Gastroenterology & Hepatology Specialists, Inc.

1687 Erringer Road, Suite 103, Simi Valley, CA 93065 Phone: (805) 583-4463 Fax: (805) 583-4465
2230 Lynn Road, Suite 210, Thousand Oaks, CA 91360 Phone: (805) 497-0961 Fax: (805) 496-4818

PATIENT REGISTRATION

Last Name:_____**First Name:**_____**Date of Birth:** _____**Age:**_____

Address:_____
Street *City* *State* *Zip Code*

SSN: _____ **Gender:**☐**M**☐**F** **Marital Status:**☐**Single**☐**Married**☐**Widowed**☐**Divorced**

Phone: _____**Cell:** _____ **Work:**_____ _ **E-Mail:**_____

Ethnicity/Race:☐**Caucasian**☐**African American**☐**Asian**☐**Hispanic**☐**AmericanIndian**☐**Other:**_____
(Required by California Cancer Registry)

Employer: _____ **Occupation:**_____**Exposure To Toxic Chemicals:**_____

Insurance Carrier/s:1._____ **2**._____ ☐**PPO** ☐**EPO** ☐**POS** ☐**Open Access**

Name of Insured:_____**Date of Birth:**_____**Relationship:**_____

Person To Be Billed:☐**Self**☐**Parent**☐**Spouse**☐**Other(Name)** _____

Emergency Contact/sName: _____ **Phone:** _____ **Relationship:** _____

Referring or Primary Doctor/s: _____**PREFFERED PHARMACY:** _____

Have You Recently: □ **Been to ER/Hospital** □ **Radiology/Nuclear Medicine Exam** □**Blood Drawn**

Please read and sign below:

Cancellation Policy for Office Appointment/Procedure

1. If I cannot make my scheduled appointment, I will make all reasonable attempts to cancel my appointment with an advanced notice of at least 24 hours for office visits, and 72 hours for procedures; this allows another patient to be scheduled in my appointment slot.
2. If I failed to cancel my appointment with at least 24 hours for office visits, and 72 hours for procedures, resulting in the inability to fill my appointment time with another patient, I agree to pay a cancellation fee of $35.00 for office visits, and $100 for procedures.
3. I understand that this is not a fee that is billable to my insurance.
4. I also understand that this policy is necessary due to the extended waiting time for appointment and the high cost of running this practice. Please be aware that we do not frivolously charge patients for missed appointments, such as a death in the family or medical illness, we accept these explanations. Our primary concern is for patients who forget their appointment , are too busy to keep their appointment's, change their mind and fail to give us adequate time to fill their appointment time with another patient .We understand that your time is valuable and in turn, pledge that pending unexpected emergencies, our office staff will make all reasonable attempts to contact you should we anticipate that we are running behind schedule or need to reschedule your appointment.

X_____

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Patient Signature/Responsible Party **Printed Name** **Date**

Insurance Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

INITALS_____

OUR FINANCIAL POLICY IS PAYMENT AT THE TIME OF SERVICE

In the event that payment is not made on this account and it is placed with a licensed collection agency, I agree to pay the fees of the collection agency equal to a maximum of 50% of our outstanding balance at the time the account is placed with the collection agency; interest of 10% per year will be accrued on the principal balance. Should legal action be necessary to collect the account, I agree to pay attorney fees and court costs incurred for collection.

HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information. If you have any questions regarding the information provided on our notice of privacy practices, please ask to speak with our compliance officer.

Our office is "HIPPA Compliant" and our staff has been trained in the "HIPPA privacy act". We will do everything we can to protect your patient health information (PHI). However, our office is designed before the law so please be respectful of other patients' privacy. We are required by the insurance companies to prove that you were here in our office on the days of service that we are billing for. Our office procedure, to prove that you were here, is that we have daily sign in sheets which you sign and put the time of your appointment.

1. **How would you like us to address you, by your first name or last name?**

   _____

2. **It is our office procedure that we call you regarding medical issues. If you are not home, whom may we leave the message with?**

   _____

3. **If no one is at home to take our call, may we leave a message on your answering machine?**

   Yes **No**

I agree to all of the above office procedures of Mayur Trivedi, M.D. and I give my authorization to all of the above-mentioned procedures.

X

Patient Signature/Responsible Party **Printed Name** **Date**