

**Connecticut GI, P.C.**  
**PATIENT REGISTRATION & CONSENT FORM**

NAME: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
MAILING ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX:  M  F  
STREET ADDRESS (IF DIFFERENT) \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
TELEPHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_  
EMAIL: \_\_\_\_\_  
PREFERRED LANGUAGE:  English  French  German  Italian  Mandarin  Polish  Spanish  Vietnamese  Other \_\_\_\_\_  
RACE:  Black Or African American  American Indian  Alaskan Native  Caucasian  Chinese  Japanese  
 Native Hawaiian Or Other Pacific Islander  Other/Undetermined  
ETHNICITY:  Hispanic Or Latino  Non-Hispanic Or Latino  Other/Undetermined  
EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_  
REFERRED BY: \_\_\_\_\_ PRIMARY CARE PHYSICIAN: \_\_\_\_\_  
RESPONSIBLE PARTY: \_\_\_\_\_ MARITAL STATUS:  Divorced  Married  Single  Widowed  Other  
SPOUSE'S NAME: \_\_\_\_\_ SPOUSE'S EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_  
EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
PREFERRED METHOD OF COMMUNICATION:  Telephone  Mail  Email  Fax  
PREFERRED PHARMACY: \_\_\_\_\_ PHONE: \_\_\_\_\_  
PHARMACY ADDRESS: \_\_\_\_\_  MAIL-ORDER PHARMACY

**INSURANCE INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
SUBSCRIBER NAME \_\_\_\_\_ SUBSCRIBER SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SUBSCRIBER D.O.B. \_\_\_\_\_  
SUBSCRIBER RELATIONSHIP TO PATIENT:  Self  Spouse  Child  
MEMBERSHIP #: \_\_\_\_\_ GROUP# \_\_\_\_\_  
**REFERRAL FROM A PRIMARY CARE PHYSICIAN REQUIRED?  YES  NO**  
SECONDARY INSURANCE: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
SUBSCRIBER NAME \_\_\_\_\_ SUBSCRIBER SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SUBSCRIBER D.O.B. \_\_\_\_\_  
SUBSCRIBER RELATIONSHIP TO PATIENT:  Self  Spouse  Child  
MEMBERSHIP #: \_\_\_\_\_ GROUP# \_\_\_\_\_

**CONSENT FOR TREATMENT AND RELEASE OF INFORMATION**

I AUTHORIZE Connecticut GI P.C. (AKA CT GI P.C.) to perform medical treatment.  
I CONSENT to CT GI P.C.'S use and disclosure of all individually identifiable personal, health, financial, and demographic information (known as Protected Health Information or PHI) for the purposes of: • Providing medical treatment • Obtaining payment and reimbursement • Obtaining authorizations from my insurance for tests (where required) • Requesting healthcare services from other providers • Cooperating with other providers in my medical treatment  
• Fulfilling requests for information when specifically authorized by me • In addition, doing all other things directly related to providing healthcare to me  
The above purposes and all other uses are known collectively as Treatment, Payment, and Other healthcare operations or TPO.  
I have reviewed and understand the terms and conditions of CTGI PC's Financial Policy.  
I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to CT GI P.C., when needed for the purposes of TPO.  
I CONSENT to CT GI P.C. discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s).

1. \_\_\_\_\_ Relationship: \_\_\_\_\_ 2. \_\_\_\_\_ Relationship: \_\_\_\_\_  
3. \_\_\_\_\_ Relationship: \_\_\_\_\_ 4. \_\_\_\_\_ Relationship: \_\_\_\_\_

I have been given the opportunity to review and agree with the terms and conditions of CT GI P.C.'S Patient Information Protection Plan.  
I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing.  
I understand that should I choose not to consent to the terms and conditions of CT GI P.C.'s Patient Information Protection Plan, the practice has the right to and will withhold treatment except where required by law.

PATIENT NAME: \_\_\_\_\_  
PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
INSURED OR GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protective health information for non healthcare related activities without specific and explicit authorization.