

# HUNTSVILLE ENDOSCOPY CENTER

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## PATIENT REGISTRATION

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

Social Security # \_\_\_\_\_

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:     Single     Married     Legally Separated     Divorced     Widowed    Sex:     Male     Female

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ May We Call You at Work?     Yes     No

Occupation: \_\_\_\_\_ Are You Self-Employed?     Yes     No    If Self, Name of Business: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ How Long Employed? \_\_\_\_\_     Full-Time     Part-Time

Are You a Student?     No     Full-Time     Part-Time

Name of Spouse: \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's Employer : \_\_\_\_\_ Occupation: \_\_\_\_\_

In Case of Emergency, Notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Have You Seen Any of Our Doctors Before?     Yes     No    If Yes, Whom? \_\_\_\_\_

Do You Have Medical Insurance 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 You Have Medical Insurance Coverage, Please Give ALL of Your Cards to the Receptionist, Along With Any Completed Insurance Forms.**

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

I directly assign all medical/surgical benefits to Huntsville Endoscopy Center and understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I hereby authorize any physician or hospital to provide copies of my medical history and treatment to The Huntsville Endoscopy Center. I further agree that a photocopy of this form 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 Huntsville Endoscopy Center 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 my insurance or myself, I agree to pay all costs 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/We further agree to waiver my/our rights of exemption under the laws of the State of Alabama or of any other state.

Signature: X \_\_\_\_\_ Date: X \_\_\_\_\_