Bhatti GI Consultants, PA
Patient Registration

Name:_____
Last Name **First Name** **M.I.**

□ MALE □ FEMALE Birth Date: _____ **Social Security #:** _____
Address: _____ **Home Phone:** _____
City/State/Zip: _____ **Cell Phone:** _____
Employer: _____ **Work Phone:** _____
□ Full Time □ Part Time □ Unemployed □ Student □ Retired **Preferred #: □ Home □ Cell □ Work**

How did you hear about Bhatti GI Consultants, PA?

□ Physician □ Family/Friend □ Social Media □ Insurance □ Internet □ Newspaper
□ Phonebook □ Mail Flyer □ Other_____

Email: _____

(Are you interested in our Patient Portal to view Medical Records online? □ Yes □ No
(If you chose yes, please provide us with an email address that you would like us to connect you with in the space provided above.)

Please Complete:
Primary Care / Referring Physician:_____ **Clinic:**_____

Preferred Language: _____ **Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino**

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White

Check Appropriate Box: □ Single □ Married □ Divorced □ Widowed □ Separated □ Minor
***If* a Minor: (Parent/Guardian Name):** _____ **Phone:** _____

Person to contact in case of emergency: _____ **Phone:** _____
Relationship to patient: _____

Billing Information: □ Same as patient

Responsible Party Name: _____ **Relationship to Patient:** _____
Address: _____ **City/State/Zip:** _____ **Home Phone:** _____

Insurance Policy Holder: □ Same as patient

Policy Holder's Name: _____ **Birth Date:** _____
Relationship to Patient: _____ **SSN:** _____

Insurance Information:

Primary
Carrier: _____ **ID Number:** _____
Group Number: _____ **Relationship to Subscriber:** _____
Subscriber SSN: _____

Secondary □ Not Applicable
Carrier: _____ **ID Number:** _____
Group Number: _____ **Relationship to Subscriber:** _____
Subscriber SSN: _____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

I acknowledge I am responsible for all charges for Bhatti GI Consultants, P.A., services provided to me, including any amount not paid by third-party payors. The undersigned agrees whether as patient, authorized representative or other financially responsible party, to pay the charges for care provided to the patient by Bhatti GI Consultants, P.A., in accordance with regular Bhatti GI Consultants, P.A., terms and rates.

I authorize payment directly to Bhatti GI Consultants, P.A., of benefits otherwise payable to me by insurance company (ies). If my health insurance will not allow direct payment to Bhatti GI Consultants, P.A., or if Bhatti GI Consultants, P.A., chooses not to accept assignment for medical benefits, I agree to pay Bhatti GI Consultants, P.A., amounts equal to all health insurance benefits I receive for medical care at Bhatti GI Consultants, P.A., immediately upon receipt of insurance. I understand that Bhatti GI Consultants, P.A., is not responsible for negotiating settlement of a disputed claim.

× _____ _____
Patient Signature Date

_____ _____
Authorized Representative (Children 18 years and younger) Relationship to Patient

_____ _____
Witness Signature (if X by patient) Date

RELEASE OF INFORMATION

I hereby authorize Bhatti GI Consultants, P.A., to release information from my medical to my insurance company for payment of my bill.

I hereby authorize Bhatti GI Consultants, P.A., to release necessary information from my medical records to any health care provider directly involved in my care and treatment.

This authorization is valid for one year as specified by Minnesota state law dated August 1, 1991.

List any insurance company you wish to exclude from this authorization: _____

× _____ _____
Patient Signature Date

_____ _____
Authorized Representative (Children 18 years and younger) Relationship to Patient

_____ _____
Witness Signature (if X by patient) Date

USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby acknowledge that on _____, I received the Notice of Privacy Practices from Bhatti GI Consultants, P.A., which sets forth the ways in which my personal health information may be used or disclosed by Bhatti GI Consultants, P.A., and outlines my rights with respect to such information.

× _____ _____
Patient Signature Date

_____ _____
Authorized Representative (Children 18 years and younger) Relationship to Patient

_____ _____
Witness Signature (if X by patient) Date