SUMMIT GASTROENTEROLOGY

SUNITHA G. PUDHOTA, MD

Board Certified Gastroenterologist

PATIENT REGISTRATION

Please complete before your visit.

ACCOUNT # _____ DATE _____ DOCTOR OF RECORD _____

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP

CELL PHONE	HOME PHONE	EMAIL	SSN LAST 4 (OPTIONAL)

PREFERRED NAME	PREFERRED LANGUAGE	RACE / ETHNICITY	MARITAL STATUS	SEX
				☐ M ☐ F

PREFERRED METHOD OF CONTACT ☐ Cell phone ☐ Home phone ☐ Email ☐ Text message ☐ Mailing address

CARE TEAM & PHARMACY

PRIMARY DOCTOR	REFERRING DOCTOR

PREFERRED PHARMACY	PHARMACY LOCATION	PHONE

RESPONSIBLE PARTY / AUTHORIZED CONTACTS

NAME	RELATION	PHONE	WORK PHONE

EMPLOYMENT STATUS	EMPLOYER	RELATIONSHIP TO PATIENT
☐ Employed ☐ Unemployed		

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

Please indicate with whom we may discuss appointments, testing, results, billing, and related care information.

☐ Spouse ☐ Children ☐ Parent(s) ☐ Other

RESTRICTIONS / OTHER _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	MEMBER ID	GROUP #

SUBSCRIBER NAME	SUBSCRIBER DOB	RELATIONSHIP	SUBSCRIBER SSN LAST 4

SECONDARY INSURANCE COMPANY	MEMBER ID	GROUP #

SUBSCRIBER NAME	SUBSCRIBER DOB	RELATIONSHIP	SUBSCRIBER SSN LAST 4

EMERGENCY CONTACT

NAME	RELATION	PHONE	ALTERNATE PHONE

ADDRESS	CITY	STATE	ZIP

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CONSENTS & AGREEMENTS

Review and sign at the bottom.

FINANCIAL AGREEMENT

I understand that I am responsible for deductibles, co-pays, coinsurance, non-covered services, and items considered not medically necessary by my insurance plan. I agree to pay required copayments and coinsurance as services are rendered. I understand that insurance verification and preauthorization are not a guarantee of payment and that my insurance company makes the final benefit determination. I understand that I am ultimately responsible for any balance on my account, including amounts not covered by insurance. If a referral and/or preauthorization are required by my insurance, I will assist Summit Gastroenterology PLLC in obtaining a referral and /or preauthorization.

ASSIGNMENT OF BENEFITS

I authorize assignment of applicable medical benefits directly to Summit Gastroenterology PLLC for services rendered. I authorize release of information necessary to process insurance claims and obtain payment for covered services.

RELEASE OF INFORMATION & COMMUNICATION CONSENT

I authorize Summit Gastroenterology PLLC, its physicians, staff, representatives, and authorized service partners to use or disclose information related to my care as necessary for treatment, payment, healthcare operations, appointment reminders, care coordination, insurance claims, referrals, preauthorizations, billing, and other healthcare-related communications. I understand that communications may occur by phone, voicemail, text message, email, patient portal message, or mail when appropriate. I may update communication preferences or restrictions in writing.

CONSENT FOR TREATMENT

I authorize Summit Gastroenterology PLLC and its providers to examine, evaluate, treat, and perform diagnostic testing or office procedures that the provider determines are medically appropriate. I understand that questions about recommended care, alternatives, benefits, and risks may be discussed with the provider before treatment.

PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that Summit Gastroenterology PLLC is required by law to maintain the privacy of protected health information and to provide a Notice of Privacy Practices describing legal duties and privacy practices. I understand that I may request restrictions on certain uses or disclosures of my protected health information, although the practice may not be required to agree to every requested restriction.

RESTRICTIONS OR SPECIAL INSTRUCTIONS REGARDING RELEASE OF INFORMATION

_____

_____

_____ _____ _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE | PRINTED PATIENT NAME | DATE

_____ _____ _____

PERSON SIGNING ON BEHALF OF PATIENT (PRINT NAME) | RELATIONSHIP TO PATIENT | DATE