PREMIER GASTROENTEROLOGY
CONSULTANTS

CHINTAN MODI, MD.
Gastroenterology & Hepatology
122 James street Edison NJ 08820

TEL: (732) 243-9694
FAX: (732) 243-9695

Premierginj.com
Office@premierginj.com

PATIENT REGISTRATION

Patient Name:_____**Date of Birth:** _____

Address:_____

SSN#:_____**E-mail:** _____**Ethnicity:**_____

Preferred Phone # _____**Alternate phone #:**_____

Emergency Contact:_____**Phone#:**_____**Relationship:**_____

Pharmacy Name:_____Address:_____ **Referred by:**_____

PATIENT'S EMPLOYER INFORMATION

Employer Name:_____Tel#:_____

Employer Address:_____Occupation:_____

_____

INSURED PERSON IF NOT PATIENT

Guarantor Name:_____Date of Birth:_____

Street Address:_____

Relationship to Patient:_____Employer Name:_____

INSURANCE DETAIL

Medicaid #: (if applicable)_____**Medicare #** :(if applicable):_____

Primary Plan: _____ID #: _____Group #: _____Phone#:_____

Secondary Plan: _____ ID #: _____Group #: _____Phone#:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I authorize the practice to release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I authorize to obtain my medication history on-line. I hereby authorize the practice to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to the practice (or to the party who accepts assignment). I certify that the information I have reported with regards to my insurance coverage is correct. If at any time my insurance coverage changes, I must notify the office staff immediately. This authorization may be revoked by either me or the insurance company at any time in writing.

Patient Name: _____**Patient's Signature:** _____**Date:**_____

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TO ALL PATIENTS:

- **I understand that it is my responsibility to provide accurate and updated insurance information at each visit. I am aware that I am responsible for all charges if my insurance has expired (with or without my knowledge) or inaccurate insurance information was given by me.**
- **I understand that, where required by my insurance company, it is my responsibility to bring updated referrals, Co-pays and deductibles. I understand that if I do not have the appropriate referral and I choose to receive treatment at that time, I will be solely responsible for the payment of any medical service charges to Dr. Modi.**
- **I understand that if my insurance company denies payment to Dr. Modi for any of the reasons stated above (i.e. failure to provide accurate and/or updated insurance information, or failure to obtain a referral where required), it is my responsibility to pay Dr. Modi's medical service charges although I may choose to follow up with the insurance company regarding getting personally reimbursed.**
- **Dr. Modi has a financial ownership interest in Oak Tree Surgical Center, Union County Surgical Center and Pleasant dale Ambulatory Care Center. You have right to be treated at another health care facility of your choice. We are making this disclosure in accordance with federal regulation.**

By signing this form I also acknowledge Dr. Modi's office has offered or given me a copy of its Privacy Notice (HIPAA), which explains how my health information will be handled.

PATIENT PRINTNAME_____

PATIENT'S SIGNATURE_____**DATE** _____