

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 following contact information: email: _____
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.

Yes No I am interested in participating in clinical research.

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

Primary Insurance

Secondary Insurance

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

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BILLING AND OPERATIONAL AGREEMENTS

I have read, understood and agree with Desert Endocrinology's Information Disclosure Policy. I AUTHORIZE DESERT ENDOCRINOLOGY TO LEAVE MESSAGES regarding my general care, appointment and billing information at any of the contact information provided above.

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 we provide. It is your responsibility to know what is and is not covered. The laboratory phlebotomist is not part of Desert Endocrinology. You must pre-arrange with him/her to send your specimen to the laboratory of your choice. The phlebotomist is present for patient convenience; Desert Endocrinology will not be held responsible for any billing issues regarding labs. Lab billing issues are between the patient, laboratory and insurance company.

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.

You are responsible for all fees derived from canceled or reversed electronic transactions.

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. 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.

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