NORTH SUBURBAN GASTROENTEROLOGY ASSOCIATES
Patient Registration – Please PRINT information and return to our receptionists. Thank you!
DATE: ______________________

LAST NAME: ____________________ **First Name:** ____________________ **Middle Initial:** ____

Home Phone #: _____/______________ **Cell Phone #:** _____/______________

Home Address: ____
Street Number & Name Apt/Unit City State Zip+4

Email address: ______________________________

***RACE/ETHNICITY:** Alaskan Indian - American Indian - Asian - Asian Pacific American – Black – Black/Nonhispanic - Caucasian – Hispanic - Native American- White/nonhispanic - Other race or ethnicity: ______________________
***Language you prefer to speak in:** ______________
NOTE: Federal regulations monitoring the use of Electronic Medical Health records by physicians require us to ask the questions above.

Soc Security #: ______________ **Birthdate**: __________ **Sex: M** ☐ **F** ☐ **Marital Status**: **S**☐ **M**☐ **D**☐ **W**☐

Employer Name: ______________________ **Employer Phone #:** ____/__________x ____
Employer Address: ____
Occupation: ____

Referring Physician: ______________________ **Phone #:** ____/__________
Referring Physician Address: ____

Emergency Contact Name: ______________________ **Relationship**: ______________
Emergency Contact Phone #: ______________________ Please add this person to your "Emergency Contacts"

*****Please give your HEALTH INSURANCE CARDS to the receptionist so that we may copy ALL of them*****
*****If you are scheduling a screening-preventative care procedure, READ and ACT on our Screening Coverage Notice provided to you at the time of scheduling your procedure – direct questions to Billing at 847-696-2336.***

PRIMARY **INSURANCE NAME:** ____
Member ID/Policy #: ______________________ **Group #:** ______________

Ins Address: ______________________ **Ins Phone #:** ______________
Subscriber Name: ______________ **Subscriber birthdate**: ______________
Relationship to Patient: ( )Self ( )Spouse ( )Child ( )Other: ______________
Effective date of plan: ______________ **Copay**: $______________
Subscriber Group Name: ____

SECONDARY **INSURANCE NAME:** ____
Member ID/Policy #: ______________________ **Group #:** ______________

Ins Address: ______________________ **Ins Phone #:** ______________
Subscriber Name: ______________ **Subscriber birthdate**: ______________
Relationship to Patient: ( )Self ( )Spouse ( )Child ( )Other: ______________
Effective date of plan: ______________ **Copay**: $______________
Subscriber Group Name: ____

This authorization must be signed so that we may bill your insurance carrier/s. Thank you.

I understand that I am responsible for my account balance regardless of delays or nonpayment by my insurance company. I agree, in the event of nonpayment, to assume the costs of interest, collection and legal action (if required). I hereby authorize RELEASE OF MY MEDICAL RECORDS NECESSARY ON MY BEHALF TO MY HEALTH INSURANCE CLAMIS DEPARTMENT IN ORDER THAT THEY MAY PROCESS AND PAY FOR MY MEDICAL CLAIMS. I hereby authorize payment of medical and/or surgical benefits to be sent to North Suburban Gastroenterology Associates, S.C. (NSGA).

______________________________ ______________________

Patient Signature/Date ***NSGA Staff Initials/Date***

NORTH SUBURBAN GASTROENTEROLOGY ASSOCIATES, S.C.

Financial Policy Statement

Your clear understanding of our practice Financial Policies and your patient financial responsibilities is important to our professional relationship. Payment of your bill is considered part of your treatment. Please call our billing department at 847-696-2336 or 708-534-9150 with any questions you may have.

- ✔ All patients must fully complete our **Patient Registration Forms**
- ✔ *If you do not have insurance,* **full payment is expected at the time of each visit**
- ✔ We accept cash, check, Visa, MasterCard, American Express and Discover

CANCELLATION OF APPOINTMENTS

All of our patients are important to us. Appointment time is allocated specifically to provide you the utmost in quality care. By providing ***at least 48 hours appointment cancellation notice,*** you allow us to help another patient in need. Repeated cancellations or failed appointments may result in a charge of $25 for office visits and $50 for procedures. Your consideration benefits all.

In order to file your claim, we must have a copy of the front and back of your insurance identification cards with the complete claims filing address as well as owner identification, policy and group numbers. Without this information, you will be billed directly. We file claims for most insurance plans. Balances that remain unpaid may be sent to our collection agency.

Managed Care Plans: EPO-HMO-PPO-POS

ALL COPAYMENTS ARE DUE AT TIME OF SERVICE. If you do not know your copayment amount, you may use our phone to call your insurance carrier. In order for your claim to be paid by your carrier, you must provide us with any required referral forms or authorizations prior to your visit. IT IS YOUR RESPONSIBILITY to verify that we are ***"in-network"*** *with your managed care plan. If you are scheduled for a procedure, you must verify that the hospital or facility is "in-network"* to avoid increased deductible and out-of-pocket cost penalties.

RE: **SCREENING BENEFITS.** You must tell us when you schedule your procedure if you are scheduling a screening procedure. Hospitals and out-patient facilities bill on the SCHEDULING diagnosis. See Well-Care, Preventative, Routine and Screening Notice.

RE: **PROCEDURES.** Patients who fail to appear for their scheduled procedures will be charged $100.00.

MEDICARE – MEDICARE REPLACEMENT PLANS

*****IF YOU HAVE A MEDICARE REPLACEMENT PLAN,* you must contact our office prior to your procedure to verify that we are participating providers with that plan.** We accept regular Medicare and Railroad Medicare assignment. You are responsible only for the difference between Medicare's approved amount, the amount they pay and any deductible or co-insurance applied. If you have supplemental insurance, we will bill them directly for you. Supplemental insurance may not cover your deductible, or pay only a portion of your co-insurance due. You will receive a bill after insurance has paid. Medicare may require that you sign an "Advanced Beneficiary Notice" (ABN) for some services; we will advise you when this may be required.

USUAL AND CUSTOMARY DETERMINATIONS

We are committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. You are responsible for payment in full, regardless of an insurance company's arbitrary determination of "usual and customary".

LEGAL OR ACCIDENT CLAIMS

If you are here as the result of an accident claim, we require that you provide us with your health insurance information so that we may bill them directly, or that you pay 100% of your charges at the time of service. We also need the name, address and phone number of the accident insurance company and/or your attorney. In case of a lawsuit, we will file a lien with them for the balance. 24 HOUR NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS AND/OR X-RAY REPORTS; there is a FEE for this service. You will be required to sign our release form.

WORKER'S COMPENSATION

Patient being seen as a result of work-related injuries are still responsible for charges incurred by them. Please notify our office if you have such a claim so that *prior to the time of your visit* we may verify coverage of your charges by your employer. If we cannot verify coverage, you will be responsible for payment of your charges. If your employer does not remit payment for your charges within a reasonable period of time, we will bill you directly for your charges.

______________________________ ______________________________

Signature of Patient or Responsible Party NSGA Staff Initials Date

______________________________ ______________________________

Print Patient's Name DOB