PATIENT REGISTRATION FORM
Bridgeview Endoscopy
21 Reade Place Suite 3300
Poughkeepsie, NY 12601

PATIENT ACCOUNT NUMBER

PATIENT INFORMATION

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

INSURANCE INFORMATION

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

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME (LAST, FIRST, MIDDLE)	SEX ❑ MALE ❑ FEMALE	LEGAL REPRESENTATIVE ❑ YES ❑ NO
RESPONSIBLE PARTY'S ADDRESS	EMPLOYER'S NAME	
CITY STATE ZIP	EMPLOYER'S ADDRESS	
TELEPHONE ( )	RELATIONSHIP TO PATIENT SPOUSE PARENT GUARDIAN OTHER _____	

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)

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PAYMENTS OF BENEFITS AUTHORIZATION

I hereby authorize payment of all services rendered to me, to be paid directly to Bridgeview Endoscopy 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 _____
Signature _____ Date _____

RECORDS RELEASE AUTHORIZATION

This record release authorization allows us to obtain and/or 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 if yes, please provide copy to reception.
If no, would you like to receive information on advanced directives? _____Yes _____No
Which type of advanced directive do you have: _ ___Living Will _____Power of Attorney?
_____Healthcare Proxy _____DNR _____ MOLST
Custodian of Document _____ Relationship: _____

Please be advised, if you do have any advanced directive, our office is required to obtain a copy for your records.

POLICIES

I acknowledge that I was provided a copy of the No Show, Bill of Rights, Grievance, and Notice of Ownership Policies from Bridgeview Endoscopy.
Print Name: _____
Signature: _____ Date: _____
*If person signing is not the patient, please print your name and relationship to patient:
Name: _____
Relationship: _____

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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 Bridgeview Endoscopy.

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 ENSURING 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:

_____
_____

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PATIENT TREATMENT/ FINANCIAL WAIVER

I, _____ realize that if I do not have the proper referral or insurance information to cover the services that I am requesting from Bridgeview Endoscopy I will be responsible for the payment of this visit and all associated charges for me or my dependent(s).

Signed: _____

Date: _____

Witnessed: _____

Revised 1/21/2020