THE CENTER FOR COLON AND DIGESTIVE DISEASE

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Huntsville, AL 35801

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Madison, AL 35758

Patient Registration

PLEASE COMPLETE (print, type, circle, or select)

Full Name:_____ Date of Birth:_____

Social Security#:_____

Sex: --Select-- Marital Status: --Select--

Language: (Please give preferred Language)_____

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

Race: --Select--

Ethnicity: Hispanic/Latino

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? --Select--

Self-Employed? --Select-- If Self Employed, Name of Business:_____

Occupation:_____ How Long Employed?_____ --Select--

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? --Select--

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? --Select-- If Yes, Whom?_____

Do you have Medical Coverage? --Select-- 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:_____ --Select--

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.

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.

Signature: X_____ Date: X_____