GASTROENTEROLOGY ASSOCIATES

Consultative Gastroenterology, Hepatology and Gastrointestinal Endoscopy

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VAJRAVEL M. PRASAD. M.D ☐

GEC #: _____ **DATE:** _____ **MED #:** _____

PROCEDURE: _____ **PRECERT?** ☐ **YES** ☐ **NO #:** _____

Patient Registration

Name: _____
Last First Middle Initial (Required)

Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Marital Status: M W D S Phone (Home): _____

Retired: ☐ Yes ☐ No Phone (Work/Cell): _____

Employer: _____ DOB: _____ Age: _____
If Retired Name of Prior Employer

Employers City, State: _____ Patient SS Number: _____

Occupation: _____ Referred by Dr. _____

Primary Care Physician: _____

Spouse or Parent Name: _____ Social Security Number: _____

Employer: _____ Employers City and State: _____

Retired: ☐Yes ☐ No If Retired – Name of Prior Employer DOB: _____

Emergency Contact (other than household members)

Name: _____ Phone: _____

Address: _____ Relationship: _____

I request that payment of authorized insurance benefits (including, but not limited to Medicare, Medicaid, HMO, PPO, BC/BS and Workers Compensation) be made on my behalf to Gastroenterology Associates for any services furnished me by physicians or employees of Gastroenterology Associates. I authorize any holder of medical or other information about me to release to my insurance company and its agents any information needed to determine these benefits or benefits for related services. I request that any other insurance benefits be paid directly to Gastroenterology Associates. I authorize Gastroenterology Associates to submit claims to my insurance carriers or their intermediaries for all services rendered by Gastroenterology Associates. I authorize the release of any information required to process any claims.

I understand that I am financially responsible for any balance regardless of insurance coverage, if any, subject to Federal Law concerning payment for services provided to Medicare beneficiaries. I also agree to be responsible for reasonable attorney's fees, court costs and other collection expenses incurred by Gastroenterology Associates in connection with collection of amounts due.

_____ _____
Patient Signature/Patient Authorized Representative Date

If not an Indiana Resident (please sign)

Please be advised that in consideration for the agreement to treat the undersigned patient who does not reside in Indiana, the patient hereby agrees that Indiana law will govern all aspects of the relationship between the patient and the physician(s) and/or other health care providers employed by or associated with Gastroenterology Associates, whether the patient has been treated in the office or in a hospital setting. Specifically, any claim that may arise from the patient's treatment by the physician's and/or other health care providers of Gastroenterology Associates will be governed by Indiana procedural and substantive law. The agreed venue for any such claim will also be Indiana.

_____ _____
Patient Signature/Patient Authorized Representative Date