UNIVERSITY PHYSICIANS BROOKLYN, INC.

DIGESTIVE DISEASE CENTER & ENDOSCOPY CENTER

760 Parkside Avenue, Brooklyn, NY 11226

REGISTRATION FORM

(Please Print)

Today's date:	PCP: Address: Telephone:

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Soc Sec No.: Cell phone no.:			Home phone no.: ( )	
P.O. Box:	City:		State:		ZIP Code:	
Occupation:	Employer:				Employer phone no.: ( )	
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr. _____			❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Other family members seen here:						

INSURANCE INFORMATION

(Please give your insurance card and Photo I.D. to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):			Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:			Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]
❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ Welfare *(Please provide coupon)*	❑ Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature *Date*

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MEDICARE ASSIGNMENT

_____ _____

Name of Beneficiary **Health Insurance Claim #**

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Dr. _____ for any services rendered to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

_____ _____ _____

Patient's Signature **Date** **Physician's Signature**

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to Downstate Medical Billing Services of the medical benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by the assignment.

_____ _____

Patient's Signature **Date**

PPO and MANAGED CARE SUBSCRIBERS

***I understand that I must notify the physician's office if I decide to join or change my managed care plan. The proper referral with co-pay (if required) must be provided on the day medical services are rendered. Referrals are not retroactive. I understand that if I fail to notify the physician's office of my disenrollment or changes in the status of any eligibility within the plan, then I will be responsible for any outstanding balance on my account due to that change. I have read and understand the above text.

_____ _____

Patient's Signature **Date**

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any physician or other person who has attended or examined me or my family members to furnish the (insurance carrier name) _____ information with respect to any illness or injury, medical history or consultation, prescription or treatments and copies of all medical records. A photocopy of this authorization shall be considered as valid as the original.

Patient's Signature **Date**

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GENERAL CONSENT TO TREATMENT

I, Knowing that I require hospital care or a course of treatment, consent to diagnostic treatment procedures by the University Physicians of Brooklyn, Inc. or assistants or person(s) they designate.

I am aware that the practice of medicine is not an exact science. No guarantees have been made to me about the benefits or results of procedures and treatments authorized above.

I authorize University Physicians of Brooklyn, Inc., to use or dispose of any tissues or specimens resulting from the procedure(s) authorized above.

I further consent to the use of patient information for training and education purposes by University Physicians of Brooklyn, Inc., SUNY Downstate, University Hospital of Brooklyn and their physicians; at the same time University Physicians of Brooklyn, Inc., SUNY Downstate, University Hospital of Brooklyn are to protect my identity.

By signing this consent form, I hereby authorize the hospital and its medical staff to use and disclose my personal health information, as necessary for the purposes of obtaining medical treatment, enabling the hospital and its staff to obtain payment for such treatment and for the normal business operations of the hospital.

I have read and understood this form and I understand that I may ask for further explanations at any time.

Patient's Name (Print)	Signature	Date

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient or the next-of-kin who is assenting to the treatment for the patient must be obtained.

Health Care Agent/Guardian (Print)	Signature/Relationship	Date

WITNESS: To be signed by a facility employee who is not the patient's health care provider.
I have witnessed the patient or other appropriate person voluntarily sign this form.

_____ _____ _____

Witness's Name (Print) Signature
Date

Indicate if applicable: [ ] Patient is unable to sign, and next-of-kin is unavailable [ ] Patient refused to sign

INTERPRETER/TRANSLATOR: To be signed by the interpreter/translator if the patient required such assistance. To the best of my knowledge, the patient understood what was interpreted/translated and voluntarily signed this form.

_____ _____ _____

Interpreter/Translator's Name (Print) Signature
Date

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HIPAA PRIVACY FORM
NOP ACKNOWLEDGEMENT

This form will be provided to you upon registration.

Name of Patient/Personal Representative:
_____

Notice of Privacy

You are entitled to our **Notice of Privacy Practices** describing how your health information can be used and disclosed by University Physicians of Brooklyn, Inc. (UPB) and how you can obtain access to and control this information.

Our Notice of Privacy Practices will be provided to you upon registration. It is also posted in our practices.

By signing below, I acknowledge that I received the Notice of Privacy Practices.

_____ _____
SIGNATURE OF PATIENT/ PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

For UPB employee use only:
__ Patient would not acknowledge receipt of NPP. Documentation of good faith effort to obtain acknowledgement and reason not obtained:
_____
_____
_____

Individuals Involved in Care

Please identify family members, relatives or close personal friends that we may share your health information with who are involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition or about the unfortunate event of your death.

Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
_____ _____
Phone #: _____ Phone #: _____
Relation: _____ Relation: _____