

## Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form. If you have any questions, we'll be glad to help you.

Last NAME \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Phone (Home) ( ) \_\_\_\_\_ (Work) ( ) \_\_\_\_\_  
Social Security No. \_\_\_\_\_ Driver's License No. \_\_\_\_\_  
Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_  
Employed by \_\_\_\_\_ Phone (work) \_\_\_\_\_  
Name and Phone of closest Relative/Friend (in emergency) \_\_\_\_\_

Name of party responsible for bill \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Referred by \_\_\_\_\_

PLEASE PRESENT ALL INSURANCE CARDS AT THE FRONT DESK

Name of Primary insurance company \_\_\_\_\_  
Policy no. \_\_\_\_\_ Group no. \_\_\_\_\_  
Deductible \$ \_\_\_\_\_ Co-payment \_\_\_\_\_

Name of Secondary insurance company \_\_\_\_\_  
Policy no. \_\_\_\_\_ Group no. \_\_\_\_\_  
Deductible \$ \_\_\_\_\_ Co-payment \_\_\_\_\_

**MEDICARE:** This Office will file all Medicare Claims and accepts Medicare assignment. We will bill Medicare and one secondary Insurance. The patient is responsible for all deductibles and any co-payments not covered by their supplemental insurance.

**INSURANCES:** Most HMO's and some PPO's require pre-authorization for services. If pre-authorization is not obtained and/or the HMO/PPO refuses to cover within 60 days, the patient is responsible for services rendered. If unsure of coverage, contact your HMO/PPO.

**LABORATORY:** Laboratory work charges are billed by the Lab and separate from our Services. If you would like your lab work to go to a specific laboratory, please notify the Medical Assistants. It is always a good idea to check with your Insurance Company to be sure the Lab studies are covered and that the lab has a current Contract to provide services.

I have read and understood all of the above and give my consent for medical treatment. We follow HIPAA Guidelines (copy available upon request). I hereby authorize Tri-City Endocrinology and Metabolism to release any medical and/or billing information to my insurance company and/or my Referring or Consulting Health Care Providers.

\*Patient signature \_\_\_\_\_ Date \_\_\_\_\_

\*Updated Month \_\_\_\_\_ Year \_\_\_\_\_ Revised 3/20/07