ARIZONA GASTRONETEROLOGY LTD

Patient Registration And Consent Forms

Patient Information:

Last Name: _____ *First Name:* _____ *Middle Initial:* _____

Mailing Address: _____ *Apt #* _____ *City:* _____

State: _____ *Zip:* _____

Date of Birth: _____ *Sex: Male or Female* Gender Identity : _____

Social Security (optional) _____-_____-_____

Marital Status: _____

Race: (please circle if applicable)

American Indian / Native Alaskan

Asian

Black / African American

Hispanic / Latino

Native Hawaiian / Pacific Islander

White / Caucasian

Other: _____

Cellphone: (_____)_____Home Phone: (_____)_____Work Phone (_____)_____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Referring Doctor: _____ Primary Care Provider: _____

How were you referred to us? **(please circle if applicable)** Family/Friend Physician

Primary Insurance information:

Insurance: _____

Self-Pay: _____ *(if applicable)*

Policy Holder's Name: _____ *Date of Birth:* ___/___/_____

Member Number: _____ *Group Number:* _____

Policy Holder's SS#: ____ -____ -_____ *Relationship to Patient:* _____

Employer: _____ *Phone:* _____

Secondary Insurance information: (if applicable)

Insurance: _____

Self-Pay: _____ *(if Applicable)*

Policy Holder's Name: _____ *Date of Birth:* ___/___/_____

Member Number: _____ *Group Number:* _____

Policy Holder's SS#: ____ - ____ - _____ *Relationship to Patient:* _____

Employer: _____ *Phone:* _____

Work Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Communication Preference: (please circle your preference)

In Order for our office to better communicate with you; please indicate your preferences below:

What is your primary phone contact: *Cellphone* *Home phone* *Work phone*

May we send you a medical text message providing healthcare information? *Yes* *No*

May we send you an email providing healthcare information? *Yes* *No*

Do you give consent for lab/results to be left on your voicemail/answering machine? *Yes* *No*

I give consent for my medical information to be shared with _____

Relationship: _____ *Phone number:* (_____)_____

If so please sign ***"Patient*** **Consent for The Release of Protected Health information" on the next page.**

Insurance Authorization and Financial Responsibility Disclosure:

My Signature below authorizes Arizona Gastroenterology LTD to release any medical information necessary to process my or my dependent's insurance claim. I authorize any benefits due be paid directly to Arizona Gastroenterology LTD.

Your insurance company only provides our office an "estimate "of covered benefits prior to receiving any services or materials from us. The "estimate "is not a guarantee of benefits. I understand that I may be required to provide a referral/authorization from my primary care provider if needed by my insurance. I also understand that I may also be required to pay a deductible, co-pay, co-insurance, or any balance not covered by my insurance plan. In the event that my insurance does not fully pay for services and/or materials rendered to me, I agree to be responsible for payment of all balances on my or my dependent's behalf.

I understand that all fees for professional services shall be paid at time of service. Unsettled Balances may be referred to an outside collection agency and the credit bureau. Returned checks will be subject to additional fees.

I certify that I have read and understand the above information to the best of my knowledge.

Patient or Guarantor Signature Date

_____

Patient Consent for The Release of Protected Health information:

Arizona Gastroenterology (AGI) is Requesting (Patient) _____

To provide consent to release confidential healthcare information to_____
for the purpose of MEDICAL CARE (all medical Information ,billing etc.) when providing needed healthcare treatment, to obtain payment for healthcare services or healthcare operations.

Conditions:

- **The patient understands that their information is to be used for treatment, payment or healthcare options.**
- **The patient understand that their healthcare information may be disclosed to other healthcare providers for the purpose of treatment, payment or for healthcare operations**
- **The healthcare organization reserves the right to either honor or dismiss the patient's request to limit the use of the patients' healthcare information**
- **This consent is between :**
  Arizona Gastroenterology (AGI) , and _____ (patient)
- **This consent can be revoked ; however , the request must be in writing**
- **Additional information can be obtained by reading AGI's Privacy Notice.**
- **This consent form will be maintained by AGI for a period of six (6) years.**

Signatures:

Patient: _____ **Date:**_____

AGI Representative: _____ **Date:** _____

HIPPA Acknowledgment of Notice of Privacy Practice:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. We are required by law to maintain the privacy of your health information and make every effort to inform you of your rights. The Notice contains a section describing your rights under the law related to your personal health information. By signing below, I acknowledge that I have reviewed or have been explained to me the notice of privacy practices and agree to continue my care with Arizona Gastroenterology LTD under said terms.

I certify that I have read and understand the above information to the best of my knowledge.

_____

Patient or Guarantor Signature _____ **Date** _____

Established Patient

Patient Name: _____

Review of systems: (Please check all that apply)

Respiratory:

___ Dyspnea

___ Frequent Cough

___ Pleuritic Pain

___ Wheezing

Cardiovascular:

___Chest Pain

___ Leg Swelling

___ Palpitations

Gastrointestinal: (Please check al that apply)

___ Abdominal Pain

___ Altered Bowel Habits

___ Black Stools

___ Bloating

___ Blood in the Stool

___ Bloody Vomit

___ Bowel Incontinence

___ Constipation

___ Diarrhea

___ Decreased Appetite

___ Difficulty Swallowing

___ Excessive Gas

___ Jaundice

___ Heartburn

___ Nausea

___ Painful Swallowing

___ Rectal Bleeding

___ Reflux

___ Vomiting

___ Weight Loss