



Anne Arundel Gastroenterology Associates, P.A.

PATIENT REGISTRATION - Please Print Clearly

TODAY'S DATE:

PATIENT NAME First Middle Last			DATE OF BIRTH	AGE
HOME ADDRESS		APT. NO.	CITY	STATE
HOME ADDRESS		ZIP CODE		
RACE: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN-AMERICAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> OTHER				E-MAIL ADDRESS
OCCUPATION	EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> STUDENT <input type="checkbox"/> FT <input type="checkbox"/> PT	SOCIAL SECURITY NO.	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	SEX
HOME PHONE	EMPLOYER (or previous employer, if retired)		ADDRESS	
WORK PHONE	SPOUSE (OR PARENT) NAME		SPOUSE (OR PARENT) EMPLOYER	
SPOUSE (OR PARENT) WORK PHONE		SPOUSE (OR PARENT) ADDRESS		
NEAREST RELATIVE/FRIEND (Contact in Case of Emergency)	RELATIONSHIP	HOME PHONE	WORK PHONE	
RELATIVE/FRIEND ADDRESS				

REFERRING PHYSICIAN/FAMILY DOCTOR	ADDRESS	TELEPHONE
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PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR OR DEPENDENT

PARENT/GUARDIAN NAME First Middle Last			
ADDRESS (IF DIFFERENT FROM PATIENT)			
WORK PHONE	HOME PHONE	DATE OF BIRTH	SOCIAL SECURITY NO.

INSURANCE INFORMATION

PRIMARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP/CODE
	DATE EFFECTIVE	INSURANCE COMPANY ADDRESS		POLICYHOLDER'S NAME (IF OTHER THAN PT)
	POLICYHOLDER'S SOCIAL SECURITY	SEX	POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S ADDRESS
	RELATIONSHIP TO PATIENT		HOME PHONE	WORK PHONE
	IS THIS THROUGH EMPLOYER <input type="checkbox"/> OR INDIVIDUAL <input type="checkbox"/>	NAME OF EMPLOYER		IS POLICYHOLDER STILL WORKING <input type="checkbox"/> Y <input type="checkbox"/> N

SECONDARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP/CODE
	DATE EFFECTIVE	INSURANCE COMPANY ADDRESS		POLICYHOLDER'S NAME (IF OTHER THAN PT)
	POLICYHOLDER'S SOCIAL SECURITY	SEX	POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S ADDRESS
	RELATIONSHIP TO PATIENT		HOME PHONE	WORK PHONE
	IS THIS THROUGH EMPLOYER <input type="checkbox"/> OR INDIVIDUAL <input type="checkbox"/>	NAME OF EMPLOYER		IS POLICYHOLDER STILL WORKING <input type="checkbox"/> Y <input type="checkbox"/> N

PATIENT AUTHORIZATION

I hereby authorize Anne Arundel Gastroenterology Associates and/or Maryland Center for Digestive Health, to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I also authorize the release of any necessary information, including medical information if requested by the above named insurance company. I permit a copy of this authorization to be used in such instances.

REFERRALS

I understand that I am responsible for obtaining a valid insurance referral form from my primary care physician if required by my insurance company.

PRE-CERTIFICATION

I understand that AAGA/MCDH will attempt to obtain a pre-certification as a courtesy for me. I understand that AAGA/MCDH is not obligated to obtain pre-certification for me and it is my responsibility to obtain or to make sure that any required pre-certification has been obtained for me prior to my procedure. I agree to advise and confirm with AAGA/MCDH that a pre-certification has been obtained for me. I understand that in the event pre-certification is not obtained by me, I will be responsible for any amounts not paid, reduced or denied by my insurance company.

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

I agree to promptly pay all charges when billed for medical services rendered. As a parent or legal guardian, I accept legal responsibility for all charges incurred by the patient. I understand AAGA/MCDH will bill accordingly up to 60 days once patient responsibility is determined. If I have not addressed balance due, I understand my account will be submitted for collection review.

Appointments not cancelled 24-48 hours prior are subject to a charge. AAGA/MCDH accepts cash, checks, credit card and money order payments.

By signing below, I agree to pay the charges for services rendered by AAGA/MCDH which are not covered by the insurance company that I have indicated on this form or advised AAGA/MCDH to bill for the services provided and/or for the services that I have agreed to pay personally without benefit of insurance (self-pay). In the event that I do not pay for services rendered as herein agreed and it becomes necessary for AAGA/MCDH to seek collection of and payment for services provided, I agree to pay for all legal, attorney and/or collection fees required to pursue the collection and payment for the services provided.

POLICY CONCERNING MEDICAL RECORDS

I hereby authorize AAGA/MCDH to release my medical information as I have directed. Medical record copying may be subject to a copying charge. Records must be requested at least two weeks in advance of desired receipt date. If there is a charge for copying my records, I understand that I will be billed based upon allowed charges under current Maryland law for copying medical records. Patients or other parties authorized by the patient to request medical records for legal issues, insurance, disability (not workman's compensation), physician change or relocation from the area are subject to a copying charge. There will be no charge for copying records to a referral to another physician made by an AAGA/MCDH physician or workman's compensation issues or any other situations covered by Maryland law.

PATIENT RIGHT TO PRIVACY/CONFIDENTIALITY (HIPAA)

Anne Arundel Gastroenterology Associates and/or Maryland Center for Digestive Health is committed to patient privacy and confidentiality. In our Patient Bill of Rights, we state that our patients have a right to privacy and confidentiality. Therefore, you will be asked for your permission prior to the release of your medical records. Your medical information will be kept confidential to the degree required under existing law and regulation. However, from time to time, we may need to contact you at home or work. If we need to contact you, may we have your permission to leave a message with regard to your care, any lab results and appointment information, if you are unavailable or do not answer the phone?

Leave a message at work _____ Yes _____ No (Please Initial); Leave a message at home _____ Yes _____ No (Please Initial)

AGREEMENT TO TERMS

By signing below, I agree to the terms and conditions, herein, and attest that the information provided is true and accurate.

Signature Date

CONSENT TO TREAT

By initialing below, I specifically give my permission to Anne Arundel Gastroenterology Associates and/or Maryland Center for Digestive Health to provide medical care, physical examination, medical decision making, order tests and prescribe medications for me that are medically necessary to diagnose and treat my medical condition.

I Consent to Treatment _____
Signature Date

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize (Consent) **Anne Arundel Gastroenterology Associates (AAGA), and its affiliate, Maryland Center for Digestive Health (MCDH)** to use and/or disclose my health information, which specifically identifies me or which can reasonably be used to identify me, to carry out my treatment, payment and health care operations. **I understand that while this consent is voluntary, if I refuse to sign this consent, AAGA and/or MCDH will be unable to treat me.**

I Consent to Release _____
Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered and received a copy of the Anne Arundel Gastroenterology Associates (AAGA), and its affiliate, Maryland Center for Digestive Health (MCDH), Notice of Privacy Practices.

Signature of patient or patient's representative Date

Printed name of patient or patient's representative Relationship to the patient

AAGA/MCDH provides medical services regardless of race, color, age, national origin, sex, religion, handicap.

Date X Patient Signature (Parent or Guardian Signature for Minor)