



PREMIER medical group



Hudson Valley Urology, P.C.
Comprehensive Urology Centers



ASSOCIATES

- Page 1 - Fill out entire page and sign at bottom of page
- Page 2 - Fill out Health History Questionnaire
- Page 3 - Fill out Notice of Privacy Practices/At time of visit please ask the receptionist for a copy of the Notice of Privacy Practices if so desired. Fill out Payment of Benefits Authorization/Records Release Authorization/Patient Rights and Responsibilities

Bring all this paperwork, filled out, to your scheduled appointment on _____ along with all medical insurance cards, picture ID, medications, any recent labs and radiology workup.

EFFECTIVE OCTOBER 4, 2010 A FEE WILL BE CHARGED TO ANY PATIENT WHO DOES NOT CANCEL THEIR APPOINTMENT WITHIN 48 HOURS OR FOR ANY NO SHOW OFFICE VISITS

If your insurance requires a referral you must bring it with you or you will be required to sign a waiver until it's received.

Co-pays are expected at the time of service

We do not accept Workers' Compensation patients

Premier Medical Group of the Hudson Valley, P.C.

Poughkeepsie | Fishkill | Kingston | Rhinebeck | New Windsor

Hudson Valley Urology Tel: 845.437.5000 | Fax: 845.452.2406 | G.I. Associates Tel: 845.471.9410 | New Windsor Tel: 845.562.0740

Web: www.premiermedicalhv.com

PATIENT REGISTRATION FORM
Premier Medical Group-GI Associates
243 North Road, Suite 304
Poughkeepsie, NY 12601
(845) 471-9410

PATIENT ACCOUNT NUMBER

PATIENT INFORMATION

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

INSURANCE INFORMATION		SECONDARY INSURANCE	COPAY _____
PRIMARY INSURANCE COMPANY NAME	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	PHARMACY NAME	TELEPHONE ()
PATIENT'S EMPLOYER NAME	TELEPHONE ()	PHARMACY ADDRESS	
EMPLOYER'S ADDRESS		CITY STATE ZIP	

RESPONSIBLE PARTY INFORMATION			
RESPONSIBLE PARTY'S NAME (LAST, FIRST, MIDDLE)	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	LEGAL REPRESENTATIVE <input type="checkbox"/> YES <input type="checkbox"/> NO	
RESPONSIBLE PARTY'S ADDRESS	EMPLOYER'S NAME		
CITY STATE ZIP	EMPLOYER'S ADDRESS	RELATIONSHIP TO PATIENT SPOUSE PARENT GUARDIAN OTHER _____	
TELEPHONE ()			

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

Reason for visit: _____

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 _____	COPD _____
Heart Murmur _____	Heart Valve Disease _____	Joint Replacement _____	Liver Disease _____
Kidney Disease _____			

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 history of previous drug abuse? Yes ___ No ___

Please list all prescription medications taken including over the counter products and the dosing instructions:

Do you have any allergies to any medications? 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 _____

PAYMENTS OF BENEFITS AUTHORIZATION

I hereby authorize payment of all services rendered to me to be paid directly to Gastroenterology Associates 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

NO SHOW POLICY

I acknowledge that I was provided a copy of the No Show policy letter from Gastroenterology Associates.

Print Name: _____
Signature: _____ Date: _____
*If person signing is not the patient, please print your name and relationship to patient:
Name: _____
Relationship: _____

EFFECTIVE OCTOBER 4, 2010

GASTROENTEROLOGY ASSOCIATES
A division of Premier Medical Group

WILL BE CHARGING A \$100.00 FEE FOR "NO SHOW" ENDOSCOPY 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

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 Gastroenterology Associates.

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:

