R. SWAMI NATHAN, M.D.,F.A.C.G.,P.A

PATIENT REGISTRATION

First Name ________________________ Last Name _____________________________ DOB_____________

Street Address ____ Apt# ______________________

City________________ State______ Zip code_______________ Ethnicity__________________ Gender F / M

Best Contact # _________________ cell/home/other) Other Contact # ___________________ (cell/home/other)

Social Security# _________________________________ E-address ______________________________________

Primary doctor name: _______________________________ Primary doctor Phone# _______________________

Primary doctor location: ____

Referred by: ____

Emergency Contact ______________________________ Relationship _________ Phone# ____________________

Pharmacy Name ___________________ **Pharmacy Address** ____

PATIENT EMPLOYER INFORMATION

Employer Name ____ Tel# _____________________________

Employer Address ____ City ______________________

State_______________ Zip________________ Occupation ____

Name ____ Date of Birth ________________

Street Address ____ City ______________________

State______________________ Zip code__________________ SS# ______________________________________

Relationship to Patient ____________________ Employer Name ____

Primary Insurance Co. Name _______________________________________

ID# ______________________________ Group# ____________________ Phone# __________________________

Secondary Insurance Co. Name _____________________________________

ID# ______________________________ Group# ____________________ Phone# __________________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

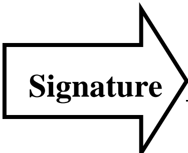
I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I authorize Dr. Nathan to obtain my medication history on-line.

I hereby authorize Dr. R. Swami Nathan 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 Dr. R. Swami Nathan 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.

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



____ **Date** ______________________

R. SWAMI NATHAN, M.D.,F.A.C.G.,P.A.
GASTROENTEROLOGY AND HEPATOLOGY
799 Bloomfield Avenue, Suite 102
Verona, NJ 07044

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, copays 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. Nathan.

I understand that if my insurance company denies payment to Dr. Nathan 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. Nathan's medical service charges although I may choose to follow up with the insurance company regarding getting personally reimbursed.

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

PATIENT PRINT NAME ____

PATIENT'S SIGNATURE ____

DATE ____