THE CENTER FOR COLON AND DIGESTIVE DISEASE

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Huntsville, AL 35801

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Patient Registration

PLEASE COMPLETE (print, write, type, check, and/or select)

Full Name: _____ Date of Birth: _____

Social Security #: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Language: (Please give preferred Language) _____

The *following* categories are required for compliance with U.S. Government regulations.

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ African American
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White
☐ Multicultural ☐ Refuse to Report ☐ Unknown

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Decline ☐ Unknown

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____ May we call you at work? ☐ Yes ☐ No

Self-Employed? ☐ Yes ☐ No If Self Employed, Name of Business: _____

Occupation: _____ How Long Employed? _____ ☐ Full-time ☐ Part-time

Employer's Address: _____

Name of Spouse: _____ Spouse's Date of Birth: _____

Spouse's Social Security #: _____ Spouse's Employer: _____

Spouse's Occupation: _____ May we call them at work if necessary? ☐ Yes ☐ No

Spouse's Work Phone: _____ Spouse's Cell Phone: _____

In Case of an Emergency, Notify: _____ Relationship: _____ Phone: _____

Who Referred You to This Office? _____ Who is your Family Physician? _____

Have You Seen Any of Our Physicians Before? ☐ Yes ☐ No If Yes, Whom? _____

Do you have Medical Coverage? ☐ Yes ☐ No Primary Insurance Company:_____

I.D. #: _____ Group #: _____

Subscriber's Name:_____ Relationship to Patient: _____

Secondary Insurance Company: _____ I.D. # _____ Group #: _____

Subscriber's Name:_____ Relationship to Patient: _____

If Responsible Party is Other than the Patient, Please Complete The following:

Responsible Party Name: _____ Relationship: _____

Address:_____ City:_____ State:_____Zip: _____

Date of Birth:_____ Social Security #:_____

Employer: _____ ☐ Full-time ☐ Part-time

Home Phone: _____ Cell phone:_____ Work Phone:_____

Email Address: _____

In order to provide our patients with the highest level of care, any procedure cancellation with less than 48 hour notice may result in a $75.00 cancellation fee. This cancellation fee is not covered by your insurance. Payment of this fee will be required prior to rescheduling the missed procedure. There will be a $10.00 administration service charge for filling out any Prior Authorization (P.A.) forms that your insurance company may require in order for you to obtain their approval for prescription medication. This fee must be paid prior to the completion of your P.A. form. There is also a $15.00 administration fee if you have to be invoiced for your co-pay.

AUTHORIZATION & ASSIGNMENT: Please Read and Sign the Following Statement:
I directly assign all medical/ surgical benefits to The Center for Colon and Digestive Disease/ Huntsville Endoscopy Center and understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize the Physician/ Practice to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:
In the event that it becomes necessary to collect any amounts owed by you, you agree that The Center for Colon and Digestive Disease, PC. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial messages and/or use of automatic dialing device, as applicable.

It is customary that payment be made when the service is rendered unless prior arrangements have been made in advance. In the event of non-payment, either by insurance or myself, I agree to pay all cost of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract.

I hereby authorize any physician or hospital to provide copies of my medical history and treatment to The Center for Colon and Digestive Disease, P.C. Photocopies of this agreement are as good as the original. I have read this entire Patient Registration form and agree to all provisions of this form, including but not limited to the Authorization and Assignment provisions and the Consent to Contact provisions.

Signature: X_____ Date: X_____