. I understand and agree to pay in full any balance due after an insurance payment. Should this account become delinquent and collection becomes necessary, the undersigned agrees to be responsible for attorney's fees of 33 1/3%, interest of 18% per annum from the last date of payment and any and all applicable court costs.

I have read and agree to the above policies and authorize the release of any information necessary for the filing of any insurance and direct payment to Gastroenterology, Ltd. for any amounts due under my present policy(ies) or any policy that I may ask to be filed at a later date. This authorization is valid for current and subsequent treatment unless I submit a written revocation. Payments may be made with cash, check or credit card. In the event that a check is returned for insufficient funds a \$35.00 returned check fee (the fee) will be added to your account. We will notify you and give you ten days to pay the total amount due (including the Fee) in full with cash. If we do not receive the cash payment in full within 10 days, we will submit this delinquent account over to our attorneys at which time any and all civil penalties as provided in Section 8.01-27.0 of the Code of Virginia (1950) will be imposed.

Please let us know if you are having a particular financial problem; we will try our best to be understanding.

If I fail to appear for a scheduled appointment, it is my responsibility to reschedule if I feel the need to do so, and Gastroenterology, Ltd. will not be expected to contact me to determine why I failed to appear. Missed appointments and last minute cancellations affect the schedule of our healthcare providers and take an appointment from other patients who have a desire or need to be seen. Unless canceled at least 24 hours in advance, we reserve the right to charge a No-Show/Late cancellation fee of up to \$50 for regular office visit. A 72 hour notice is required for our Endoscopy procedures, without adequate notice there will be a \$75 fee. These fees will not be charged to your insurance company and will need to be paid prior to your next scheduled appointment. Please help us serve you better by keeping your scheduled appointments. Thank you.

Patient/Responsible Party Signature _____ Date _____

Witness _____ Date _____