

Patient Registration Information Form
All Island Gastroenterology & Liver Associates
Harold Lipsky, M.D. Pradeep Bansal, M.D. C.J. Singh, M.D.

PATIENT INFORMATION

Patient Full Name _____
Please Print Last First MI Social Security #

Permanent Address _____

City: _____ State: _____ Zip Code: _____

Home Phone # _____ Cell Phone: _____ Sex: [] M [] F Date of Birth _____ Age: _____

If there is no change to the information noted below since your last visit please check here () and proceed to bottom of form.

***** If an interpreter is needed please advise our Front Desk Staff upon arrival.*****

PRIMARY LANGUAGE SPOKEN OTHER THAN ENGLISH: _____

Employer: _____ Work Phone # _____

Spouse Name _____ : _____ Spouse Date of Birth: _____

Emergency Contact: _____ Phone # () _____

Referring Physician: _____

Phone# _____ Fax # _____

Insured's Insurance Information-Primary

Insurance Carrier: _____

Insured Name: _____ Insured DOB: _____

Insurance ID #: _____ Policy #: _____ Group# _____

Insured's Insurance Information-Secondary

Insurance Carrier: _____

Insured Name: _____ Insured DOB: _____

Insurance ID #: _____ Policy #: _____ Group# _____

ASSIGNMENT OF BENEFITS & AUTHORIZATION OF RELEASE OF INFORMATION:

I (the Patient as noted above) hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier (s), including Medicare, Private Insurance and any other Health/Medical plan to issue payment checks directly to **ALL ISLAND GASTROENTEROLOGY & LIVER ASSOCIATES** for any medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any, I understand that I am **RESPONSIBLE** for any amount not covered by my insurance.

I hereby authorize the physicians of **ALL ISLAND GASTROENTEROLOGY & LIVER ASSOCIATES** to furnish and/or release any information necessary to any of my other doctors and all relevant insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, and to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from the physicians of **ALL ISLAND GASTROENTEROLOGY & LIVER ASSOCIATES** on behalf of myself and/or by the referral of my primary care and referring physician, and understand that by making this request, I become fully **FINANCIALLY RESPONSIBLE** for any and all charges incurred in the course of the treatment authorized. **I further understand that fees (deductibles, co-pay) are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon services rendered.** A photocopy of this assignment is to be considered as valid as the original.

ATTESTATION:

I have had the opportunity to review the Practice's Notice of Privacy (HIPAA), Patient's Rights & Responsibilities Policy, Patient Safety Statement and MD Biographical information (located in a binder in the waiting room).

DISCLOSURE: The physicians of All Island Gastroenterology & Liver Associates, P.C. have a financial interest in Meadowbrook Endoscopy Center, 865 Merrick Avenue, Westbury, NY 11590.

Patient / Responsible Party – Signature: _____ Date: _____

Responsible Party (if not patient)- Print Full Name: _____