SOUTH OAKLAND GASTROENTEROLOGY ASSOCIATES
PATIENT REGISTRATION FORM

PATIENT INFORMATION – PLEASE PRINT

DATE: _____

Name of Patient: _____ SSN: _____

Address: _____ Marital Status: S M D W

City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ home/cell/work/other

Secondary Phone #: _____ home/cell/work/other

Birthday: _____ Age: _____ Sex: Male Female

Email: _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____ Phone # of Employer: _____

Name of Primary Physician: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

PHARMACY INFORMATION

Name of Pharmacy #1: _____

Phone #: _____

Address of Pharmacy: _____

City/State: _____

Name of Pharmacy #2: _____

Phone #: _____

Address of Pharmacy: _____

City/State: _____

Rx COVERAGE INFORMATION

Rx Company: _____

ID #: _____

Phone: _____

In order to provide quality care, I hereby authorize South Oakland Gastroenterology Associates to request Electronic Medical History from my Pharmacy.

Signature: _____

SOUTH OAKLAND GASTROENTEROLOGY ASSOCIATES
PATIENT REGISTRATION FORM

INSURANCE INFORMATION

Insurance #1: _____

Policy #: _____ Group #: _____

Subscriber Name: _____

Subscriber DOB: _____ Sex: Male Female

Relationship of Patient to Subscriber: _____

Subscriber Employer: _____

Address: _____

Phone #: _____

Insurance #2: _____

Policy #: _____ Group #: _____

Subscriber Name: _____

Subscriber DOB: _____ Sex: Male Female

Relationship of Patient to Subscriber: _____

Subscriber Employer: _____

Address: _____

Phone #: _____

I authorize the release of medical and other information to my insurance company for review of my coverage and/or for the processing of claims of services rendered to me. I understand that I AM responsible for any charges incurred that are not covered by my insurance company. I have read this information and understand it.

_____ _____

Patient/Responsible Party Signature Date

Cancellation and No Show Policy

In order to be respectful of the medical needs of other patients, please be courteous and call South Oakland Gastroenterology promptly if you are unable to make your appointment. This time will be reallocated to a patient on our waiting list in need of treatment. We require that you call at least 24 hours in advance. Office appointments which are cancelled with less than 24 hours notification will be subject to a $50.00 cancellation fee.

We track missed (non- cancelled), appointments. A "NO SHOW/ LATE CANCELLATION" is defined as missing an appointment without cancelling at least 24 hours before the scheduled time. The cancellation and no show fees are the sole responsibility of the patient and are NOT covered by your insurance. This fee MUST be paid in full before the patient's next appointment.

We reserve the right to not reschedule a "NO SHOW" appointment for all scheduled New Patients to our practice. Established patients are subject to be dismissed from the practice if they have two (2) or more NO SHOW appointments in a 12 month period.

We understand that unforeseen circumstances may cause you to cancel within the 24 hour time frame. Fees in this instance may be waived but ONLY with management approval.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about the cancellation and no show fees should be directed to the Office Manager at 248-471-8982.

Please sign that you have read, understand and agree to this cancellation and no show policy.

_____ _____

Patient name (please print) patient date of birth

_____ _____

Signature of patient or representative date signed

Krf/6-2016

SOUTH OAKLAND GASTROENTEROLOGY ASSOCIATES

AUTHORIZATION FOR TREATMENT

I request and authorize this provider office as my provider, (including his/her assistants or designees) healthcare treatment that may be deemed necessary and advisable. This care may include, but not limited to, physical examinations, routine diagnostic services, such as radiology, laboratory procedure, administration of routine drugs, biologicals and other therapeutics, and routine medical land nursing care. I understand that my care, as a patient, is directed by my providers, and that other personnel render care and services to me according to the providers' instructions. I understand that the practice of medicine is not an exact science. No guarantees or promises have been made to me regarding the results of any medical care or treatment.

I have been informed and understand that HIV (human immunodeficiency virus), AIDS and HBV (hepatitis B virus) tests may be performed on me without my consent if a health professional or facility employee sustains an exposure to my blood or other body fluid.

