Capital Endocrine & Diabetes

PATIENT REGISTRATION FORM

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Patient's Name: Last First MI	Maiden Name:	DOB:	Patient's Social Security #:
Residence Address: City State Zip		Sex: ☐ M ☐ F	Driver's License: State:
Patient's Email:	Home Phone:	Cell Phone:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☑ Divorced
Name of Employer	Is insurance through your employer? ☐ Yes ☐ No		Occupation
Employer's Address: City State Zip		Work Phone:	May we contact you at work? ☐ Yes ☐ No
Person to contact in case of emergency:	Relationship to patient:		Phone:
Reason for Visit:	Referred by: (include address and phone)		

Insured's Name:	Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other_____		Driver's License: State:
Insured's Social Security #:	DOB:	Home Number:	Work Phone:
Insured's Employer:	Employer's Address: City State Zip		
Primary insurance:	Claims Address:		
Policy #	Group #		Effective Date:
Secondary insurance:	Claims Address:		
Policy #	Group #		Effective Date:

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Capital Endocrine & Diabetes services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

x_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

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Capital Endocrine & Diabetes

Patient Rights & Responsibilities

As a patient at Capital Endocrine & Diabetes, you have the right:

- To be treated with courtesy and respect.
- To have your privacy protected and to receive our Notice of Privacy Practices.
- To have your questions answered promptly.
- To know the name, role and qualifications of your caregiver.
- To know what services are available, including translators.
- To know what rules apply to you.
- To have information about your diagnosis, choices, risks and benefits of treatment so you can assist in developing your plan of care, including the management of pain.
- To refuse treatment except as otherwise provided by law.
- To be given, on request, information and counseling on available financial resources.
- To know, on request and before treatment, whether Medicare assignment is accepted.
- To receive, on request and prior to treatment, a reasonable estimate of charges for medical care and, on request, an itemized bill with charges explained.
- To receive medical treatment regardless of race, national origin, religion, physical handicaps, or sources of payment and to expect appropriate management of pain.
- To receive treatment for any emergency medical condition that may get worse if not treated.
- To know if medical treatment is for research and to either consent or refuse.
- To have the right to make Advance Directives.
- To be free from restraint and seclusion which are not medically necessary.
- To the confidentiality of your medical record and the right to access information from it.
- To have a family member or representative and your physician notified promptly of admission to the hospital.

As a patient at Capital Endocrine & Diabetes, you are responsible:

- To give your health care provider correct and complete information about your present medical condition, past illnesses, hospitalizations, medications, including over-the-counter drugs/herbal supplements, and other health matters.
- To report changes in your condition and report perceived safety concerns in your care.
- To tell your health care provider if you understand the plan of treatment and what is expected of you, including pain relief options and ask questions if you do not understand.
- To follow the treatment plan recommended by your health care provider.
- To keep appointments or notify the health care provider or facility if you cannot.
- To accept responsibility for your actions if you refuse treatment or do not follow the health care provider's instructions.
- To meet your health care financial obligations promptly.
- To follow rules and regulations on patient care.
- To be considerate of the hospital's personnel and property.

I have read and understand my rights and responsibilities as stated within this form.

Patient (or Responsible Party) Signature

Date

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Capital Endocrine & Diabetes

Acknowledgement of Receipt of Privacy Notice

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand CAPITAL ENDOCRINE & DIABETES reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for dental/medical information from persons not listed above will require a specific authorization prior to disclosure of any dental/medical information.

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient/Legal Representative Signature Date

_____

Relationship to Patient

_____ _____

Witness Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for CAPITAL ENDOCRINE & DIABETES to share my protected health information with:

_____ _____

Name Relationship

_____ _____

Name Relationship

I wish to be contacted in the following manner:

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Work Phone

Ok to leave message with detailed information?

- ☐ Yes ☐ No
- ☐ Yes ☐ No
- ☑ Yes ☐ No

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Capital Endocrine & Diabetes

Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

What Is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If You Have…	You Are Responsible For…	Our Staff Will…
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visits, tests, procedures, injections, and other charges at the time of office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable copays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you & File an insurance claim on your behalf.
HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, copay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services & File an insurance claim on your behalf.
Medicare	If you have Regular Medicare, and have not met your deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. If you have Regular Medicare as primary, and also have secondary insurance: You will be responsible for any charges that your insurance does not cover. We ask that it be paid at the time of service. If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% copay is requested at the time of the visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

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Capital Endocrine & Diabetes

FINANCIAL POLICY

Thank you for selecting Capital Endocrine & Diabetes as your healthcare provider. Our personnel will be happy to discuss our fees and this policy with you at any time. Please read and sign this financial policy prior to seeing the provider. Payment for services is due at the time services are rendered. We accept ***exact cash, and major credit cards- VISA, MasterCard, Discover and Amex. No checks will be accepted.***

Insurance Plan(s):

1. Your insurance policy is a contract between you, (your employer), and the insurance carrier. ***We are NOT a party to that contract.*** Our relationship is with you. It is your responsibility to keep us informed of your correct insurance plan and of any changes to your insurance plan. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, coinsurance payments etc.

2. Please present your insurance card at the front desk so that we can file a claim on your behalf. If your plan requires a referral or prior authorization for your visit, it is your responsibility to obtain it ahead of your visit.

3. ***All charges are your responsibility whether your insurance company pays or does not pay.*** Not all services are covered benefits in all contracts. Some insurance companies and some employers decide what a covered benefit is and what is not. Please check your insurance plan document for any questions. WE HIGHLY RECOMMEND THAT YOU READ YOUR INSURANCE BOOKLET OR CALL YOUR INSURANCE COMPANY REQUESTING A BENEFIT DESCRIPTION FOR SPECIALIST OFFICE VISIT. This will provide you some basic information prior to your visit(s).

4. ***All copays, deductible payments and coinsurance payments are due at the time of service.*** We will also need to collect any past dues prior to appointments. If you are unable to pay at the time of service, the appointment may be rescheduled.

5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. ***If your insurance company does not pay within 60 days, you will***

be responsible for payment. Your credit card information will be stored securely and unpaid balances will be charged to your saved card.

6. If we are forced to send your account to collections, a 50% fee will be added to your balance. Should you default on your balance, Capital Endocrine & Diabetes has the right to discharge you as a patient.

Initial_____

Appointments:

1. We have specifically set aside a time and slot for your appointment because we value the time spent with you. We ask that ***all cancellations must be made at least 48 hours in advance***, which allows us to care for other patients in need of our services. If you fail to cancel your appointment, you may be charged a ***$50 service fee*** which will not be covered by your insurance plan.
2. If you have to cancel within 48 hours of your appointment due to illness please provide us with proper documentation such as discharge papers, doctor's note etc.

Initial_____

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Capital Endocrine & Diabetes

Prescription Refills:

1. ***We encourage you to request any/all relevant prescriptions/refill authorizations at the time of office visit.***
2. If you have been recommended a follow up by our provider(s) and haven't made so, and you request refill of a prescription, and if the prescriber agrees for a temporary refill, you will be charged an ***administrative fee of $25***
3. Please note we will not be able to honor requests for prescriptions/refill authorizations during weekends or holidays Prescription refills or new prescriptions requested during weekends/holidays will incur a fee of $25
4. We require 72 hours processing time for refills outside of your office visit. Please have your pharmacy send in pharmacy request by fax to ensure accuracy.
5. Multiple/frequent pharmacy switches will incur a charge of $15 Prior authorizations will incur a fee of $15

Initial_____

Other Fees:

Medical Records fee- $25 (for up to 25 pages) and $0.50 per page after first 25 pages
Form fees- $10 (basic forms); $25 (detailed forms/letters)

Initial_____

I authorize my insurance benefits to be paid directly to the physician and that I am directly responsible for any balances. I also authorize Capital Endocrine & Diabetes or the insurance company to release my information required to process my claims.

Patient Name: _____

Signature:_____ **Date:** _____