Middlesex Gastroenterology Associates, LLC

Patient Registration & Consent Form

NAME: _____**DOB**: _____ **SEX: Male Female Other**

MAILING ADDRESS:_____

CITY: _____ **STATE**: _____ **ZIP**:_____

TELEPHONE: HOME:_____ **WORK**:_____**CELL**:_____

PREFERRED METHOD OF COMMUNICATION: Telephone Mail E-Mail Text

EMAIL: _____

PREFERRED LANGUAGE: English French German Italian Mandarin Polish Spanish Vietnamese Other:_____

RACE: Black or African American American Indian Alaskan Native Caucasian Chinese Japanese Native Hawaiian or Other Pacific Islander Other/Undetermined: _____

ETHNICITY: ___Hispanic or Latino ___Non-Hispanic or Latino ___: Other/Undetermined

OCCUPATION: _____ MARITAL STATUS: Divorced Married Single Widowed Other

EMERGENCY CONTACT: _____PHONE:_____RELATIONSHIP:_____

Conservator or POA? No Yes *(Name/Number/Relation)* _____

PRIMARY CARE PHYSICIAN: _____REFERRED BY: _____

PREFERRED PHARMACY: _____**PHONE**: _____

PHARMACY ADDRESS: _____

PRIMARY INSURANCE: _____ **PHONE**: _____

SUBSCRIBER NAME: _____DOB:_____

SUBSCRIBER RELATIONSHIP TO PATIENT: ___ Self ___ Spouse ___ Child

MEMBER ID # _____ GROUP # _____

REFERRAL REQUIRED: __ Yes __ No

SECONDARY INSURANCE: _____ PHONE: _____

SUBSCRIBER NAME: _____**DOB**:_____

SUBSCRIBER RELATIONSHIP TO PATIENT: ___ Self ___ Spouse ___ Child

MEMBER ID#:_____**GROUP #:_____**

Consent For Treatment & Release of Information

I AUTHORIZE Middlesex Gastroenterology Associates (MGA) to perform medical treatment.

I CONSENT to MGA use and disclosure of all individually identifiable personal, health, financial and demographic information (known as Protected Health Information or PHI) for the purposes of providing medical treatment, obtaining payment and reimbursement, obtaining authorizations from my insurance for tests (where required), requesting healthcare services from other providers, cooperating with other providers in my medical treatment, fulfilling requests for information when specifically authorized by me. In addition, doing all other things directly related to providing healthcare to me.

The above purposes and all other uses are known collectively as Treatment, Payment and Other healthcare operations or TPO.

I have reviewed and understand the terms and conditions of MGA's Financial Policy.

I authorize any physician or healthcare facility to provide upon request any PHI to MGA when needed for the purposes of TPO. I understand my rights to restrict the use and disclosure of PHI, and the right to revoke this consent at any time in writing.

PATIENT NAME: _____

SIGNATURE: _____DATE:_____

Revised 2/2024