DIABETES CARE CENTER

PATIENT INFORMATION FORM

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Diplomates of the American Board of Internal Medicine
Diplomates of the American Board of Endocrinology, Diabetes and Metabolism

Date:_____ Patient No. [ ]

Name: _____ Home Phone: (_____) _____-_____
(Last) (First) (MI)

Local Address:_____
(Street Name and Number)

_____
(City) (State) (Zip)

Email Address:_____

Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ W ❑ D Date of Birth_____/_____/_____ Age: _____

Social Security #: _____-_____-_____ Driver's License No.: _____

Who is Financially Responsible for this Bill? _____

Are You Employed? ❑ Yes ❑ No

Employer Name: _____ Work Phone: (_____) _____-_____

Job Title: _____ Description/Duties:_____

_____

Spouse's Name: _____ Work Phone: (_____) _____-_____

Spouse's Employer Name: _____

Spouse's Date of Birth_____/_____/_____ Spouse's Social Security #: _____-_____- _____

Whom May We Contact in Case of Emergency (other than spouse):_____ Phone:(_____) _____-_____

Whom May We Thank for Referring You to Us? _____

Primary Care Physician:_____ City:_____State:_____Phone: (_____) _____-_____

Name of Pharmacy:_____ Phone: (_____) _____-_____

INSURANCE INFORMATION - (Please show card to receptionist)

****PRIMARY Insurance or Medicare**: _____

Policyholder's Name:_____ Social Security No.:_____/_____/ _____
(Last) (First) (MI)

Does Your Insurance Require a Referral: ❑ Yes ❑ No Co-Pay Amount: $_____

Insurance Company Address: _____
(Street) (City) (State) (Zip)

Policy ID / Certificate No.: _____ Group Name & No.: _____
(Make sure you name the one that pays for physician services)

****SECONDARY Insurance or Medicare**: _____

Policyholder's Name:_____ Social Security No.:_____/_____/ _____
(Last) (First) (MI)

Insurance Company Address: _____
(Street) (City) (State) (Zip)

Policy ID / Certificate No.: _____ Group Name & No.: _____

(PLEASE READ PAGE 2 OF THIS FORM)

LIFETIME AUTHORIZATION
Insurance Assignment and Authorization to Release Information

I. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any Diabetes Care Center physician examining and/or treating me to release to any other healthcare provider or third party payor (such as an insurance company or governmental agency, i.e. Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by any party for its use in treatment or determination of payment for services.

If we are unable to contact you personally, are we authorized to leave your personal medical information on your telephone answering machine/voicemail? Yes ☐ No ☐

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named patient, hereby authorize payment directly to any Diabetes Care Center physician examining or treating me.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carrier any information needed for this or any related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENT TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. A photocopy of my signature is as valid as an original.
This assignment will remain in effect until revoked by me in writing.

I acknowledge final responsibility for the payment of services rendered to me. I understand and agree that health insurance policies are an arrangement between my INSURANCE CARRIER AND ME. I understand and agree it is my responsibility to pay any deductible amounts, co-insurance, co-pays and non-covered services, or any other balance not paid by my insurance carrier, in accordance with state and federal statutes.

As a courtesy to you, we will file your claims to your insurance carrier. If you have a Medicare supplement, we will bill the supplement. If they do not respond to the claim, it will be your responsibility to contact the insurance company and pay your out of pocket expenses.

Our office charges a fee based on Florida Statute 832.07 for any returned check. If your account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to recover the cost of collection. If this account is turned over to a collection agency, then the prevailing party shall be entitled to recover the cost of collection which may be as high as 40% of the outstanding balance.

I have read and agree to all the above terms, authorizations and conditions.

SIGNED _____ DATE_____

Responsible Party Signature _____ DATE_____