

THE CENTER FOR COLON AND DIGESTIVE DISEASE

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119 Longwood Drive SW
Huntsville, AL 35801

2007 Gallatin Street SW
Huntsville, AL 35801

8263 Madison Blvd., Suite E
Madison, AL 35758

Patient Registration

PLEASE COMPLETE (print, write, type, check, and/or select)

Full Name: _____ Date of Birth: _____

Social Security #: _____ Sex: Male Female

Marital Status: Single Married Legally Separated Divorced Widowed

Language: (Please give preferred Language) _____

The following categories are required for compliance with U.S. Government regulations.

Race:	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> African American
	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> White	
	<input type="checkbox"/> Multicultural	<input type="checkbox"/> Refuse to Report	<input type="checkbox"/> Unknown	
Ethnicity:	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Decline	<input type="checkbox"/> Unknown

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____ May we call you at work? Yes No

Self-Employed? Yes No If Self Employed, Name of Business: _____

Occupation: _____ How Long Employed? _____ Full-time Part-time

Employer's Address: _____

Name of Spouse: _____ Spouse's Date of Birth: _____

Spouse's Social Security #: _____ Spouse's Employer: _____

Spouse's Occupation: _____ May we call them at work if necessary? Yes No

Spouse's Work Phone: _____ Spouse's Cell Phone: _____

In Case of an Emergency, Notify: _____ Relationship: _____ Phone: _____

Who Referred You to This Office? _____ Who is your Family Physician? _____

Have You Seen Any of Our Physicians Before? Yes No If Yes, Whom? _____

Do you have Medical Coverage? Yes No Primary Insurance Company: _____
 I.D. #: _____ Group #: _____
 Subscriber's Name: _____ Relationship to Patient: _____
 Secondary Insurance Company: _____ I.D. # _____ Group #: _____
 Subscriber's Name: _____ Relationship to Patient: _____

If Responsible Party is Other than the Patient, Please Complete The following:

Responsible Party Name: _____		Relationship: _____	
Address: _____		City: _____	State: _____ Zip: _____
Date of Birth: _____		Social Security #: _____	
Employer: _____		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
Home Phone: _____		Cell phone: _____	Work Phone: _____
Email Address: _____			

In order to provide our patients with the highest level of care, any procedure cancellation with less than 48 hour notice may result in a \$75.00 cancellation fee. This cancellation fee is not covered by your insurance. Payment of this fee will be required prior to rescheduling the missed procedure. There will be a \$10.00 administration service charge for filling out any Prior Authorization (P.A.) forms that your insurance company may require in order for you to obtain their approval for prescription medication. This fee must be paid prior to the completion of your P.A. form. There is also a \$15.00 administration fee if you have to be invoiced for your co-pay.

AUTHORIZATION & ASSIGNMENT: Please Read and Sign the Following Statement:

I directly assign all medical/ surgical benefits to The Center for Colon and Digestive Disease/ Huntsville Endoscopy Center and understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize the Physician/ Practice to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:

In the event that it becomes necessary to collect any amounts owed by you, you agree that The Center for Colon and Digestive Disease, PC. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial messages and/or use of automatic dialing device, as applicable.

It is customary that payment be made when the service is rendered unless prior arrangements have been made in advance. In the event of non-payment, either by insurance or myself, I agree to pay all cost of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract.

I hereby authorize any physician or hospital to provide copies of my medical history and treatment to The Center for Colon and Digestive Disease, P.C. Photocopies of this agreement are as good as the original. I have read this entire Patient Registration form and agree to all provisions of this form, including but not limited to the Authorization and Assignment provisions and the Consent to Contact provisions.

Signature: X _____ Date: X _____