

Welcome To Our Office

New Patient Information

Acct: _____

Name Last, First, MI - Please Print		SS #	Sex M F	DOB	Age	Marital Status
Street Address Not PO Box		City	State	ZIP	Drivers License #	State
Home Phone #		Work Phone # [ext]	Cell Phone #		Referring MD	
Patient's Employer		Address			Occupation	
Emergency Contact		Phone #	Relationship to Patient		Address	

Insurance Info [Please print clearly and fill out all that apply.] • We are not providers for: Health First, GHI or TriCare Prime

Type of Coverage: [Circle One]		<input type="checkbox"/> Medicare <input type="checkbox"/> Railroad Medicare <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Self-Pay <input type="checkbox"/> Other _____				
Primary Insurance	Policy #	Group #	Effective Date	Co-Pay \$		
Claims Address Street or PO Box, City, ZIP		Claims Telephone #			Deductible Amt \$ Have you met?	
Relationship of Patient to Insured [Circle One] Self Spouse Child Other	I will be paying today: [circle] Cash Check Visa / MasterCard		Insurance			
Guarantor's Name	SS #	DOB	Employer	Phone #		

Secondary Insurance		Policy #	Group #	Effective Date	Co Pay \$	
Claims Address Street or PO Box, City, ZIP		Claims Telephone #			Deductible Amt	
Relationship of Patient to Insured [Circle One] Self Spouse Child Other	Does your 2ndry insurance pay for office visits? Yes No		Does it pay you? Yes No			
Guarantor's Name	SS #	DOB	Employer	Phone #		

- Financial Responsibility • Co-pays • HMO • Authorization to Pay Physician • Release of Information •
- Acknowledgement of Receipt of Privacy Practices [PHI] • Returned Checks • Missed Appointments •

• I understand that I must provide a legible copy of my current insurance cards [with claims address and telephone number.] The above-listed insurance is what I have in effect on this date. **We will request a copy of your insurance card at each visit.** • I understand that I will be asked to provide my insurance card at each visit. **Please note that you will be responsible for any and all unpaid balances due to erroneous or incomplete information regarding your insurance information at the time of service.** Please initial: _____

• **FINANCIAL RESPONSIBILITY:** We cannot render services on the assumption that our charges will be paid by an insurance company. • All services are charged directly to the patient and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance and will credit any such collections to the patient's account. • I understand and agree that regardless of my insurance status, I am financially responsible for the balance of my account. • I acknowledge that I am responsible for any deductible, co-pay, or other balance not covered by my insurance carrier [s]. • I understand that billing my 2ndy insurance carrier is a service provided as a courtesy to me and it is my responsibility for all follow up with my insurance carrier.

• **Insurance requirements:** You are responsible for knowing the requirements of your insurance plan regarding where you can go for your lab work, any diagnostic testing or any referrals to other physicians made by our office. We request that you verify with your insurance carrier before proceeding [with any diagnostic testing] that the facility where you are scheduled is covered by your plan. Please initial that you understand you are responsible for knowing & verifying this. Initial

• **Co-payments and/or deductibles are due at time of service.** I understand that I will be charged a \$25 service fee if my co-pay is not made at the time of service. Please initial: _____ • **Please note that insurance is a contract between you & your carrier.**

• **HMO Patients:** If you have an HMO plan, you are responsible for making sure you have a current referral number for each visit. If a current referral number is not received in time for your visit, **your choices are:** [1.] You may reschedule until a referral is received by our office or [2.] You may sign a waiver, making you financially responsible for the visit [this is the full allowable payment • not just your co-payment]

• **AUTHORIZATION TO TREAT:** I hereby authorize any treatment[s], agreed upon with the physician which may be deemed advisable.

• **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment directly to the provider for services, if any, otherwise payable to me for his/her services as described.

• **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the provider to release full details of my medical history for the purposes of healthcare management and/or for processing of all medical claims on my behalf. I hereby authorize the provider to release any information acquired in the course of my treatment necessary to process insurance claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. A photocopy of these assignments shall be valid as the original.

• I authorize MAB, Endocrinology to speak with: _____ [my _____] specify info to be discussed: _____

• **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES: [PHI]** I have been presented with a copy of the provider's NOTICE of PRIVACY PRACTICES, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and agree to the disclosures named in the notice.

• **Returned Checks:** Checks returned to us by the bank will be assessed a \$35 service charge, in addition to the original amount of the check. **You will have 10 days to clear up the outstanding check. We will only accept cash or credit card [Visa/MasterCard] for any future visits.**

• **MISSED APPOINTMENTS:** If you need to cancel or reschedule an appoint, we request that you kindly give a 24 hr notice.

• **May we contact you at work for non-urgent matters? Yes No** • **ALLERGIES/REACTIONS:** _____

• I have read and fully understand and agree with the financial policies and other policies contained within this New Patient Information for MAB, Endocrinology

Signature Patient/Guardian

Date of First Visit

