PAMELA J. CONNORS, MD PC
Gastroenterology and Digestive Wellness

PATIENT REGISTRATION

NAME_____BIRTHDATE_____AGE_____
Patient's Full Name.

ADDRESS_____
Street City State Zip

PHONE#S (H) _____ (C)_____EMAIL_____

MARITAL STATUS_____ SOC.SEC.#_____DRIVERS LIC#&STATE_____

EMPLOYER_____WORK PH._____

SPOUSES NAME_____ D.O.B. _____

SPOUSES EMPLOYER_____WORK PH_____

NAME OF DR., RELATIVE, FRIEND,(OR SELF) WHO REFERRED YOU_____

CLOSEST RELATIVE NOT LIVING WITH YOU (RELATIONSHIP)_____

_____ (_____)_____
Last Name First Phone

_____
Street City State Zip

PRIMARY CARE PHYSICIAN_____

PREFERRED PHARMACY NAME_____LOCATION_____

PRIMARY INSURANCE CARRIER_____ID#_____

POLICYHOLDER_____D.O.B._____RELATIONSHIP_____

SECONDARY INSURANCE CARRIER_____ID#_____

POLICYHOLDER_____D.O.B._____RELATIONSHIP_____

INSURANCE AUTHORIZATION, ASSIGNMENT AND RECORDS RELEASE

I hereby authorize Pamela J. Connors, MD PC to furnish information to insurance carriers concerning my health and treatment. I assign to the physician all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance. I authorize Pamela J. Connors, MD PC to obtain my medical records including but not limited to medication lists from my pharmacy to ensure quality of care.

DATE_____SIGNATURE_____

PAMELA J. CONNORS, MD PC
Gastroenterology and Digestive Wellness
80 Beach Street
Westerly, Rhode Island 02891
(401) 348- 7010

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

Patient's Full Name: _____ **DOB:** _____

Patient's Address: _____

City, St Zip: _____

Patient's Phone#s: **Home** _____ **Cell** _____

Work _____

Date the Notice was Provided: _____

Patient's Signature: _____

Signature of Guardian or Legal Representative: _____

Relationship to Patient: _____

Individual Refused to Sign: _____ **Date:** _____

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HIPAA RELEASE FORM

Patient's Full Name:_____ DOB: _____

Due to Federal Guidelines (HIPAA- Health Insurance Portability and Accountability Act), we will no longer be able to speak to any person on your behalf without your signed consent. Please indicate below by name, if there is a family, friend or physician with whom you would like us to share your medical information via telephone, mail, fax, or in person.

RELATIONSHIP	**NAME**
Primary Care Physician	_____
Other Physician	_____
Mother	_____
Father	_____
Spouse	_____
Child	_____
Friend	_____
Other	_____
	_____
	_____

Patient's Signature: _____ Date: _____

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HIPAA PATIENT CONTACT FORM

Patient's Full Name:_____ DOB: _____

The staff at Gastroenterology and Digestive Wellness strives to provide our patients with test results in a timely manner. Please fill in this form to indicate your preferred method of contact. Leave Email, Cell Phone and Home Phone BLANK if you do not want to be contacted by these methods. If an alternative contact method is selected, we will make our best efforts to contact you in this manner. Thank you.

Email: _____

Cell Phone: _____

Home Phone: _____

Alternative Contact Information:_____

_____

Patient's Signature: _____ Date: _____

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Patient Name: _____DOB: _____

A missed appointment leaves an empty slot that could have been used by a patient in need of medical care. Not cancelling an appointment in a timely fashion is unfair to other patients. We therefore request that patients who are unable to keep their scheduled appointment notify us at least 24 hours in advance, so the time might be made to someone else.

Please see our no-show policy below.

No-Show Policy

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time.

Our no-show policy is as follows: a 24-hour notice is required. After the first no-show appointment you will receive a phone call to remind you of the missed appointment and to reschedule your appointment. After the second no-show you (not your insurance company) will be charged $25 for the time slot we were not able to fill when you were a no-show.

I _____ have reviewed the above new policy.

_____ Signature _____ Date