IDE

Indiana Diabetes and Endocrinology, pllc

Patient Registration Form

Patient Name: _____ _____ _____ _____
Last First M.I. Date of Birth

Address: _____ _____ _____ _____
Street / PO Box City State Zip Code

Home Phone: (_____) _____ _____ Work Phone: (_____) _____ _____ Cell Phone: (_____) _____ _____

Preferred Communication: □ Home □ Work □ Cell

Social Security #: _____/_____/_____ Preferred Name: _____

Driver License #: _____ State Issued: _____ Primary Language: _____

Marital Status: □ Single □ Married □ Widowed Gender: □ Male □ Female □ Other:_____

Race: _____ Religion: _____

Emergency Contact: (Someone outside of permanent residence)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Subscriber Name: _____ Insurance Subscriber: _____

Subscriber's D.O.B: _____/ _____/ _____

PCP Name: _____

Preferred Pharmacy: _____

Referred by: □ Physician: _____ □ Friend □ Other: _____

_____ _____

Patient's / Guardian's (if minor) Signature Date

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FINANCIAL AGREEMENT

If You Have Medical Insurance:
As a courtesy to you, Indiana Diabetes and Endocrinology will bill your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information that is provided to our office is accurate and current. If there is a change in insurance information, please let us know immediately. We will submit claims to secondary/tertiary insurance as long as we are given the correct information.

Deductibles, Co-payments, and Coinsurance:
Copayments and deductibles are due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy and we can only approximate the percentage covered by each plan you will begin receiving monthly statements with any balances after your insurance company has been billed. Delinquent accounts may be turned over to a collection agency.

Referrals and Authorizations:
A copy of your insurance card is required at every service. The card is descriptive and indicates whether or not an authorization is needed. If your insurance has designated a primary care physician (PCP), you must have any required prior authorization form your PCP prior to your specialty office visit. If authorization is not provided, whether by yourself or through your insurance carrier, you will be required to pay for the visit at the time of service or rescheduled appointment until authorization is received.

Nonparticipating Insurance Accounts:
The financial obligations of patients who are insured by non-participating carriers are considered a self-pay account. Self-pay accounts apply to patients who are covered by carriers with which the practice does not participate or patients without an insurance card on file at the time of service. It is ultimately your responsibility to verify coverage for your particular plan. If the insurance company denies the claim for a plan provision (for example pre-existing conditions, maxed benefits, no outpatient service coverage), you will be responsible for the balance, and you agreed to pay the full charge at the time of service.

Medical insurance coverage is a contract between you and your insurance company. Indiana Diabetes and Endocrinology will not be involved in disputes between you and your insurance company regarding deductibles, copayments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply of factual information as necessary. **You are ultimately responsible for the timely payment of your account.**

A Special Note:
In situations of divorce, separation, "orders, etc., the party initiating treatment will be financially responsible for the count.

Payment methods:
* We accept cash, check, visa, master card, discovered, and American Express.
* A $25 fee will be charged to all patients for any return checks.
* Accounts can be set up on payment plans if necessary at no additional cost.

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. You are clear understanding of our financial policy is important to our relationship. Please ask if you have any questions about are free, financial policy, or your financial responsibility.

I acknowledge that I have read and agree to the above financial policy.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Witness: _____ Date: _____
*Parent or guardian must sign if patient is under 18 years of age

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Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Indiana diabetes and endocrinology originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serve as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- As source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party pair can verify that services build where actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with Indiana Diabetes and Endocrinology Privacy Standards Notice of Health Information Practices that provides a more complete description of information uses and disclosures I understand that I have the following rights and privileges:

- The right to review the note is prior to signing this consent,
- The right to subject to the use of my health information for directory purposes
- The right request restrictions as to how my health information may be used to disclose to carry out treatment, payment, or healthcare operations.

I understand that IDE is not required to agree to the restrictions requested. I understand that I am may revoke this consent in writing, except, to the extent that the organization has already taken action in the reliance upon this consent. I may deliver my revocation by any means I choose (e.g. personally or by mail). I also understand that by refusing to sign this consent or revoking this consent, disorganization may refused to treat me as permitted by section 164.506 of the code of federal regulations.

I further understand that IDE reserves the right to change their notice and practices prior to implementation, in accordance with section 164.520 of the code of federal regulations. Should IDE change their notice, they will send a copy of any device noticed to the address I have provided (whether US mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____
Patient's signature

_____
Date

_____
Signature if you are the patient's representative

_____
Describe your Authority

_____
Print Representative's Name