WELCOME BACK TO TEXAS DIABETES & ENDOCRINOLOGY, P.A.

THANK YOU IN ADVANCE! WE APPRECIATE YOU UPDATING YOUR INFORMATION ANNUALLY SO WE CAN BETTER ASSIST YOU.

PLEASE TURN THIS INTO THE FRONT DESK WHEN COMPLETED.

Patient Name: ____ Date of Birth: __________________ Legal Gender: M or F

Address: ____City_____________________ State________ Zip______________

Marital Status (please circle) : Single / Married / Separated / Divorced / Widowed / Other ____________________________

Race (please circle): White / African American / Asian / American Indian / Other_____________________________________

Ethnicity: __________________ Preferred Language: __________________ Email address: ___________________________

Social Security Number: ______________________________ Drivers License: ______________________ State: ___________

Employer Name: ____ Phone: __________________________________

Primary Insurance: __________________________________ Policy #: __________________________ Group #: _______________

Secondary Insurance: ________________________________ Policy #: __________________________ Group #: _______________

Pharmacy Benefits: _________________________ Policy #:________________________ RX Group#___________ RX Bin#________

Emergency Contact: _______________________________Phone: ________________________ Relation: _________________

Primary Care Physician: ____Phone: ___________________________________

Most convenient means of communication for appointments, lab results and general information:
Please note: if you provide an email address, we can communicate to you via our patient portal.

Home Phone: _________________________________ Cell Phone: __________________________________

Work Phone: _________________________________ Email address: _______________________________

Appointment reminders are sent through an automated service via Text Message. If this is not convenient, please let us know.

Preferred method for receiving appointment reminders: ☐ Email ☐ Home Phone

If you wish to not be reminded of any future appointments at all, please select this box: ☐ DO NOT CONTACT

Signature: ____ Date: ____________________________

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

Parent/Guardian (print) ____

Parent/Guardian (signature) ____

SS#______________________________

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

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.

Full payment is due at the time of service for self-pay patients unless other arrangements have been made in advance. For your convenience we accept Discover, Mastercard, Visa, Personal Checks and Cash.

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 on your behalf. You will only be responsible for any "out of pocket" expenses at the time of service including: copays, coinsurances, and deductibles.

- If you have insurance coverage with a plan for which we do not have a prior agreement, payment is due at the time of 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 office. Any balance due is your responsibility and is due at the time of service. A credit card can be placed on file for you out of convenience, just ask a receptionist.

- If you have Medicaid or obtain Medicaid at any time during your care, you understand TD&E is accepting you as a private pay patient and that you are responsible for payment of any and all services rendered at time of service. TD&E will not file a claim to Medicaid for the services that are provided to you. Your signature below indicates your understanding and agreement with this policy.

Minor Patients:

- For all services rendered to minor patients, the accompanying adult or the parent/guardian with custody is responsible for payment.

Other Fees:

- If you have a balance on your account, you will receive a total of two statements. Should your account become more than 60 days past due, your account may be sent to a collections agency. A collections fee of 30% of your total balance will be added to your account. Please note: If you have an appointment scheduled, the total balance will be due upon check-in. If you are unable to pay the full amount, a payment arrangement can be made with a credit card on file. Failure to resolve your account will result in your appointment(s) being canceled.

- In certain circumstances, your provider may charge for telephone services that include more extensive medical discussions. This charge will be billed to you directly.

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.

____ **DOB: _____________________**

Printed Name of the Patient

____ Date ______________________

Signature of Patient or Responsible party if a Minor

Texas Diabetes & Endocrinology, P.A.

Friendly Patient Reminders

Appointments: We will make every effort to schedule an appointment within a reasonable time frame with one of our practitioners. We appreciate our patients and understand that your time is valuable. Our goal is to be as punctual as possible and to see you in a timely manner. We require a 24 hour notice to cancel your appointment. This allows us to give your appointment to another patient. There is a $50 charge for no show appointments and same day cancellations. If we are unable to confirm your appointment due to incorrect phone numbers, your appointment will be cancelled.

Lab Reporting and Review: Lab testing is a necessary tool in the treatment of chronic conditions. It is important that you get your lab tests done and keep your follow up appointments to discuss your plan of care. If lab testing is done between visits, results will be reported within two weeks through our patient portal or via mail. You may be contacted via phone by a nurse with instructions. Please allow two weeks before contacting our office to allow time for lab processing, review, and mailing of results. If you would like for us to review and interpret labs done elsewhere, please get copies of the labs and bring them with you to the appointment. **PLEASE NOTE: CLINICAL PATHOLOGY LABORATORIES (CPL) IS OUR DESIGNATED LAB. IF YOU USE A DIFFERENT LAB, PLEASE NOTIFY YOUR PROVIDER AT YOUR VISIT. WE ARE NOT RESPONSIBLE FOR OBTAINING LABS DONE AT OTHER OFFICES.**

Medication Refills: We provide 30 and/or 90 day prescriptions and refills are done at the time of your appointment. We send prescriptions electronically, so if you are using a mail order company please notify them when you would like your prescriptions filled and shipped. If you need a refill between visits, please do not contact our office. Contact your pharmacy and they will send a refill request on your behalf. Please allow 48 hours for processing of these refills.

Nurse Call Backs: To better serve your needs, nurses are available via phone from 8:30a.m. – 12:00p.m. and 1:30p.m. – 4:30p.m. If the nurses are unavailable, please 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 4:30p.m. will be returned the following business day. If you have an urgent request, please speak directly with the receptionist and do not leave a message.

HIPAA RELEASE OF INFORMATION

I acknowledge that I have received Texas Diabetes & Endocrinology's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information. Please list names, relationships, and contact numbers of all persons TDE is authorized to release medical information to.

______________________	______________________	______________________
Name	**Relationship**	**Contact Number**
______________________	______________________	______________________
Name	**Relationship**	**Contact Number**
______________________	______________________	______________________
Name	**Relationship**	**Contact Number**

______________________________ **DOB:** ____________________

Printed Name of the Patient

______________________________ Date ____________________

Signature of Patient or Responsible party if a Minor

Auto Pay Withdrawal Authorization

I, ____________________________, hereby authorize Texas Diabetes & Endocrinology, P.A. to debit my credit card for any amount that is in my responsibility. Texas Diabetes & Endocrinology, P.A. will file my claim to my insurance on my behalf (if applicable-please see Private Pay Agreement). Once the patient responsibility portion has been determined, Texas Diabetes & Endocrinology, P.A. will charge my credit card on file for the amount due and email me a receipt of payment. I understand that I may still be able to dispute said charge at any point up to 90 days from the date of service. I also may request that if the amount due exceeds a certain limit that I be called prior to deducting payment from my card.

_________________________________ _________________________

Signature of Patient or Responsible Party Date

______________________________ _________________________

Email Phone #

Credit Card Information

I understand that this authorization will remain in effect until you cancel it in writing. I agree to notify Texas Diabetes & Endocrinology, P.A. in writing of any change in my account information or termination of this authorization. I certify that I am an authorized user of this account.

Type of Card: **We do NOT accept AMEX or Care Credit.*

☐ VISA ☐ MasterCard ☐ Discover

Patient Name: ____ Patient DOB:__________________

Name of card holder (as it appears on the card):____

Credit Card #: ______________________________ Expiration Date (mm/yy): _______________

Zip Code of the cardholder (from the billing address of the credit card): ______________________

Office use only

Witnessed by (employee's name): _______________________________

Date: ________________________________