

TEXAS DIABETES & ENDOCRINOLOGY, P.A.

6500 N. MoPac Expwy.
Bldg. III, Suite 200
Austin, TX 78731
(512) 458-8400

PATIENT DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____ M or F

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Marital Status: Single / Married / Separated / Divorced / Widowed

Referring Physician: _____ Phone: _____

Social Security Number: _____ TX Drivers License: _____

Employer Name: _____ Phone: _____

Address: _____

Emergency Contact: _____ Phone: _____ Relation: _____

MINOR PATIENTS – please provide a *parent or guardian's* Name and Social Security Number –

Parent/Guardian (print) _____ SS#: _____

****Please complete this section regarding your insurance coverage and present your card to the person at the front desk. Thank you.****

Primary Insurance: _____ Insurance Phone #: _____

Insured Name: _____ DOB: _____ Relationship: _____

Policy #: _____ Group #: _____

Secondary Insurance (if any): _____ Insurance Phone #: _____

Insured Name: _____ DOB: _____ Relationship: _____

Policy #: _____ Group #: _____

In order to provide private/confidential information to our patients, we are asking that you complete the following questionnaire. Please be as thorough as possible and print legibly.

Most convenient means of communication of appointments, lab results and general information:

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email address: _____

Please be advised that our Privacy Policy is posted in our waiting room for you to review.

Should you have any questions concerning this policy, please inquire at the front desk.

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Mastercard and Visa.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of the Patient

Signature of Patient or Responsible Party if a Minor

Date

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Texas Diabetes & Endocrinology, P.A. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Texas Diabetes & Endocrinology, P.A. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Texas Diabetes & Endocrinology, P.A. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature

Date

Witness

Date

Texas Diabetes & Endocrinology, P.A
Patient Information – Revised 07/30/2007

Due to the many changes in healthcare and our ability to comply with those changes and the growth in our practice, we have designed the following policies and procedures for our office. This handout is designed to provide you with the concise information about conditions, expectations and procedures by the physicians and our staff.

Appointments: We will make every effort to schedule an appointment within a reasonable time frame. Sometimes an appointment may take longer than planned or an emergency may arise. Every effort is made to stay on schedule. Patients arriving more than 10 minutes late for an appointment will be asked to reschedule. Please be advised that if you cancel your appointment less than 24 hours in advance repeatedly or no-show for an appointment twice we will document this in our files and ask that you find medical care with another physician. There will be a \$50 charge for all no shows and appointments cancelled with less than 24 hours notice.

Letters: If you request that we generate a letter on your behalf, your account will be charged \$25. The fee is due when the letter is requested. This is not a covered insurance benefit and will be billed directly to the patient.

Lost Items: Should you misplace any items generated by this office there will be a \$10 charge for replacing them. This is not an insurance benefit and is due at the time of the request. This includes lost prescriptions, lab requisitions and physician orders for testing.

Lab Reporting and Review: Most labs will be done prior to your office visit and discussed during that visit. When lab is ordered at a new patient visit and/or consult, lab will be discussed at a face-to-face reports visit which is scheduled at the end of the first visit. If lab is done between visits, it will be reported between 1-2 weeks after it is done. If you have not heard from us by mail or phone concerning your lab by the end of the second week, please contact our office. Lab done by other physician's offices will not be reported without a scheduled visit with our office. If you would like for us to review and interpret labs done elsewhere, please get the copies of the lab and bring them with you to the visit. WE WILL NOT BE RESPONSIBLE FOR OBTAINING LAB DONE AT OTHER OFFICE. This is your responsibility. We discourage having labs faxed to us as it is our experience that labs or results that are supposed to be faxed are not sent to us about 50% of the time which is why we require that you bring the lab results with you.

Medication Refills: Refills will only be done at the time of an office visit. It is your responsibility to keep with medications and refills. This includes diabetes supplies, medications and insulin pump supplies. We will provide 30 and/or 90 day scripts at the time of the visit if you request refills. If your insurance changes and your scripts need to be re-written there will be a \$25 charge. This is not a covered insurance benefit and will be due at the time of pick-up or mailing. We will not sign for generic substitutions between visits. All prescription functions must be taken care of at the time of your visit.

Nurse Call Backs: If you need to speak with the nurse and they are unavailable, you will be asked to leave a voicemail message. Voicemail is checked in the morning and after lunch. Messages left in the morning will be returned the same day. Messages left after 4:00 will be returned the following business day. In emergent situations, please speak directly with the receptionist.

Signature: _____ Date: _____ Witness: _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority