Associates of Mid-Cities

Patient Registration

Legal Name: First _____MI_____Last_____Preferred Name: _____

Parent/Legal Guardian Name (if required) _____ DOB_____ Mobile_____

SS# _____ DOB: _____ Legal Sex: □ M □ F

Address: _____ Apt# _____ City _____ State _____ Zip _____

Phone: Home: _____ Mobile: _____ Work: _____

E-Mail: _____ □ No E-Mail

Marital Status: □Married □Divorced □Single □Legally Separated □Significant Other □Widowed

Race: □Asian □Black □Native American □Native Hawaiian/Pacific Islander □Two or More Races □White

Ethnicity: □Hispanic □Non-Hispanic

Spoken Language: _____ Written Language: _____ Need Interpreter? □ Y □N

Preferred Communication Method: □No Preference □Mail □Phone □E-mail □Portal □Accept Text Message

Do you have any communication difficulties or special needs? □Y □N

If so, please list: _____

Primary Care Physician: _____ □ No PCP

Employment Status: □Disabled □Full time □Part time □Retired □Student □Unemployed

Employer Name: _____

Contacts:

1) Name: _____ Rel. to Patient _____ Phone #_____

Emergency Contact: □Y □N May we leave a message? □ Y □ N

You May release the information regarding the following to the person above: □ Appointments □Billing □Medical Care

2) Name: _____ Rel. to Patient _____ Phone #_____

Emergency Contact: □Y □N May we leave a message? □ Y □ N

You May release the information regarding the following to the person above: □ Appointments □Billing □Medical Care

3) Name: _____ Rel. to Patient _____ Phone #_____

Emergency Contact: □Y □N May we leave a message? □ Y □ N

You May release the information regarding the following to the person above: □ Appointments □Billing □Medical Care

OR

□ **Only release information to Patient** If no answer may we leave you a message? □ Y □ N

Billing

Financially Responsible Party – Guarantor:

□ Same as Patient Information (If different please complete this section)

Name: First _____ MI ____ Last _____ DOB _____

Rel. to patient_____ Employment □Student □Part Time □Full Time □Retired □Disabled □Unemp.

Address: _____ Apt: _____ City: _____ St_____ Zip _____

Phone: Home_____ Cell _____ Work _____

Insurance

Primary Insurance _____ ID _____Group _____

Subscriber Name _____ Sex: □M □F Rel. to patient: _____

Sub. DOB_____ Employer_____ Status: □Student □Part Time □Full Time □Retired □Disabled □Unemp.

Secondary Insurance _____ ID _____Group _____

Subscriber Name _____ Sex: □M □F Rel. to patient: _____

Sub. DOB_____ Employer_____ Status: □Student □Part Time □Full Time □Retired □Disabled □Unemp.

Pharmacy

Pharmacy Name: _____ Location/Phone #: _____

Financial And Payment Guidelines

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility to obtain the referral prior to your appointment. If one is not obtained the patient will be responsible for any incurred.

- I authorize direct payment of my insurance benefits to Endocrine Associates of Mid-Cities for services rendered to myself or dependents.
- Insurance will be filed for services rendered. Any changes for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered.
- Patient or guardian is responsible for notifying our office of any changes to demographics or insurance billing information.
- Out of network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.
- Endocrine Associates of Mid-Cities or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.
- I hereby consent to credit bureau inquiries and to receiving auto-dialed/artificial or pre-recorded message calls, and or text messages to my cellular telephone and to any telephone number provided during my registration process. I understand that these collection attempts could be performed by Endocrine Associates of Mid-Cities or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.

Lab/X-Ray/Diagnostic Services:

- I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles, and co-insurance due for these services if they are not reimbursed by my insurance.

Release Of Information, Authorization & Assignment Of Benefits

- I authorize the release of all medical records to specialists and or consulting physicians if applicable to my care and condition.
- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider or any party who may be responsible for paying for my treatment.
- I further authorize and request that insurance payments be directed to Endocrine Associates of Mid-Cities.

Authorization to Treat a Minor (Ages 0-18th Birthday) □Not applicable (patient is an adult)

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers of Endocrine Associates of Mid-Cities to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to Endocrine Associates of Mid-Cities of changes or update. I authorize Endocrine Associates of Mid-Cities to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and or medical care.

Name _____ Rel. to Patient _____ Phone _____

Name _____ Rel. to Patient _____ Phone _____

Privacy Practices

Endocrine Associates of Mid-Cities, physicians and staff, are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.

Acknowledgment

I have read, fully understand and agree to the above release of medical information to others, financial and payment guidelines, release of information & assignment of benefits, authorization to treat a minor and privacy practices. I also certify that all of the information provided is complete and accurate.

_____ _____ _____

Patient Name (Printed) Patient Signature Date