The Gastroenterology Group, P.A.

Demographic Information Form

Name: _____ Date: _____
Address: _____ Sex: M F
_____ Marital Status: S M W Partner
Birthdate: _____ Age: _____ SS #: _____
Email Address: _____

Language:
❑ English ❑ Indian ❑ Spanish
❑ Russian ❑ Other

Race:
❑ American Indian/Alaska Native ❑ Asian ❑ Black or African American
❑ Hispanic ❑ Native American ❑ Native Hawaiian or Pacific Islander
❑ Other Race ❑ White ❑ Declined

Ethnicity:
❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined

Telephone #: (Home)_____ (Work)_____
(Cell) _____
Primary Care Physician (PCP)_____ Telephone #: _____
Referring Physician: _____ Telephone # _____
Employer:_____ Telephone #: _____
Pharmacy Name/Address: _____
Emergency Contact Name/Relationship:_____
Emergency Contact Phone Number: _____

Authorized Representative(s): Please list the names and relationships of persons we may discuss your protected health information (PHI) with on your behalf:

_____ _____

_____ _____

Is your Emergency Contact listed above the same individual(s) with whom we may discuss your PHI?

☐ Yes ☐ No

Do we have permission to leave a detailed message regarding test results, future appointments, etc. on your:

answering machine ☐ Yes ☐ No cell phone ☐ Yes ☐ No

Have you ever been seen by one of our doctors? Kravitz Volpe Salowe Barash Modena

If so, where/when were you seen? ☐ office _____ ☐ hospital _____

INSURANCE INFORMATION

Primary insurance: _____ ID #: _____Group #: _____
Subscriber:_____ Subscriber's Date of Birth:_____
Secondary insurance: _____ ID #: _____Group #: _____
Subscriber: _____ Subscriber's Date of Birth: _____
Third insurance: _____ ID #:_____Group #: _____
Subscriber: _____ Subscriber's Date of Birth: _____

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☐ **Notice to HMO Patients:** HMO insurance companies require patients to have referrals BEFORE they have a consultation, procedure, follow-up visit or office visit. Your insurance company made this policy. We are simply asking you to make sure you have your referrals prior to any healthcare services being rendered. Referrals have expiration dates. Please note the expiration date of your referral. It is your responsibility to obtain referrals and to ensure that they are current. Most HMO's do not let the family doctors backdate referrals. If you do not have a valid referral on file, you may try to obtain one at the time of service, you may re-schedule for a later date/time or you may choose to be seen. If you choose to be seen without a valid referral, you will be required to pay for the visit. **Please initial in the box that you have read and understand our HMO Policy.**

☐ **Rx Consent:** By my signature below, I authorize The Gastroenterology Group, PA and its affiliated providers to view my external prescription history via the RxHub Service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here and it may include prescriptions back in time for several years. **Please initial in the left box that you understand the contents of this paragraph AND agree to give consent**.

NO Rx PERMISSION GRANTED: _____(Signature Required)

☐ **HIPAA Privacy Practices Acknowledgement:** I have either received a copy of the Notice of Privacy Practices for The Gastroenterology Group, PA or have previously had the opportunity to review it. **Please initial in the box indicating acknowledgement of our HIPAA policy.**

☐ **Payment Authorization and Collection Policy:** I authorize direct payment of all medical benefits to which I am entitled including Medicare, major medical, private insurance, or any other health plan to The Gastroenterology Group, PA. I authorize The Gastroenterology Group, PA to release any information needed for settlement of this claim to my carrier(s).

I understand that my insurance carrier determines settlement of this claim based on the terms of my policy in place at the time of service. Should there be any balance due after insurance settlement, I understand that it is my responsibility (co-pay, deductible, co-insurance). I understand that as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by the insurance. If this balance is not paid within 90 days, I understand that my account will be turned over to collections. At that time, I will be responsible for both the outstanding balance AND all collections costs associated with the account. **Please initial in the box that you have read and understand our Payment Authorization and Collection Policy.**

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

☐ **Procedure Cancellation Policy:** When you make a procedure appointment with us, we reserve a block of time especially for you and only you. If you do not appear for your procedure, that block of time is unavailable to someone else who is waiting for our care. We require **48 hours notice** to cancel or reschedule a procedure. If you fail to give the required notice, you will be subject to a $100 fee. The cancellation fee is not covered by your insurance. **Please initial that you have read and understand our Procedure Cancellation Policy**.

THE GASTROENTEROLOGY GROUP, PA – SIGNATURE ON FILE REGISTRATION

My signature below indicates that I have fully read and understand the policies in place for services provided to me by the physicians of The Gastroenterology Group, PA.

I permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date