# PATIENT REGISTRATION

Northland Gastroenterology, PA

**Please verify the following information, make corrections/additions as needed and sign where indicated. Bring this completed form, insurance card(s) and driver's license with to your appointment. Thank you!**

**APPOINTMENT DATE: _____**

**PATIENT INFORMATION** **CHART #**

NAME: _____ BIRTH DATE: _____
ADDRESS: _____ SSN: _____
ADDRESS: _____ PHONE #: _____
CITY/STATE/ZIP: _____ MOBILE #: _____
EMAIL: _____ WORK #: _____

**PRIMARY/REFERRING PHYSICIAN**

NAME: _____ PHONE**:** _____
FACILITY: _____

**EMPLOYMENT INFORMATION** ❒ Full or part time ❒ Retired ❒ Not employed ❒ Student

Employer Name: _____
Address: _____

**RESPONSIBLE PARTY INFORMATION** ❒ Same as patient (Skip to next section)

Name: _____ Phone #: _____
Address: _____
Relationship to patient: _____

**EMERGENCY CONTACT INFORMATON**

Name: _____ Phone #: _____
Address: _____
Relationship to patient: _____

**INSURANCE INFORMATION**

**Primary Insurance**:
Company Name: _____ **ID/Group#:** _____
Subscriber Name: _____ DOB**:** _____ SSN: _____
Relationship to patient: _____

**Secondary Insurance**: ❒ Not applicable
Company Name: _____ **ID/Group#:** _____
Subscriber Name: _____ DOB**:** _____ SSN: _____
Relationship to patient: _____

**Tertiary Insurance:** ❒ Not applicable
Company Name: _____ **ID/Group#:** _____
Subscriber Name: _____ DOB**:** _____ SSN: _____
Relationship to patient: _____

**LAST NAME/FIRST NAME _____ DOB: _____**

## STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

I acknowledge I am responsible for all charges for Northland Gastroenterology PA (NG) services provided to me, including any amount not paid by third-party payors. The undersigned agrees whether as patient, authorized representative or other financially reponsible party, to pay the charges for care provided to the patient by NG in accordance with regular NG terms and rates.

I authorize payment directly to NG of benefits otherwise payable to me by insurance company(ies). If my health insurance will not allow directpayment to NG or if NG chooses not to accept assignment for medical benefits, I agree to pay NG amounts equal to all health insurance benefits I receive for medical care at NG immediately upon receipt of insurance. I understand that NG is not responsible for negotiating settlement of a disputed claim.

_____ _____
Patient Signature Date

_____ _____
Authorized Representative Relationship to Patient

_____ _____
Witness Signature (if X by patient) Date

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## RELEASE OF INFORMATION

I hereby authorize Northland Gastroenterology, PA (NG) to release information from my medical records (including but not limited to that which involves treatment for psychiatric, psychological, drug/alcohol abuse, acquired immune deficiency syndrome, or sickle cell anemia) to my insurance company for payment of my bill.

I hereby authorize NG to release necessary information from my medical records to any health care provider directly involved in my care and treatment.

This authorization is valid for one year as specified by Minnesota state law dated August 1, 1991.

List any insurance company you wish to exclude from this authorization: _____

_____ _____
Patient Signature Date

_____ _____
Authorized Representative Relationship to Patient

_____ _____
Witness Signature (if X by patient) Date

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## USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge a copy of the notice of privacy practices is available upon request.

_____ _____
Patient Signature Date

_____ _____
Authorized Representative Relationship to Patient