OGDEN GASTRO

CHAD M. GONZALES, M.D.

Ogden Gastroenterology

REGISTRATION RECORD

PATIENT

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH	SEX
				M F

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	ALT. PHONE	MARITAL STATUS	SOCIAL SECURITY NUMBER

EMPLOYER	POSITION	HOW LONG EMPLOYED	WORK PHONE

PRIMARY CARE PHYSICIAN	PREFERRED PHARMACY	EMAIL ADDRESS

RACE	ETHNICITY	PREFFERED LANGUAGE

RESPONSIBLE PARTY

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH	SEX
				M F

ADDRESS	CITY	STATE	ZIP

RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE	MARITAL STATUS

EMPLOYER	POSITION	HOW LONG EMPLOYED	WORK PHONE

SPOUSE OF RESPONSIBLE PARTY

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH	SEX
				M F

ADDRESS	CITY	STATE	ZIP

RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE	MARITAL STATUS

EMPLOYER	POSITION	HOW LONG EMPLOYED	WORK PHONE

CONTACT

NAME OF PERSON OR NEAREST RELATIVE (NOT LIVING WITH YOU)	RELATIONSHIP

ADDRESS	CITY	STATE	ZIP	HOME PHONE	WORK PHONE

INSURANCE CO.	**GROUP#**	**ID#**	**INSURED PARTY**	**EFFECTIVE DATE**	**RELATIONSHIP TO INSURED**
PRIMARY					
SECONDARY					

INSURED BIRTH DATE	INSURED EMPLOYER	EFFECTIVE DATE

COPAY DUE AT TIME OF SERVICE

FINANCIAL AGREEMENT

WHEN COLLECTION EFFORTS OVER AND ABOVE THE NORMAL BILLING ARE REQUIRED, AN ADDITIONAL SERVICE CHARGE MAY BE ASSESSED. AN ADDITIONAL CHARGE WILL BE ASSESSED FOR ALL CHECKS RETURNED FOR INSUFFICIENT FUNDS. THE OFFICE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTION OF INSURANCE, OR OTHER CLAIMS. YOU ARE RESPONSIBLE FOR PAYMENT ON YOUR ACCOUNT IN ACCORDANCE WITH OUR POLICY. WE ANTICIPATE PAYMENTS ON YOUR ACCOUNT EVEN THOUGH YOU MAY HAVE AN INSURANCE CLAIM PENDING.

IN CONSIDERATION FOR MEDICAL SERVICES RENDERED, I (WE) ACKNOWLEDGE THAT I (WE) HAVE RECEIVED WRITTEN NOTICE OF DR. CHAD M. GONZALES' ACCOUNT TERMS AND AGREE TO MAKE PAYMENT FOR SAID MEDICAL SERVICES ACCORDING TO SUCH TERMS. IT IS UNDERSTOOD AND AGREED THAT IF PAYMENT ON THIS ACCOUNT IS NOT MADE IN ACCORDANCE WITH THE TERMS OF THIS POLICY, I (WE) WILL PAY REASONABLE ATTORNEY'S FEES, COURT COSTS AND/OR CHARGES OR COMMISSIONS THAT MAY BE ASSESSED BY ANY COLLECTION AGENCY RETAINED TO PURSUE THE COLLECTION OF THIS ACCOUNT. I (WE) AGREE TO PAY UP TO 40% COLLECTION EXPENSE INCURRED BY DR. CHAD M. GONZALES IN ATTEMPTING TO COLLECT SUCH AMOUNTS IN ADDITION TO THE AFOREMENTIONED ATTORNEY'S FEES AND COSTS. RECEIPT OF THIS POLICY STATEMENT IS NOTICE OF THE OFFICE'S ACCOUNT TERMS.

RELEASE OF INFORMATION

YOUR SIGNATURE AUTHORIZES DR. CHAD M. GONZALES TO RELEASE MEDICAL INFORMATION THAT MAY BE NECESSARY TO REQUEST CLAIM REIMBURSEMENT FROM INSURANCE COMPANIES OR OTHER PAYERS TO WHOM CLAIMS HAVE BEEN SUBMITTED AND TO RELEASE CREDIT INFORMATION GATHERING AGENCIES.

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. CHAD M. GONZALES OR HIS AGENTS. YOUR SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THE CLAIM. IN CASE OF A MEDICARE CLAIM, THE PATIENT'S SIGNATURE AUTHORIZES ANY ENTITY TO RELEASE TO MEDICARE MEDICAL AND NON MEDICAL INFORMATION, INCLUDING EMPLOYMENT STATUS, AND WHETHER THE PERSON HAS EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKERS COMPENSATION OR OTHER INSURANCE WHICH IS RESPONSIBLE TO PAY FOR THE SERVICES FOR WHICH THE MEDICARE CLAIM MADE.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____