Tri-Cities Digestive Health Center, PS Mid-Columbia Endoscopy Center, LLC

8819 W. Victoria Ave., Kennewick, WA 99336

Phone: 509-460-5500 Fax: 509-460-5111 www.checkmycolon.com

REGISTRATION FORM

FIRST NAME _____ M.I. _____ LAST NAME_____

HOME PHONE _____ CELL PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMPLOYER _____WORK PHONE _____

SOCIAL SECURITY # _____

SEX _____ AGE _____ BIRTH DATE _____ MARITAL STATUS _____

RACE: ☐Am. Indian/Alaska Native ☐Asian ☐Native Hawaiian/Other Pacific Islander ☐Black/African American ☐White ☐Hispanic ☐Other

ETHNICITY: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Refuse to answer

PRIMARY LANGUAGE: ☐English ☐Spanish ☐Russian ☐Other

_____

PHARMACY _____ CITY _____

REFERRING DOCTOR _____

PRIMARY CARE DOCTOR _____

EMAIL ADDRESS _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

GROUP # _____ ID# _____

SUBSCRIBER'S NAME _____ SEX _____

EMPLOYER _____WORK PHONE _____

SOCIAL SECURITY # _____ BIRTH DATE _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____

GROUP # _____ ID # _____

SUBSCRIBER'S NAME _____ SEX _____

EMPLOYER _____ WORK PHONE _____

SOCIAL SECURITY # _____ BIRTH DATE _____

RELATIONSHIP TO PATIENT _____

EMERGENCY INFORMATION

NAME OF RELATIVE/FRIEND _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

HAVE YOU ESTABLISHED ANY ADVANCE DIRECTIVES? YES _____ NO _____

(Please note: It is your responsibility to provide a valid copy to us) Copy Provided? YES _____ NO _____

WOULD YOU LIKE INFORMATION REGARDING ADVANCE DIRECTIVES? YES _____ NO _____

*PLEASE NOTE THAT WE ARE COMPLIANT WITH THE FEDERAL AND STATE LAWS GOVERNING IDENTITY THEFT PREVENTION AND DETECTION AND THE FTC'S "RED FLAG RULE".

STATEMENT OF FINANCIAL RESPONSIBILITY

I authorize payment of private insurance benefits to Tri-Cities Digestive Health Center, PS, and/or Mid-Columbia Endoscopy Center, LLC. I understand that I am financially responsible for the charges not covered by my insurance. I assume financial responsibility for all charges incurred by my dependants and myself. I understand that if my account is turned over to a collection agency, for any reason, there will be a $30.00 processing fee added to the balance of my account.

Signature _____ Date _____

Printed Name _____

Acknowledgement of Patient Rights/Advance Directives/Physicain Financial Statement

By my signature below, I acknowledge receipt of the Patient's Rights, Advance Directives, and Physician Fiancial Statement for Tri-Cities Digestive Health Center, PS, and/or Mid-Columbia Endoscopy Center, LLC. (A copy of this Statement is located on this website on the left menu bar in the "Forms" tab).

Patient or Legally Authorized Individual Signature _____

Printed Name _____ Date _____

Acknowledgement of Notice of Privacy Practices

By my signature below, I acknowledge receipt of the Notice of Privacy Practices for Tri-Cities Digestive Health Center, PS, and/or Mid-Columbia Endoscopy Center, LLC. (A copy of our privacy practices is located on this website on the left menu bar in the "Patient Privacy" tab.)

Patient or Legally Authorized Individual Signature _____

Printed Name _____ Date _____

Authorization to disclose Medical Information to a Family Member

By my signature below, I give my written permission to allow the providers and staff of Tri-Cities Digestive Health Center, PS, and/or Mid-Columbia Endoscopy Center, LLC, to share my medical information with:

Family member's name _____

Relationship _____ Phone # _____

I understand that this notice may be revoked at any time upon receipt of written request.

Signature _____ Date _____

FOR OUR PATIENTS WITH MEDICARE INSURANCE

Medicare Lifetime Insurance

I request that payment of authorized Medicare benefits be made to Tri-Cities Digestive Health Center, PS, and/or Mid-Columbia Endoscopy Center, LLC, on my behalf for any services furnished to me by their providers. 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 if benefits are payable for related services.

Signature _____ Date _____