PATIENT REGISTRATION **MIDDLESEX GASTROENTEROLOGY ASSOCIATES**

Last Name: _____ First Name: _____ M.I.: _____

Sex: Male Female Date of Birth: _____ Social Security Number: _____

Street: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Please check the phone number we should call first:

☐ Home Phone: _____

☐ Cell Phone: _____

☐ Business Phone: _____

☐ Other: _____

Preferred Communication:

◯ Home Phone ◯ Business Phone

◯ Patient Portal ◯ Cell Phone

◯ Email

Employer: _____ Occupation: _____

Employer's Address: _____

Primary Care Doctor: _____ Who Referred You: _____

Preferred Pharmacy: _____ Location: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Preferred Phone: _____ Alternate Number: _____

Alternate Emergency Contact—Person not living with you to notify in case of an emergency:

Name: _____ Phone: _____

Insurance Information:

Primary Insurance: _____ Employer: _____

Policy Holder Name: _____ Their Date of Birth: _____

Relationship: _____ Policy ID: _____ Group: _____

Secondary Insurance: _____ Employer: _____

Policy Holder Name: _____ Their Date of Birth: _____

Relationship: _____ Policy ID: _____ Group: _____

1. Your insurance is filed as a courtesy to you. All services not paid within 30 days by your insurance company will become your responsibility.
2. All copays, deductibles, co-insurance, previous balances, and fees for non-covered services are due at the time of your visit. You will be responsible for all collection fees associated with the collection of your account.
3. We will be happy to provide you with a statement of your account, when requested, to file with a secondary or tertiary insurance, once your account is paid in full. We will file secondary insurances, when needed, if required by a specific contract.

4. If you are a Medicare recipient, we will file your Medicare as required for participation in the Medicare program. If your Medicare is primary, please notify Medicare of your supplemental insurance. Medicare normally forwards claims to a supplement for processing of co-insurance or deductibles. This does not guarantee your supplement will pay these balances.

5. As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. You are responsible for knowing the benefits/coverage of your insurance.

6. Our office requires 24 business hour notice for any cancellation failure to do so may result in a last minute cancellation fee of $35.00. Failure to not show up for a scheduled appointment may result in a $35.00 no show charge.

7. Any non-urgent calls (prescription refills, confirming or cancelling an appointment) can leave a message with the answering service. Please do not have the on call physician paged unless it is an urgent medical matter, doing so will result in a minimum fee of $50.00.

8. I request that payment of authorized benefits be made on my behalf to Middlesex Gastroenterology Associates for any services furnished to me I give permission to Middlesex Gastroenterology Associates to release medical information pertaining to claims to my insurance carrier for services provided by them.

Name (Please Print) _____

Signature: _____Date: _____