In order for my provider to make well informed decisions about my healthcare, I grant permission to my provider to view my prescription history from an external electronic source.

I understand that at the end of my appointment, I will be provided with an Office Visit Summary. I will be responsible for the confidentiality of this form after I receive it.

TEACHING INSTITUTION

I understand that Beaumont Farmington Hills Campus is a teaching institution and as such, services may be performed by individuals selected and deemed qualified by the teaching staff. Further, treatment and medical records may be reviewed by approved student and faculty for teaching, studies and research purposes. Information identifying patients will never be published without prior patient consent.

IDENTITY VERIFICATION

I understand that my identity will needs to be conformed and protected. I must present either my valid (meaning not expired and bears current name and address) driver's license, state photo ID, or passport, along with my health insurance card.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF INSURANCE BENEFITS

I assign and authorize payment from my insurance company directly to South Oakland Gastroenterology Associates for any and all services provided. I also authorize the release of my medical information necessary to process the insurance claim. **I understand that I am financially responsible for any services or procedures that may not be covered by my health insurance company including deductibles, copays and coinsurance.** I understand that it is my primary responsibility to pay South Oakland Gastroenterology Associates for all charges for services rendered irrespective of any dispute or disagreements between myself and insurance companies. I also understand that I will be financially responsible for all services rendered due to failure to provide billing information and/or formal written authorization from the appropriate insurance carrier. **Co-pays will be collected at the time of service**.

It is further agreed that, if at a later date (within the established time limitations by the insurance), I provide South Oakland Gastroenterology Associates with the necessary billing information and/or with approved authorization for these specific dates and services, every attempt will be made to obtain payment directly from my insurance. However, such attempt shall not relieve the undersigned of financial responsibility until all sums are paid in full.

By signing this form, I acknowledge that I have had the opportunity to read this form (or have it read to me), ask questions, and have these questions answered.

This authorization will remain effective indefinitely, unless I revoke this arrangement.

Name of Patient (print):_____

Signature of Patient: _____ **Date:** _____

Signature of Parent, Guardian or Relative: _____
(If patient is unable to sign or is a minor)

Date: _____ **Relationship:** _____

REVISED: 10/21/2016

South Oakland Gastroenterology
23133 Orchard Lake Rd., Suite 200
Farmington, MI 48336

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.
To comply with one of the HIPAA requirements, South Oakland Gastroenterology is providing you with a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing MI laws requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse / neglect investigation.
In some instances, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another covered entity for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

Please sign this form below under the heading "acknowledgment" to acknowledge that you have today received a copy of our Notice of Privacy Practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____
Patient or Parent/Guardian Signature Patient Name (Please Print)

_____
Date

For Office use only

Patient refused to Sign
The following circumstances prohibited the patient form signing the Acknowledgement.

_____

An emergency situation prevented the patient from signing the Acknowledgement.

_____

_____

South Oakland Gastroenterology
23133 Orchard Lake Rd., Suite 200
Farmington, MI 48336

Patient Consent & Authorization

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment.

Communication with laboratories or other specialists for any medical treatment, consultations, and educational purposes or for any other purpose deemed appropriate by South Oakland Gastroenterology.

_____

Patient or Parent/Guardian Signature

_____

Patient Name (Please Print)

_____

Date

SOUTH OAKLAND GASTROENTEROLOGY ASSOCIATES, PC

PERMISSION AUTHORIZATION WAIVER

Provided below are the name(s) of the person(s) in which South Oakland Gastroenterology has the authorization to discuss any of my medical records with, whether the office staff or physician calls my home and I am not home, or if a family member(s) calls wanting to know about my medical records.

Person(s) to release information to:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I have read all the information above and agree here within to the statements made. I agree to notify the office immediately, in writing, when changes are to be made to the above listed information.

_____ _____

Patient Name (please print) Patient Signature

_____

Date

Consistent with HIPPA, this information shall be updated annually.