Gastroenterology
& Hepatology
ASSOCIATES OF MID-MICHIGAN, PC

Dear New and Established Patients,

•Welcome to our practice! We look forward to having you as our patient and appreciate the opportunity to serve you and provide excellent medical care. Please take a few minutes go over the enclosed paperwork so that all aspects of your experience will go smoothly.

•Dr. Holtz and Dr. Ofori-Darko are certified through the American Board of Internal Medicine and Gastroenterology. Dr. Murphy and Dr. Huang are certified through the American Osteopathic Board of Internal Medicine and Gastroenterology. Leann Schwedler and Susan Knoerr are certified through the American Academy of Nurse Practitioners. Patient care and comfort are of primary importance to them.

•If you are joining us for a procedure there will be a" facility fee charge" for your care and use of the treatment room as well as a "professional fee" from the physician performing the procedure. There will also be a charge from anesthesia and there may or may not be a pathology charge depending on whether or not there will be a biopsy taken. Our billing is independent from them.

•If you are joining us for an office appointment you will receive a **"Patient Interview Form"** that you need to complete and return to our office prior to your upcoming appointment. If you would prefer to fax the information our fax number is **989.839.9037**

•You also need to return the enclosed **"Patient Registration Form"** & **"Financial Policy"** if provided. ***Our billing practices are independent of the facility you may be having your procedure, therefore, you must complete and return our registration information to us.***

Thank you for letting us provide you excellent health care and we encourage you to contact our office staff if you have any comments, suggestions or questions.

Todd Holtz, M.D., Ernest Ofori-Darko, M.D., Christina Murphy, D.O., Karen Huang, D.O. FACOI

Leann Schwedler, NP-C, Susan M. Knoerr, DNP, FNP-C

4230 Bay City Rd, Midland, MI 48642

P: 989.839.0750, F: 989.839.9037

DIRECTIONS

East (Bay City)

Take US-10 west to Bay City Rd. exit, turn left at W. Midland Rd. which turns into Bay City Rd.

West (Mt. Pleasant)

M-20 east, right at Buttles St./US-10 Business. Buttles St. turns into Lyons Rd. Continue to take US-10 Business east toward Bay City Rd. exit. Merge onto US-10 east, take Midland exit toward Bay City Rd. Turn left at W. Midland Rd. which turns into Bay City Rd.

South (Saginaw)

Take Midland Rd./M-47 north, exit onto US-10 west toward Midland, exit to Bay City Rd., turn left at W. Midland Rd. which turns into Bay City Rd.

North (Sanford)

US-10 east toward Bay City. Take Midland exit toward Bay City Rd. Turn left at W. Midland Rd. which turns into Bay City Rd.

