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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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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Financial Policy

Please read and sign this policy prior to seeing the provider(s).

Appointment:

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 **2 business days in advance**, which allows us to care for other patients in need of our services. If you fail to cancel your appointment within this time frame, you will be charged **a $50 service fee** (which will not be covered by your insurance plan).
2) If you must cancel within **2 business days** of your appointment due to illness, please provide us with supporting documentation such as discharge papers, doctor's note etc.

Financials:

1) It is your responsibility to know your health insurance plans. You will be responsible for any and all **co-payments, deductibles and co-insurances**.
2) All payments are due at the time of visit prior to seeing the provider
3) We accept all major credit cards and exact cash. **NO CHECKS WILL BE ACCEPTED**.
4) Cards can be kept on file for easier check in. Please make the front office staff aware if you would like to utilize this feature or not.

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 honor requests** for prescriptions/refill authorizations **during weekends or holidays**.
4) We require at least a **3 business days 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** that require us to re-send your prescriptions will incur a service **charge of $20**.

Prior Authorization:

1) There is an ever-increasing trend of prior authorization (PA) requests from insurance plans for medications or procedures duly prescribed by our providers resulting in additional staff- and provider-time involvement. **A service fee of $20** will be charged to you for doing **PA per medication/procedure every time such a request is made** (this fee will **not be covered by your insurance plan**). We cannot guaranty that your insurance will approve or deny such requests for PA.

Insurance Plan:

1) it is your responsibility to understand your health insurance plan and what your insurance covers or does not cover.
2) You are **required to provide us with the most accurate health insurance plan details** so we can send claims accurately. Failure do so will result in claim denials and transfer of payment responsibility to you.
3) It is your responsibility to inform us of **any changes to your insurance plan** information at **least 3 business days before your appointment**
4) Our billing office will contact your health insurance to verify network, benefits and eligibility.

Form Fees/Messaging Fees:

1) Requests to fill out forms will incur a service fee. You will be charged **$10 per page, up to 5 pages** (e.g., 2 pages will be billed $20). Any more than **5 pages, the charge will be capped at $50**, with rare exceptions.
2) **Medical Records fee** - **$25 (for up to 25 pages)** and **$0.50 per page after first 25 pages**
3) **Custom letters** will cost **$25 or $50** depending on complexity and time involved.
4) **Responses to your electronic messages**, that require your **provider's clinical time and expertise to answer, will be billed**. These messages (e.g., Portal, Klara, Voicemail) that will be billed take longer for your provider to answer — typically taking 5+ minutes for your provider to respond.

   Such messages include but not limited to:
   - Changes to your medications
   - New symptoms
   - Changes to a long-term health condition
   - Check-ups on your long-term health condition
   - Request for additional labs/tests

   The provider looking at your message would be reviewing the information you sent over and changing part of your treatment plan, or recommending you to get a test, as indicated. The provider may need to look at your medical history and do an in-depth review of your records to provide his/her recommendations. **A service fee of $40** will apply for this (this will not be covered by your insurance plan). Your provider at his/her own discretion may recommend you make a follow-up appointment for situations that would not be best handled through messaging or would require follow-up assessments following messaging.

Lab orders:

1) Any lab or radiology orders/requests that your provider orders are intended from a medical perspective to either help diagnose/identify a medical condition or for ongoing surveillance of a pre-diagnosed medical condition. The provider or our company is not responsible for any payments due to the labs/imaging centers for these tests. It is your responsibility to check with your insurance for coverage for these labs/tests. **Any charges** (that result from getting these tests done) that are **not covered by your insurance plan will be your responsibility.** The provider or our company is in no way responsible to make payments for these tests on your behalf.

Patient Assistance Programs:

1) If a request is made to help fill a **patient assistance form** for a medicine that has been prescribed by our provider, a **service fee of $25** will apply (**per medicine or device**). We are unable to receive or stock your supplies/product(s) at our office, but we suggest that you have the product shipped directly to your residence by the manufacturer/supplier.

I have read, understood, and accept this policy. I am responsible for any payments outlined above.

Patient Name: _____ Patient signature: _____ Date: _____