Regional Digestive Consultants, P. A.
Premiere, patient centered digestive care

Phone: 281-528-1511
Fax: 281-419-8485
www.rdctx.com

Patient Registration and consent Form

Patient Information

Date: _____ □ **New Patient** □ **Existing Patient**

Patient Name (Last, First, MI): _____ **DOB** (mm/dd/yyyy): _____ **Age**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____ **DL**(State & #): _____

Email: _____ **Home Phone**: _____ **Mobile Phone**: _____

SS#: _____ **Sex**: □ M or □ F **Marital Status**: □ Married □ Single □ Divorced □ Widowed

Occupation: _____ **Employer/Name of School**: _____ **Work Phone**: _____

Emergency Contact (not in same household): _____ **Relationship to Patient**: _____ **Phone Number**: _____

Race: □ White □ Hispanic/Latino □ African American □ American Indian □ Asian □ Other □ Decline to Specify

Ethnicity: □ White □ Hispanic □ Not Hispanic □ Decline to Specify **Preferred Language**: □ English □ Spanish/Castilian □ Decline to Specify

Preferred Pharmacy (Name/Address/Phone): _____

Referring Physician (Name/Phone): _____

Name(s) of Other Physicians who care for you: _____

How did you hear about us? □ Physician _____ □ Friend/Family_____ □ Insurance directory

□ Yellow Pages □ Advertisement □ Mailing □ Internet Search Site_____ □ Other

HIPAA Communication Preference

In order for our office to better communicate with you, please indicate your preferences below:

What is your primary contact preference? □ Mobile Phone □ Home Phone □ Work Phone □ Email

May we send you text messages? □ Yes □ No | May we communicate with you by email? □ Yes □ No | May we leave a voicemail? □ Yes □ No

May we communicate with anyone on your behalf? □ Yes □ No

Do you authorize to disclose verbal and written health information? □ Yes □ No | Do you authorize us to send billing information? □ Yes □ No

Contact Name 1: _____ Relationship to Patient: _____ Phone Number: _____

Contact Name 2: _____ Relationship to Patient: _____ Phone Number: _____

I understand that all information requested will be provided to these individuals and I release RDC from all liability pertaining to the release of this information. I understand that this request can be changed at any time through a signed written request.

_____ _____ _____
(Printed Name) (Signature of Patient or Legal Representative) (Date)

This information sheet must be updated every 12 months or sooner if there are changes

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Insurance Information

Date: _____ □ **New Patient** □ **Existing Patient**

Patient Name (Last, First, MI): _____ **DOB** (mm/dd/yyyy): _____

We will request to scan your photo identification and insurance cards at your appointment. Referrals and insurance prior-authorizations are patient responsibility. Please check with your insurance provider. We will file your primary and secondary insurance for you as a courtesy if the information has been provided and the Assignment of Benefits has been signed.

Primary Insurance: _____
Member ID: _____
Group Number: _____
Insurance Phone Number: _____
Patient is Subscriber/Policy Holder: □ Yes □ No
If No, Policy Holder (Name/Date of Birth/SSN):
_____
Relationship to Patient: _____
Does your policy require a referral? □ Yes □ No

Secondary Insurance: _____
Member ID: _____
Group Number: _____
Insurance Phone Number: _____
Patient is Subscriber/Policy Holder: □ Yes □ No
If No, Policy Holder (Name/Date of Birth/SSN):
_____
Relationship to Patient: _____
Does your policy require a referral? □ Yes □ No

_____ (Initials) **Assignment of Benefits**

I auhorize to release medical information necessary to process my health insurance claim and request payment of benefits be made to Regional Digestive Consultants. I understand I am financially responsible for charges not covered or denied by my insurance company. A photocopy of this agreement shall be as valid as the original. This authorization is to remain in effect until revoked in writing by myself or my legal representation.

_____ (Initials) **Assignment of Benefits (Medicare and/or Medicaid)**

I authorize any holder of medical or other information about me to release to the Social Security Administration and The Health Care Financing Administration or their intermediaries or carriers, or the billing agent of this Physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself, or to the party who accepts this assignment.

_____ (Initials) **Financial Agreement**

I have read and agreed to the terms and conditions of the Financial Policy of Regional Digestive Consultants as provided. I agree that a photocopy of this agreement shall be as valid as the original. I understand that all fees for professional services shall be paid at the time of service. Unsettled balances may be rendered to an outside collection agency and the credit bureau. I certify that I have read and understand the above information to the best of my knowledge.

_____ (Initials) **Acknowledgement of Receipt of Privacy Practices**

I have received the Notice of Privacy Practices from Regional Digestive Consultants. I understand that a copy of this signed Acknowledgement of Receipt of Privacy Practices will be kept on file. If I am unable to or choose not to sign this document, a staff member will initial and date to verify the Notice of Privacy Practices were given to me. If I desire a copy of the Notice of Privacy Practices, or my signed copay of the Acknowledgement of Receipt of the Notice of Privacy Practices, I may be given such a copy upon request. I also acknowledge I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____ _____ Consent refused by patient. Witness by: _____
(Signature of Patient or Legal Representative) (Relationship to Patient) (Date)

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