Colon and Rectal Surgery and The Colonoscopy Center Inc.

PATIENT REGISTRATION FORM

Date: **Patient Information** **Account #:**

Patient Name:		SS#:	Date of Birth/Age:
Marital Status: S M Sep D W Sex: M F	Home Phone:		Cell Phone:
Address:	City/State/Zip		
Occupation (Indicate if Student):		Employer:	
Employer Address:	Employer Number:		Length of Employment
Spouse/Significant Other/Parent or Guardian:		Date of Birth:	SS#:
Occupation:	Employer Address:		Employer Number:
Emergency Contact Name and Number:		Relationship	Referred by:
Do you have a PCP?	PCP Name:		PCP Phone #:
Primary Insurance Carrier	Primary Insured Name and Employer		Primary Insured DOB and SS#
Primary Insurance ID Number	Primary Insurance Group Number		
Secondary Insurance Carrier	Secondary Insured Name and Employer		Secondary Insured DOB and SS#
Secondary Insurance ID Number	Secondary Insurance Group Number		

Financial Policy Statements/Authorizations

A) <u>Financial Responsibility:</u> I have requested medical services from Colon and Rectal Surgery Inc. ("CRS")/The Colonoscopy Center Inc. ("CCI") on behalf of myself and/or my dependents. I understand that I am fully financially responsible for any and all charges incurred in the course of the authorized treatment. I understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

B) <u>Assignment of Insurance Benefits:</u> I hereby assign all medical and surgical benefits to which I am entitled. I authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to CRS/CCI for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I will fully cooperate with CRS/CCI to obtain payment from my insurance carrier(s), if any. I understand that I am fully responsible for any amount not covered by insurance.

I understand that in order to determine whether I need pre-certification or pre-authorization for my services, I can contact my insurance company. I understand that if I am still unsure, I can ask my nurse to contact my insurance company on my behalf. I acknowledge that it is my responsibility to make sure that any pre-certification or pre-authorization requirements of my insurance company are satisfied prior to my visit.

I understand that depending on my visit, I may receive a separate bill from both CRS for my physician's services and CCI for my use of its facilities. I may also receive a separate bill from third party labs or other third party providers. I understand that all CRS/CCI billing is performed in accordance with Medicare's or my insurance company's guidelines.

I understand that CRS/CCI accepts Medicare and most insurance plans; however, CRS/CCI is not a preferred provider on all plans and some insurance plans will not pay charges from The Colonoscopy Center Inc. I acknowledge that I am responsible for all charges not paid by my insurance plan. I understand that it is my responsibility to make sure that CRS/CCI has accurate information about my insurance coverage. At each visit, I will verify that the insurance on file for me is accurate.

C) <u>Medical Record Authorization:</u> I hereby authorize CRS/CCI to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This authorization shall remain in effect until revoked by me in writing.

Patient/Responsible Party Signature: ____ Date: __________________

Witness: ____