GASTROENTEROLOGY, LTD

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☐ D☐ S☐ W☐	Gender M☐ F☐	E-mail Address

Race
☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native
☐ Black Non-Hispanic ☐ White Non-Hispanic ☐ I decline completing this information
☐ Two or more races ☐ Other Race

Ethnicity
☐ Latino/Hispanic
☐ Other
☐ I decline completing this information

Employer's Name and Address	Work Phone	Occupation

Note: Please do not list a number if you do not wish us to call or leave messages.

Name of Primary Care Physician	Name of Referring Physician

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 and Do Not Resuscitate orders while under sedation for a procedure in our facility will be Suspended. All practical measures will be utilized to prevent loss of life during your care in our endoscopy unit.
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 business hours in advance, we reserve the right to charge a No-Show/Late cancellation fee of $50 for regular office visit. A 72 business hour notice is required for our Endoscopy procedures, without adequate notice there will be a $100 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 _____