ENDOCRINE AND METABOLIC SPECIALISTS, LLC.

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PATIENT REGISTRATION FORM

(All information is strictly confidential)

Today's Date _____

♦ **REFERRED BY:**_____

*** INDICATES REQUIRED INFORMATION**

PATIENT INFORMATION

*First Name_____*Last Name _____*M.I. ___

*Address _____ Apt/Unit _____

(No P.O. Boxes, please.)

*Zip _____ * City_____ * State_____

* Date of Birth_____ Social Security Number_____

Please give numbers where we can leave messages

*Primary Number:_____ Secondary Number_____

* Office Phone_____*E-mail..... .....

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Separated ☐ Unknown ☐

Gender: Male ☐ Female ☐

*** Race:**_____ *** Ethnicity:**.....

*** Preferred Primary Language:**..... .....

*** Preferred Pharmacy**:

Name:_____

Phone Number:_____Fax Number:_____

♦***Primary Care Physician: First Name**_____**Last Name**_____

Phone Number: _____

****I consent to receiving my medications from my Pharmacy from all providers – Yes/ No.** ***(Please respond)***

Emergency Contact:

Name _____ Phone _____

Relationship to Responsible-Party: Self ☐ Spouse ☐ Child ☐ Other ☐

Employer_____ **Phone Number**_____

Address_____

City, State, Zip_____

Benefits Contact_____Phone_____

♦ **PRIMARY INSURANCE COMPANY**

_____ _____ _____

Name of Primary Ins. ID Number Group Number

Subscriber Information:

Subscriber Last Name_____First Name_____ M.I._____

Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐ Student ☐ Ret

If your spouse or partner or parent is the primary insurance holder, please fill out the following: Date of birth of policy holder _____

SECONDARY INSURANCE COMPANY

_____ _____ _____

Name of Secondary Ins. ID Number Group Number

Subscriber Information:

Subscriber Last Name_____ First Name_____ M.I._____

Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐

If your spouse or partner or parent is the primary insurance holder, please fill out the following: Date of birth of policy holder _____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE INFORMATION, FINANCIAL RESPONSIBILITY

I hereby authorize payment directly to physicians providing services for which benefits are payable. I hereby authorize the release of pertinent medical information to insurance carriers. I understand that I am financially responsible for all charges for services to me, including the remaining balance of possible insurance benefits payments. I will also pay all recovery costs if my account is referred to collection.

HIPAA

Acknowledgment of receipt of Notice of Privacy Practices.

I (print) ..... have received a copy of this office's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Authorized Representative to whom we can disclose health information:

Name:_____ **Relationship:**.....

Address: _____ **Phone Number:** _____

Signature ..... **Date** _____

TO OUR PATIENTS

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care programs and continue to accept or participate in other insurance plans.

While we are pleased to be able to provide this service to you, it is very difficult for us to be aware of all the individual requirements of each plan. Each has different stipulations regarding how often services may be rendered and even more importantly, where those services may be performed. Even within the same insurance company, the plans differ depending upon the type of contract your employer has negotiated.

If your insurance plan requires authorization (referral) from your primary care physician, it is your responsibility to present it to our staff upon arrival. It is also your responsibility to be aware of the number of visits you have. If you do not have the appropriate authorization, we will be happy to reschedule your appointment or you may see the doctor and pay for the day's visit.

IF YOU ARE SEEN AND WE LATER FIND THAT YOU DID NOT BRING A REFERRAL OR THAT YOUR REFERRAL IS NOT VALID, YOU WILL BE BILLED FOR THAT VISIT.

If your insurance requires a co-payment, it is due at the time of service. Co-payment is a requirement of our participation with your insurance company and will not be billed.
For your convenience we accept cash, credit cards and personal checks.
Please note that there will be a $40.00 fee on returned checks.
It is your responsibility to know of any special requirements or limitations in your contract or in your coverage with your health insurance carrier. Please verify your coverage for any services ordered by us, including but not limited to lab work or hospitalization, radiology, pathology or any medical supplies or services. If we order services and subsequently it is found to be not covered, either in the office or in any other facility, payments for those charges are your responsibility. With your cooperation and help, you should be able to receive all the benefits offered to you and we will be able to concentrate on caring for your medical needs.

We emphasize as health care professionals, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems do arise and we encourage you to contact us promptly for assistance in managing your account. **If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.**

I have read and understand the office policy and agree to accept responsibility for payment in full for non-covered services and/ or supplies, co-payments and non-referral visits.

Your signature below attests to the fact that you have read this statement and agree to comply with this financial policy.

Patient's Signature_____ **Date**_____