PATIENT REGISTRATION & HIPAA COMPLIANT CONTACT INFORMATION - PLEASE PRINT

Patient Name: _____ Date of Birth: _____ Marital Status: S M D W

I authorize Desert Endocrinology to leave messages regarding my general care, appointment and billing information at the contact information provided below.

Home phone: _____ Cell phone: _____ Work phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Additional Contact: _____ Phone: _____

Pharmacy Name/Address: _____ Phone: _____

_____ I give Desert Endocrinology my consent to access my Rx history as available, through pharmacy databases.
initials

Referring MD, DO, PA-C, APN: _____ Primary Care Provider: _____

Primary Insurance	Secondary Insurance
Insurance: _____	Insurance: _____
Insured's Name: _____	Insured's Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
Insured's DOB: _____	Insured's DOB: _____
Insured's Insurance ID#: _____	Insured's Insurance ID#: _____
Insured's employer: _____	Insured's employer: _____

BILLING AND OPERATIONAL AGREEMENTS

I have read, understood and agree with Desert Endocrinology's Information Disclosure Policy. I AUTHORIZE DESERT ENDOCRINOLOGY TO COMMUNICATE /LEAVE MESSAGES regarding my general care, appointment and billing information at any of the contact information provided above and with any contact information I may verbally provide in the future as my address and contact numbers may change from time to time.

All co-payments, deductibles, co-insurance and cash based appointment payments are due at the time of your appointment. We reserve the right to collect on Health Reimbursement Plans.

Your insurance company may not cover all of the services your doctors provide; it is your responsibility to know what is and is not covered by your plan.

If your health plan requires a referral or written authorization for specialists visits, it is your responsibility to obtain a referral. It is your responsibility to make sure we are participating providers with your insurance. Moreover, you agree it is your responsibilty to check with your insurance company if any facility or physician we refer you to is in your carrier's network and you accept financial responsibility for the cost of those services.

In the event you are unable to keep your appointment, please call 24 hours prior to your appointment time to cancel or reschedule. By doing this, we can accommodate other patients waiting for appointment openings. A fee up to $75 may be billed to your account for all appointments NOT cancelled or rescheduled 24 hours prior to your appointment.

Insurance companies may be billed as a courtesy to you. You are responsible for any amounts not paid by your insurance company, such as, but not limited to amounts applied to deductibles, insurance non-payments, payment denials and shortages up to contracted allowables. Should this account become delinquent, you are responsible for any and all legal fees, court costs, late fees and collection charges involved as a result of any collection activity, plus 18% interest. You agree to pay all fees derived from canceled or reversed electronic transactions.

The terms of this agreement supercedes any prior agreements made by either party with insurance, self funded carriers, networks or third party administrator companies. I have read, understood and agree to comply with the above terms. I authorize my insurance benefits to be paid directly to Desert Endocrinology or its physicians and I understand and agree that I am financially responsible for non-covered or denied services. I authorize this office to release any information required in the processing of this claim.

_____ _____
Signature Date