HALIFAX GASTROENTEROLOGY, PC
Patient Registration Form

Patient Name:_____ D.O.B_____ SSN: _____

Address: _____ City _____ State ____ Zip _____

Phone#: _____ Gender: Male/Female Marital Status:_____
(By giving your number, you authorize HGPC to contact you or leave a message.)

Please circle your contact preference: Email Phone Letter

Email Address: _____

Employer: _____ Phone#: _____ Occupation: _____

Address:_____City:_____Zip:_____

Primary Care Physician:_____

Emergency Contact: _____

Phone#: _____ Relationship: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

DATE: _____ SIGNATURE:_____

I hereby authorize Dr. Yerra to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to Dr. Yerra (or to the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either myself or by my insurance company in writing at any time.

DATE: _____ SIGNATURE:_____

ADVANCED BENEFICIARY NOTICE

I, _____ , have been explained about the possibility of this service being denied due to "medically necessary" reasons, or as a non-covered service. If so, I agree to be personally responsible for the full payment.

DATE: _____ SIGNATURE:_____

INDIVIDUAL PATIENT'S AUTHORIZATION
HIPAA

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of organizations named in this form.

DATE: _____ SIGNATURE:_____

If this authorization is signed by a personal representative for the individual patient:

Personal Representative's Name: PRINT:_____

SIGNATURE:_____

Relationship to Individual Patient:_____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.