ENDOCRINE & METABOLIC DISORDERS INSTITUTE, PLLC

Patient Information:

Name (must have patient's legal name)_____, _____ _____
Last Name First Name MI

Mailing Address: _____

City _____ State _____ Zip _____

Date of Birth ____/____/____ Social Security # ____/____/____

Sex: (M / F) Marital Status: (M / S / W / D) Phone:_____ Cell:_____ Email:_____

Employer:_____ Employer Address: _____

Employer Zip Code: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Language: English _____ Spanish_____ Japanese_____ Other_____

Ethnicity: Non Hispanic_____ Hispanic_____ Declined_____ Unavailable_____

Race: White/Caucasian_____ Black/African American_____ American Indian/Alaska Native_____ Asian_____

Native Hawaiian/Other Pacific Islander_____ Multiracial_____ Declined_____ Unavailable_____

Responsible Party Data (If Other Than Patient)

Name: _____ , _____ _____
Last Name First Name MI
Address _____

City _____ State _____ Zip _____

Date of Birth ____/____/____ Social Security # ____/____/____

Relationship to Patient: _____ , ____/____/____
Date of Birth

Primary Insurance:
Insured's name: _____ Date of Birth: ____/____/____ Employer: _____
Secondary Insurance:
Insured's Name: _____ Date of Birth: ____/____/____ Employer: _____

WE MUST HAVE A COPY OF THE INSURANCE CARD, FRONT AND BACK, TO FILE INSURANCE

Disclosure of Personal Health Information:

Endocrine & Metabolic Disorders Institute, PLLC will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. Please list the names and relationship of those you authorize us to discuss your personal health information.

Contact Names:	Relationship:	Daytime Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Authorization for release of information and assignment of benefits

I hereby authorize Endocrine & Metabolic Disorders Institute, PLLC (EMDI, PLLC) to furnish any and all information to my insurance carrier(s) concerning my illness and/or treatment. I hereby assign all rights, benefits and interest in all plans of health insurance, cases, or claims arising from my condition, whether against an insurance, company, corporation, individual or any other entity, to EMDI, PLLC. I understand that I am ultimately responsible for payment of all charges if not otherwise paid (unless prohibited by law or plan contract). I further understand that any amount paid in excess of the regular charges will be refunded as appropriate to the third party payor or to the patient or guarantor. However, in cases where the patient or guarantor has other outstanding accounts, the overpayment will be added to the outstanding account(s).

Date: _____ Patient/Guardian Signature: _____

ENDOCRINE & METABOLIC DISORDERS INSTITUTE, PLLC

Patient _____ Date___/___/____

SS#_____/___/____ DOB___/___/_____ Referring MD _____

I, the undersigned, agree to the following.

CONSENT FOR MEDICAL TREATMENT

I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician, nurse practitioner, his/her assistant, designees or consultants, as may be necessary in the judgement of my physician/nurse practitioner. I also understand that I will be billed direct for those services provided by other healthcare providers to whom I am referred, such as radiologists, pathologists, anesthesiologists, etc. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the results of treatments or examination in this clinic. I understand that my medical record may be maintained on a computer-based system and is available to persons involved in my care. (_____)

RELEASE FROM RESPONSIBILITY

If I should leave the clinic against medical advice or prior to treatment being completed, I hereby relieve said physician/nurse practitioners and the clinic of all liability for my action, (_____)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the clinic's designee to release to the payer/insurers herein specified, Center for Medicare and Medicaid Services, or to any other insurer or agency concerned with the payment of my charges, any and all information, by phone, mail, fax, or electronic mail, including copies of records, and any and all medication information, related to clinic services which are deemed by the payer/insurers or other agencies, to be required in the processing of applications for financial coverage for services rendered. I authorize these intermediaries to pay direct to Endocrine & Metabolic Disorders Institute, PLLC. I also authorize release of my medical records to other health care organizations consulted by my physician/nurse practitioner. (_____)

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible to the clinic for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurances, non-covered charges, and other items not paid by insurance, self insured health plans or other third party payer is due and payable upon services based on the best estimates available as determined by Endocrine & Metabolic Disorders Institute, PLLC. Charges remaining on this account are payable upon demand. It is also agreed that in case of default of payment and this account is placed in the hands of a collector or attotney for collection or suit, all reasonable collection fees, reasonable attorney fees, cost and other expenses will be paid by the undersigned. (_____)

(OVER)

NON-CERTIFICATION OF SERVICES

I hereby agree that as the policyholder or patient I share the responsibility of assuring certification is obtained from the insurance company on the above party for any services indicated. If certification is not obtained I further agree that in the event the insurance denies either all or part of their payment on the clinic account I will pay the account in full upon demand. (_____)

CONSENT TO PHOTOGRAPH, VIDEO TAPE OR OTHER IMAGING

I authortize the clinic to photograph, video tape or digitally image me as appropriate for medical record identification purposes and/or to document my medical condition. I understand that these original images will be stored in a secure manner. Images that identify the patient/resident will be released and/or used outside the institution only upon written authorization from my self or my authorized party or as required by law. I release Endocrine & Metabolic Disorders Institute, PLLC. physicians, employees and agents from any liability in the making and use of these requested photographs, videos, or digital images. (_____)

I have read the above consent and various releases, assignments or benefits and agreement for payment of charges and herewith execute the same voluntarily. A copy of this document shall be as valid as the original.

_____
PATIENT SIGNATURE (OR PERSON RESPONSIBLE AND RELATIONSHIP)

PATIENT IS UNABLE TO CONSENT BECAUSE _____

_____

_____

_____ _____
WITNESS (REQUIRED) DATE (REQUIRED)