PREMIER *medical group*

PATIENT REGISTRATION FORM PACKET

INSTRUCTIONS

Please complete all pages

Bring all paperwork to your scheduled appointment (***DO NOT FAX OR MAIL BACK TO THE OFFICE***) along with all medical insurance cards, picture ID and a list of medications. If you have been vaccinated for COVID-19, please bring the original document. Additionally, bring any recent labs and radiology workups.

If your insurance company requires a referral it is the patient's responsibility to bring the referral with them at the date of their appointment.

All co-pays are due at the time of service.
We do NOT accept Worker's Compensation insurance or patients.

NO SHOW POLICY

A fee will be charged to any patient who does not cancel their appointment within 48 hours or for any no-show office visits.

PATIENT REGISTRATION FORM

Premier Medical Group-GI
243 North Road
Poughkeepsie, NY 12601
(845) 471-9410 Fax (845) 471-7943

PATIENT ACCOUNT NUMBER

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL) SEX ❑ MALE ❑ FEMALE	PRIMARY PHYSICIAN
PATIENT'S ADDRESS	EMERGENCY CONTACT NAME AND TELEPHONE #
CITY STATE ZIP	STUDENT STATUS: If 18 years or older: (Circle one) Full Time Part Time Not a Student
TELEPHONE ( ) CELL PHONE ( ) DATE OF BIRTH _____/_____/_____ MO DAY YEAR	MARITAL STATUS: (Circle one) Single Married Separated Divorced Widowed
RACE: **ETHNICITY:** **PRIMARY LANGUAGE:**	**EMAIL ADDRESS:**

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME COPAY _____	SECONDARY INSURANCE COPAY _____
INSURANCE ADDRESS	INSURANCE ADDRESS
CITY STATE ZIP	CITY STATE ZIP
INSURED'S ID NUMBER GROUP PLAN NUMBER	INSURED'S ID NUMBER GROUP PLAN NUMBER
PATIENT'S EMPLOYER NAME TELEPHONE ( )	**PHARMACY NAME** **TELEPHONE** ( )
EMPLOYER'S ADDRESS	**PHARMACY ADDRESS**
CITY STATE ZIP	CITY STATE ZIP

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME (LAST, FIRST, MIDDLE)	SEX ❑ MALE ❑ FEMALE	LEGAL REPRESENTATIVE ❑ YES ❑ NO
RESPONSIBLE PARTY'S ADDRESS	EMPLOYER'S NAME	
CITY STATE ZIP	EMPLOYER'S ADDRESS	
TELEPHONE ( )	RELATIONSHIP TO PATIENT SPOUSE PARENT GUARDIAN OTHER _____	

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other Balance not paid for by your insurance.

If your insurance requires a written referral from your physician and you do not obtain one prior to your visit or procedure, you will be responsible for payment for Services rendered.

COPAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED.

If this account is assigned to an attorney of collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.
I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.
I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and Other health plans to the practice named on this form.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I Am financially responsible for all charges whether or not paid by said insurance.

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THIS PAGE. **YOU SHOULD READ THESE TERMS CAREFULLY.** THANK YOU FOR YOUR COOPERATION.

X _____DATE _____

SIGNED (Patient, or parent if under 18 years of age)

MEDICAL INFORMATION

Patient Name : _____ **Acct#** _____ **Dr.** _____
Reason for visit: _____
Have you recently been seen in the Hospital/ER? Where/When? _____
Have you had recent bloodwork/imaging done? Where? _____

Do you have or have you had any of the following:

Diabetes _____	Stroke____	Seizure Disorder _____	Hepatitis _____
Heart Attack _____	Heart Disease ____	Mitral Valve Prolapse ____	Anemia _____
High Blood Pressure _____	Sleep Apnea _____	High Cholesterol _____	Asthma _____
Pacemaker ____	Defibrillator ____	Thyroid Disease _____	Liver Disease ____
Heart Murmur _____	Heart Valve Disease ____	Joint Replacement _____	
Kidney Disease ____	Renal Insufficiency ___	COPD ___ (if yes, are you on oxygen at home? Y or N)	

Other medical/psychiatric conditions: _____

Past Surgical History (list ALL surgeries and the dates):

_____
_____
_____

Are you under the care of any other physicians/specialists? Yes ___ No ___
If yes, list name and specialty: _____
_____
Do you require information to be released to above physicians? Yes ____ No ____