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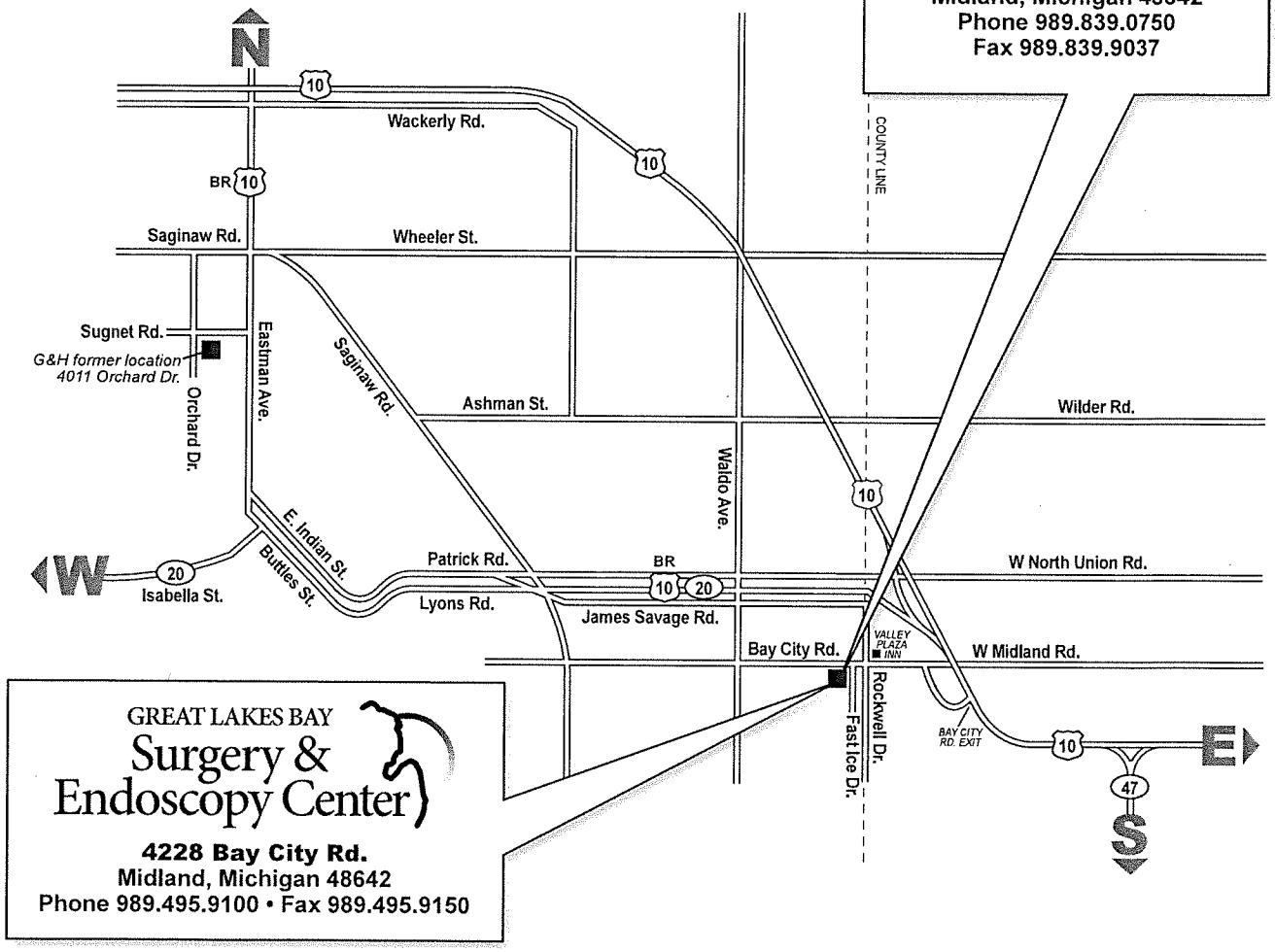

GREAT LAKES BAY
Surgery & Endoscopy Center

4228 Bay City Rd.
Midland, Michigan 48642
Phone 989.495.9100 • Fax 989.495.9150

□ Todd K. Holtz, M.D.
□ Ernest Ofori-Darko, M.D.
□ Christina L. Murphy, D.O.
□ Karen F. Huang D.O., FACOI
□ Leann M. Schwedler NP-C
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www.gastroandhep.com

PATIENT REGISTRATION FORM

Welcome to our office! We are very pleased to have you with us. Please fill in all the paper work enclosed. This information is important for your health and our records. It also helps in expediting your insurance payment. We must have this completed and signed so we have the authorization to bill your insurance. If you have any questions please do not hesitate to ask.

Appointment Date_____ Appointment Time_____

Account Number_____ □ Office Visit □ Colon □ Endo □ ERCP □ Flex □Motility/PH Study □ Other

Last Name: _____ First Name: _____ MI_____

Address: _____ City: _____ State: _____ Zip: _____

Previous Name: _____ □ Female □ Male □ Single □ Married □ Divorced □ Widowed □ Other

Date of Birth: _____Social Security Number_____Email: _____ @ _____

Employer: _____ Family Doctor _____

May we leave a detailed message regarding medical care/treatment at this number?

Home Phone: _____ □ **Yes** □ **No**

Mobile Phone: _____ □ **Yes** □ **No**

Business Phone: _____ □ **Yes** □ **No**

We would also like to make you aware that you may receive an automated reminder call 48 hours prior to your scheduled appointment.

PRIMARY INSURANCE COMPANY

_____

Address_____

_____

Insured's Name (if not the patient)

_____ DOB: _____

Contract/ID #:_____ **Gr#:**_____

SECONDARY INSURANCE COMPANY

_____

Address _____

_____

Insured's Name (if not the patient)

_____DOB:_____

Contract/ID#:_____**Gr#:**_____

(CONTINUED ON BACK SIDE)

Designation of Release of Heath Information

Gastroenterology & Hepatology Associates of Mid-Michigan are committed to releasing protected health information to the patient and any individuals the patient may choose. Please read the information below and you can designate others to receive your health information.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about mental health services, and treatment for alcohol and drug abuse.

