REGISTRATION FORM

Today's Date: ____/____/____

PATIENT INFORMATION **THIS INFORMATION IS REQUIRED TO BILL YOUR INSURANCE (Please Print)**

Patient's Last Name First Middle	□Mr. □Miss □Mrs. □Ms	Marital Status (Circle One) Sing / Mar / Div / Sep / Wid

Name Other (Legal / Maiden if applicable)	Date of Birth	Age	Sex

Mailing Address	City	State	Zip Code

Social Security	Home Phone No. ( )	Cell Phone No. ( )	E-Mail Address

Occupation	Employer	Employer Phone No. ( )
Driver's License State and No.	**Primary Doctor**	**Referral Doctor**

SUBSCRIBER INSURANCE INFORMATION (Please Print)

Subscriber's Name	Subscriber's S.S.#	Birth Date	Group #	Policy #	Co-Pay $

Insured Address	City	State	Zip Code	Insured Phone No. ( )

Subscriber's Occupation	Subscriber's Employer and Address	Subscriber's Employer Phone No ( )

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Secondary Insurance(if applicable)	Group #	Policy #

IN CASE OF AN EMERGENCY (Please Print)

Name of Friend or Relative	Relationship to Patient	Home Phone No. ( )	Cell Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize Kuldip Banwait MD or the insurance company to release any information required to process my claims.

X____

PATIENT/Guardian Signature DATE

Panhandle Gastroenterology, PA Kuldip Banwait, MD – 800 Quail Creek Drive, Suite -101 Amarillo TX 79124
Ph: (806) 354-9400 Fax: (806) 354-9403

CONSENT TO TREATMENT

ASSIGNMENT OF BENEFITS AUTHORIZATION, RELEASE, AND LIABILITY

DATE: _______________

a. I, ____, hereby voluntarily consent to out-patient care by Panhandle Gastroenterology, PA encompassing routine diagnostic procedures, examinations and medical treatment including (but not limited to routine laboratory work [such as blood, urine, and other studies], taking x-rays, heart tracings, and administration of medications).

b. I hereby authorize the release of any medical information including the diagnosis and the treatment or examination rendered to me during the period of such care to third (3rd) party payer to process this claim and /or other health practitioners. Moreover, I authorize the holder of my medical records to release a CMS/ Centers for Medicare & Medicaid Services and its agents any information to determine these benefits payable for related services.

c. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize and request Medicare or other insurance company benefits be made on my behalf directly to the doctor or doctors group, otherwise payable to me for any services furnished by him.

d. I further understand that my insurance carrier may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on my behalf or me dependents. Moreover, I agree to pay for any services that are rendered if my insurance denies them for any reason.

PATIENT SIGNATURE: ____

PLEASE LIST BELOW THE PHARMACY YOU WOULD LIKE TO USE:

____

____

Phone #: ______________________________

Mail In:

____

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____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, acknowledge that I have received a copy of Notice of Privacy Practices from the office of Panhandle Gastroenterology, PA.

PERMISSION TO LEAVING RESULTS

In the event that there is lab, pathology results, or post procedure follow-up calls for the physicians, or his staff, please specify how this office may leave messages, (example: Answering machine, or designated relative).

I give my permission for this office to leave lab, pathology results, or post procedure follow-up calls as follows:

- ○ Myself only
- ○ My spouse
- ○ Anyone who answers the telephone
- ○ My answering machine
- ○ Other ___________________________________

____

Patient Signature Date

____

Patient Legal Representative (if applicable) Date

____

Print Name of Legal Representative Relationship to Patient

Panhandle Gastroenterology, PA

Kuldip S. Banwait, MD
800 Quail Creek Drive
Amarillo, TX 79124
Ph: 806-354-9400 Fax: 806-354-9403

Authorization for Release of Confidential Information

Patient Name: ______________________________

Patient's Address: ______________________________

Patient's Social Security #: ____________________ Patient's Date of Birth: ____________________

I authorize and request that a copy of my medical records be released as follows:

Information to be released to:	**Information to be released from:**
Dr. Kuldip S. Banwait, M. D.	______________________________ (Name of facility or physician)
800 Quail Creek Drive	______________________________ (Address)
Amarillo, TX 79124	______________________________ (City, State & Zip)

This authorization covers patient care given from ________________________ to ____________________

Check all types of records that may be released:

______ History & Physical ______ Progress Notes ______ Operative Reports

______ Lab & X-ray Reports ______ Other (please specify) ______________________________

____

This authorization shall be valid for one hundred twenty (120) days from the date of signature. The patient can revoke this authorization in writing at any time prior to the expiration date. This patient agrees that a photocopy of this authorization may be considered valid: ______ Yes ______ No

______________________________ ______________
Signature of Patient, Parent, Legal Guardian Date

In addition to the above records, I hereby authorize Panhandle Gastroenterology to release information given to them by me concerning mental health, drug, or alcohol use or treatment, or the presence of antibodies to the Human Immunodeficiency Virus (AIDS). I understand that this information is strictly confidential and disclosure is limited by State and Federal law.

I hereby release Panhandle Gastroenterology from liability for the release of information made in accordance with this authorization.

______________________________ ______________
Signature of Patient, Parent, Legal Guardian Date