SOUTH ORANGE COUNTY ENDOCRINOLOGY PATIENT INFORMATION SHEET

Marital Status: Single Married Divorce Widow

Name: ______________________________ **Gender**: Male Female

Address: ______________________________ **Date of Birth**: ____________ **Age**: ____________

City, State, Zip: ______________________ **Cell Phone**: ______________________________

Home Phone: __________________________ **Email**: __________________________________

Work Phone: __________________________ **Referring Physician**: ________________________

Pharmacy phone and address: ____

Nearest relative not living with you in case of Emergency: __________________________

Phone: ______________________________ **Relationship**: __________________________

Insurance Information/Person Responsible for Account (MEDICARE ONLY)

Primary Insurance: __________________________ **SS# of Primary Subscriber**: ______________

ID/Policy #: __________________________________ **Group #**: ______________________

Primary Subscriber's Last Name: ______________________ **First Name**: ______________________

Relationship to Patient: ______________________ **Primary Subscriber's DOB**: ______________

Subscriber's Address: ____

Employer: ____

Employer's Address: ____

Secondary Insurance: ______________________ **SS# of Secondary Subscriber**: ______________

ID/Policy #: __________________________________ **Group #**: ______________________

Secondary Subscriber's Last Name: ______________________ **First Name**: ______________________

Relationship to Patient: ______________________ **Secondary Subscriber's DOB**: ______________

Subscriber's Address: ____

Employer: ____

Employer's Address: ____

SOUTH ORANGE COUNTY ENDOCRINOLOGY AUTHORIZATION TO RELEASE

INFORMATION AND ASSIGNMENT TO PAY PROVIDER DIRECTLY

I hereby authorize payment directly to South Orange County Endocrinology of the insurance benefits to which I am entitled. I understand that I am financially responsible for charges not covered by this assignment. A photocopy of this authorization will be considered as valid as the original.

Patient Signature: ______________________________ **Date**: ______________________________

(Parent/Guardian if patient is a minor)

I hereby authorize South Orange County Endocrinology to provide information to insurance carrier and/or referring or family physician concerning my condition and treatments rendered. A photocopy of this authorization will be considered as valid as the original.

Patient Signature: ______________________________________ **Date:** ____

(Parent/Guardian if patient is a minor)

Appointment/Cancellation/No Show Policy

South Orange County Endocrinology

Appointments:

Office visits are by appointment only please call **(949)770-4177**. Please **arrive 10 minutes early** for your appointment. Patients who are late for an appointment may be asked to reschedule at the physician's discretion. Remember to bring all your prescriptions, over-the-counter medicines, vitamins, and supplements to each office visit. If you would not like to bring all your medications please bring a **current medication list**. This will enable Dr. Marcus to review the medications at each visit. We kindly ask to **call the office back when we are leaving messages to confirm your appointment**.

Cancellations:

We would like to thank you for being a patient in our office. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, **please give us at least a 24 hours' notice**. This courtesy makes it possible to give your reserved time to another patient who would like it. We know your time is valuable.

Missed Appointments (Non-Cancelled)

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. We track missed (non-cancelled) appointment. A **"NO SHOW/LATE CANCELLATION"** is defined as missing an appointment without cancelling 24 hours before scheduled time. There will be a charge for a missed non-cancelled appointment. **The fee is $50**. **No refunds will be given**. Repeated missed appointments may result in a letter discharging you from the practice. We will offer a 30 days of emergent care only and transfer your records when you find a new doctor.

Payment

Payment is due in full at the time of service **no exceptions**.

______________________	______________________	______________________
Patient Name	**Signature**	**Date**

Dear Patient, Please Read This and Sign Below

Per HIPPA regulations, we are required to ask you to sign **Acknowledgment of Receipt of Notices of Privacy Practices.** You have the right to refuse our request, in which case, we must document your refusal for the record.

Sign your acknowledgment below for having reviewed your **Notice of Privacy Practices** and then return this page to our staff. **Thank You**

PATIENTS ACKNOWLEDMENT OF RECEIVING NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided my personal copy of my health care providers Notice of Privacy Practices to read and keep as my own.

____

Patients Name

____

Signature of Patient or Parent Responsible Party

____

Patients Date of Birth

____

Print Name of Patient or Parent Responsible Party & Relationship to Patient

____

Patients Social Security Number

____

Today’s Date

Patient Liability Financial Agreement

South Orange County Endocrinology is dedicated to providing the very highest level of care and service to all of our patients. South Orange County Endocrinology and our staff will make every effort to ensure that you receive quality medical care which is medically necessary; however, please be aware that your health plan or designated medical group makes the final determination regarding your care.

We will bill your insurance company for the healthcare services you receive in our office, less any co-payment(s) or deductibles(s), and with the exception of private insurances. In the event that your insurance company denies payment for services as a result of **BUT NOT LIMITED TO,** any of the reasons listed below, you will be held financially responsible for the charges incurred.

Payment may be denied if your health plan or medical group determines:

- The care given is not medically necessary.
- The care given is a non-covered benefit.
- The recipient is intelligible to receive the insurance benefit.
- Services not covered for a **non-participating provider.**

Please remember, it is the patient's responsibility to know how their insurance works and South Orange County Endocrinology will not be held responsible for any financial decisions made by said insurance company. Your coverage us a contract between you and your insurance company disputes are not to be taken up with your insurance company and are not our responsibility.

Should we terminate our contract with your insurance company, please be aware that it is your responsibility to verify that information prior to **EVERY** visit not ours. Also, due to contracts between you and your insurance, we are **NOT** required to notify you when we terminate with insurance.

Therefore, any services which are denied for reasons such as, but not limited to, "non-covered" or "not medically necessary" will be financial responsibility of the patient.

I also agree that should I refuse to or fail to pay any co pay's, deductibles, or outstanding balances and I am sent to a collection agency, I will also be responsible for any collection fees set forth by South Orange County Endocrinology. (Breakdowns of the fees are available upon request.)

I have read the above information and understand its content and will accept financial responsibility for such services

Signature: ________________________________ **Date**: _________________