□ **I choose to have my protected health records released only to me and to all providers associated with my care.**

□ **I choose to have my protected health record released to all providers associated with my care and to the following individual(s):**

Name_____ Relationship _____Telephone_____

Name_____ Relationship_____ Telephone_____

This information will be valid for a 12 month period. If at any time you would like to change your above selection you can do so by completing a new release of health information form.

****SIGNED-PATIENT/PARENT/LEGAL GUARDIAN _____ Date_____**

Authorization to Pay Benefits to Physician: I authorize Gastroenterology & Hepatology Associates to release to my insurance company any information regarding my treatment and diagnosis of my condition that they may consider appropriate to obtain payment for services rendered to me. I also authorize and request such payment to be made directly to this practice for any amounts due for medical and procedural services. I understand that I am financially responsible for any balance not covered by my insurance or any non-covered benefits, including injections or other laboratory tests necessary to diagnose or treat my condition.

_____ _____

****SIGNED (patient or parent if minor)** **Date**

**** 2 signatures needed on this paperwork**

Revised 10.23.17

FINANCIAL POLICY - We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policy as an essential element of your care and treatment.

YOUR INSURANCE - We participate with Medicare, Blue Shield Medicare Advantage, Humana Medicare Advantage, Medicaid, Molina Medicaid, McLaren Medicaid, Meridian Medicaid, ConnectCare, Aetna, Cofinity, Blue Shield, Blue Shield PPO, Tricare and Tricare Prime, Cigna, Priority Health and HealthPlus of Michigan, Blue Care Network. We have contracted with these insurance companies and must accept their "allowable" fee as reimbursement in full. Patients are responsible for deductibles, copay's and co-insurance balances. It is your responsibility to find out this information before your visit.

Co-pay's will be collected at the time of your visit.

If we don't have a contract with your insurance company we may not accept their "allowable" fee, you may have a balance after your insurance company pay's their portion. If your insurance plan is not listed, please check with your insurance company or employer with regards to their participation prior to receiving any medical services. We have an agreement with you as our patient, not your insurance company, so you are ultimately responsible for your bill.

We accept cash, personal checks, Visa, MasterCard and Discover

NO INSURANCE-Patients with no insurance coverage may be granted a discount. Arrangements must be made with our billing staff.

MINOR PATIENTS - The adult accompanying a minor and the parents (or legal guardian of the minor) are responsible for payment. Minor patients also **MUST** be accompanied by an adult/guardian over 18 for any appointment or procedure.

MISSED APPOINTMENTS – In order to provide the best possible service and availability to all our patients, if you are unable to keep your appointment to contact our office as soon as you aware there may be a conflict. We utilize an automated appointment reminder system that will call 48 hours prior to appointment. Your consideration will enable us to fill that time with another patient.

NSF CHECKS – If your check is returned for non-sufficient funds, a fee of $12.00 will be added to your account.

NO SHOW/CANCELLATION POLICY Gastroenterology & Hepatology Associates is committed to helping you manage and maintain your healthcare needs. When you schedule an appointment with one of our physicians that time is reserved exclusively for you to discuss and review your medical concerns. We do understand that on occasion unforeseen circumstances to arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment, we ask you to show consideration by calling our office in advance. Providing our office with adequate notice will allow us to offer that appointment time to another patient who needs to see the provider.

(CONTINUED ON BACK SIDE)

The following no-show and/or late cancellation fee will be assessed:

No Show/Cancellations Fee:

To avoid a no show/cancelation fee please notify our office 24 hours in advance for office appointments. Failure to do so may result in the following fee:

Office Appointment: $25.00

****These charges are not billable to your insurance and will ultimately be the responsibility of the patient. All no show charges will need to be paid before your next appointment with the physician.**

I have read and understand the financial policy and practices of Gastroenterology& Hepatology. Your signature indicates that you have read, understand and agree to the information within this document.

_____	_____	_____
Print the Name of Patient	Signature of Patient or Responsible Party	Date

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