HATTIESBURG G. I. ASSOCIATES, PLLC

NEW PATIENT REGISTRATION

OFFICE USE ONLY

PATIENT ACCOUNT # ____________

PHYSICIAN/NURSE PRACTITIONER YOU ARE SEEING TODAY: ☐ DR. FOX ☐ DR. MORRISSETTE ☐ DR. BUCKLEY ☐ DR. FARMER ☐ SUSAN WALLACE, CFNP

PATIENT NAME ____________ (LAST) ____________ (FIRST) ____________ (MIDDLE)

DATE OF BIRTH ___ | ___ | ___ ☐ MALE ☐ FEMALE

SOCIAL SECURITY # ____________

REFERRING PHYSICIAN ____________

PRIMARY CARE PHYSICIAN ____________

MARITIAL STATUS ____________

EMAIL ADDRESS ____________

HOME PHONE # (_____) ____________ WORK PHONE # (_____) ____________ CELL PHONE # (_____) ____________

HOME MAILING ADDRESS ____________ ____________ (CITY) ____________ (STATE) ____________ (ZIP CODE)

EMPLOYER NAME/ADDRESS ____________

PATIENT'S SPOUSE INFORMATION

SPOUSE NAME ____________ SPOUSE DATE OF BIRTH ___ | ___ | ___ ☐ MALE ☐ FEMALE

EMPLOYER NAME/ADDRESS ____________ WORK PHONE # (_____) ____________

EMERGENCY INFORMATION

NAME OF SOMEONE NOT LIVING WITH YOU ____________ PHONE # (_____) ____________

ADDRESS ____________ RELATIONSHIP ____________

INSURANCE COVERAGE INFORMATION

PRIMARY	ID #	GROUP#	SUBSCRIBER'S NAME
SECONDARY	ID#	GROUP#	SUBSCRIBER'S NAME
OTHER	ID#	GROUP#	SUBSCRIBER'S NAME

IF YOU HAVE INSURANCE, WE WILL BE GLAD TO HELP YOU FILE FOR ANY BENEFITS TO WHICH YOU ARE ENTITLED. HOWEVER, IT REMAINS THE RESPONSIBILITY OF THE INDIVIDUAL PATIENT TO SETTLE HIS/HER ACCOUNT PROMPTLY. TO HELP US FILE YOUR INSURANCE CLAIM CORRECTLY, PLEASE FILL IN THE ABOVE INFORMATION. WE WILL ALSO NEED A COPY OF YOUR INSURANCE CARD.

WHOM SHOULD WE CONTACT TO VERIFY WORKER'S COMP COVERAGE? ____________

CLINIC POLICY STATEMENT

I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED TO ME BY THIS CLINIC. (IF THE PATIENT IS UNDER 18, THE PARENT/GUARDIAN REQUESTING TREATMENT ASSUMES RESPONSIBILITY OF ALL CHARGES) FULL PAYMENT IS DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT IF MY ACCOUNT SHOULD EVER REQUIRE ACTION BY A COLLECTION AGENCY OR ATTORNEY IN ORDER TO INSURE PAYMENT, THE FEES CHARGED BY THESE AGENTS MAY BE ADDED TO THE BALANCE DUE AND UNPAID ON MY ACCOUNT. I HEREBY ACKNOWLEDGE AND AGREE TO ACCEPT THESE POLICIES STATED HERE.

SIGNATURE ____________ DATE ____________

AUTHORIZATIONS

INSURANCE AND/OR MEDIGAP

I, THE UNDERSIGNED, AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THIS PHYSICIAN, FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE POLICY. I ALSO AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY, INFORMATION CONCERNING HEALTHCARE, ADVICE, TREATMENT OR SUPPLIES PROVIDED TO ME. THIS INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS OF BENEFITS.

DATE ____________ SIGNED ____________ (LIFETIME SIGNATURE)

MEDICARE

I, THE UNDERSIGNED, UNDERSTAND THAT THIS CLINIC ACCEPTS ASSIGNMENTS ON MEDICARE. I AGREE TO BE RESPONSIBLE FOR MY DEDUCTIBLE AND/OR ANY UNCOVERED CHARGES, AS WELL AS, 20% OF THE ALLOWANCE OF COVERED SERVICES. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THIS PHYSICIAN FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO "THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS" ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.

DATE ____________ SIGNED ____________ (LIFETIME SIGNATURE)

MEDICAID

I AGREE TO BE RESPONSIBLE FOR ANY SERVICE NOT COVERED BY MEDICAID. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAID BENEFITS BE MADE ON MY BEHALF TO THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE DIVISION OF MEDICAID OR ITS FISCAL AGENT ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

DATE ____________ SIGNED ____________ (LIFETIME SIGNATURE)

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