Is there any family history of colon polyps, colon cancer or any other cancers? Yes ___ No ___
If yes, what type and who? _____

Do you smoke? Yes___ No___ If yes, how long? _____
Do you drink alcohol? No ___ Occasionally ___ Regularly ___
Do you have a current/past history of drug abuse? Yes ___ No___
Are there any cultural beliefs that might affect the care you will receive in our office today? Yes__ No __
Do you require interpreter services? Yes __ No __

Please list <u>all</u> prescription medications taken including over the counter products and the dosing instructions:

_____
_____
_____
_____

Do you have any allergies to any medications? Yes____No _____ **Or to Oral/IV contrast?** Yes___ No___
Name of drugs: _____
Type of Reaction: _____

Gastro-Intestinal: Have you ever experienced any of the following?

Vomiting Blood ____	Diarrhea ___	Change in Bowel Habits ___	Black Stools ___
Rectal Bleeding ___	Constipation ___	Difficulty Swallowing ___	Weight Loss ___

Have you had a previous colonoscopy/endoscopy? Yes ___ No ___
When _____ Where _____

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PAYMENTS OF BENEFITS AUTHORIZATION

I hereby authorize payment of all services rendered to me to be paid directly to Premier Medical Group providing that my insurance company will forward payment directly to them. I understand that regardless of my insurance, I am financially responsible for payment of services rendered to me. I also authorize the release of any information that is needed by my insurance company to process such claims.

Name _____ Address _____

Signature _____ Date _____

RECORDS RELEASE AUTHORIZATION

This record release authorization allows us to obtain/release your records to and from your primary physician and other physicians you are under the care of.

Date _____

Physician/Hospital _____

Address _____

Phone number ( ) _____

ADVANCED DIRECTIVES

Do you have an advanced directive in place? _____Yes _____No

If yes, do you have: ___Living Will ___Power of Attorney ___Healthcare Proxy ___DNR

Please be advised, if you do have any advanced directive, our office is required to obtain a copy for your records.

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PATIENT TREATMENT/ FINANCIAL WAIVER

I, _____ realize that if I do not provide the proper referral or insurance information to cover the services that I am requesting from Premier Medical Group, I will be responsible for the payment of this visit and all associated charges for me or my dependent(s).

Signed: _____

Date: _____

Witnessed: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and the Patient Rights and Responsibilities Brochure for Premier Medical Group.

Print Name: _____

Signature: _____ Date:_____

*If person signing is not the patient, please print your name and relationship to patient:

Name: _____

Relationship: _____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION AND RECORDS TO THE FOLLOWING PEOPLE (PLEASE LIST YOURSELF, AND FAMILY MEMBERS, FRIENDS, OR PHYSICIANS WHO DID NOT REFER YOU):

_____

_____

FYI: IN FILLING OUT THIS FORM, YOU ARE INSURING THAT WHOEVER YOU HAVE LISTED WILL HAVE THE RIGHT TO YOUR MEDICAL RECORDS/INFORMATION.

For Office Use Only:

If the patient/representative requested a copy of notice, please provide date copy was given:

Date:_____

If no acknowledgement could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgment:

_____

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NO SHOW POLICY

PREMIER MEDICAL GROUP WILL BE CHARGING A $150.00 FEE FOR “NO SHOW” PROCEDURES AND A $50.00 FEE FOR “NO SHOW” OFFICE VISITS.

IF YOU MUST CANCEL AN APPOINTMENT, PLEASE DO SO **AT LEAST 48 HOURS BEFORE YOUR APPOINTMENT** – THIS WILL ALLOW US TO EXTEND AN OPENING TO ANOTHER PATIENT.

IF YOU DO NOT APPEAR FOR YOUR APPOINTMENT AND HAVE NOT CANCELLED WITHIN 48 HOURS, WE WILL CHARGE YOUR ACCOUNT TO HELP OFFSET OUR COSTS AND ASSOCIATED INCONVENIENCE TO OTHER PATIENTS.

THANK YOU.

NO SHOW POLICY ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the No Show policy letter from Premier Medical Group.

Print Name: _____

Signature: _____ Date: _____

*If person signing is not the patient, please print your name and relationship to patient:

Name:_____

Relationship:_____