

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!

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

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 responsible 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 direct payment 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

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.

Patient Signature

Date

Authorized Representative

Relationship to Patient

USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge receipt of the notice of privacy practices. These can be found on our website at www.northlandgastro.com.

Patient Signature

Date

Authorized Representative

Relationship to Patient