Connecticut GI, P.C.

PATIENT REGISTRATION & CONSENT FORM

NAME:_____

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 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 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 discloure 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 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.