

# Diabetes & Endocrinology Consultants - Patient Information

## PATIENT

Name \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
First Middle Last Who may we thank for referring you to us?

Mailing Address \_\_\_\_\_  
Street City State Zip

Home Address \_\_\_\_\_  
Street City State Zip

Male  Female  Marital Status: Single  Married  Widowed  Divorced  Separated

Language Spoken: English  Spanish  Other \_\_\_\_\_ Ethnicity (optional): \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Spouse Name \_\_\_\_\_

E-mail \_\_\_\_\_ **PLEASE PRINT CLEARLY**

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

## EMPLOYMENT

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_

## RESPONSIBLE PARTY (If patient is under 18, we must have person legally responsible)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS # \_\_\_\_\_

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INSURANCE INFORMATION	PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insurance Co.		
Policy #		
Group#		
Policy Holder/Subscriber		
Date of Birth of Policy Holder		
Social Security # of Policy Holder		
Employer of Policy Holder		

PREFERRED PHARMACY AND PHONE # \_\_\_\_\_

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Diabetes & Endocrinology Consultants, PC to furnish information to any doctor, hospital, or insurance carriers pertinent to my medical care, which may include treatment for physical/emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS or AIDS related information. I assign payments to Diabetes & Endocrinology Consultants, PC from contracted insurance companies and networks for medical services rendered to myself or my dependents.

\_\_\_\_\_  
**Patient's Signature or Responsible Party** \_\_\_\_\_  
**Date**

## Financial Policy

This is just a friendly reminder of this medical office's financial policy. We often find ourselves in the awkward position of discussing finances with patients at the time of their visits. We feel that the better you understand our policies, the better we will be able to serve you.

Please bring your insurance card(s) for us to copy. Payment for all co-pays, deductibles and any other charges are due at the time you check-in for your visit. We accept cash, personal checks, and most credit cards. Please make certain that you bring one of these forms of payment with you each time you visit our office. **To speed the check-out process we collect co-payments at check-in time.** If you are unable to pay your entire bill, please ask to speak with one of our billing administrators who will be happy to discuss payment arrangements. For our patients who are totally uninsured, we will do everything possible to work out a monthly payment plan to suit your needs.

As a service to our patients, we will file insurance claims for almost all insurance companies once you have provided your complete insurance information. We apologize that we cannot participate with every form of insurance for all of our patients. We do have contracts with

- Medicare (and "automatic" secondary crossovers),
- N.C. & Federal Blue Cross/Blue Shield Plans,
- Atlantic Integrated Health (AIH), and
- Tricare Prime Specialty (you still need to get an authorization for Tricare)

With the exception of Medicare, BCBS and AIH, you are financially responsible for the portion of the bill your insurance company does not pay. Please remember, your insurance coverage is a contract between you and your insurance company. We will do everything possible to expedite your claim with proper filing and forms; however, you are responsible for all fees. Please also advise our office if there is any change in your insurance plan or benefits. Please remember, most of our policies are based on those of YOUR insurance provider.

### **ACKNOWLEDGMENT OF FINANCIAL POLICY**

I, the undersigned, acknowledge the Financial Policies of Diabetes & Endocrinology Consultants. I understand that I am financially responsible for all charges relating to co-payments, deductibles and non-covered services at the time of my visit. I authorize my insurance benefits to be paid directly to Diabetes & Endocrinology Consultants. I acknowledge that if I have insurance coverage other than those listed above, or if I am uninsured, that I am responsible for all charges incurred in this office at the time of service. I understand that all unpaid balances that are 90 days past due are sent to a collection agency, and I will be discharged from Diabetes & Endocrinology Consultants unless prior arrangements have been made with a billing administrator.

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**Patient's Signature or Responsible Party**

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**Date**

### **ONE TIME AUTHORIZATION FOR MEDICARE ONLY**

I authorize any holder of medical or other information about me to release to the Social Security Administration Health Care Financing Administration or its intermediate or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Diabetes & Endocrinology, a participating provider in the Medicare system. Regulations pertaining to Medicare assignment of benefits apply.

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**Patient's Signature or Responsible Party**

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**Date**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
DIABETES & ENDOCRINOLOGY CONSULTANTS, PC**

The undersigned hereby acknowledges receipt of a copy of the Notice of Privacy Practices and FAQ (Frequently Asked Questions) brochure of Diabetes & Endocrinology Consultants, PC.

I authorize Dr. Lucas and/or her staff to leave medical or account information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes. If neither the YES or NO selection is marked, we will consider YES to be your selection.

Home answering machine	Yes <input type="checkbox"/> No <input type="checkbox"/>	Work telephone	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cell phone	Yes <input type="checkbox"/> No <input type="checkbox"/>	Voice mail	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	E-mail	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please list names of authorized people (such as spouse, parent, etc.)

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**APPOINTMENT REMINDER CALLS, NO-SHOW FEE, & E-VISIT SERVICE CHARGES**

Please provide as much notice as possible if unable to keep your appointment. You should receive an appointment reminder card when your appointments are made in our office. You should also receive a telephone reminder call for all appointments **2 days** prior to your scheduled office visit. **You will be charged for the office visit if you fail to cancel in a timely manner and do not keep your scheduled appointment. If you fail to keep 3 appointments without giving us proper notice, you will be discharged from the practice.** The new patient (and patients not seen in over a year) no-show fee is \$50. The regular “recheck” office visit no-show fee is \$25. We do not want your no-show fee; we want you to keep your appointment or call ASAP to make the time available for another patient. **No-show fees are donated to diabetes related charities.**

When you call us on the telephone or contact us via e-mail, we make every effort to answer questions and provide assistance free of charge. However, if your requests require a significant allocation of time on the part of our nurses and/or doctors, we often find it necessary to charge a minimal fee for the time allocated to your request. Most insurance companies recognize the necessity for medical offices to charge for their time in this way and provide us billing codes; however most insurance companies still consider this a non-covered service and the charges will most likely be your responsibility. Additional details are available in the FAQ (Frequently Asked Questions) section of [www.BeachDoctor.com](http://www.BeachDoctor.com) or the FAQ brochure available in our office.

\_\_\_\_\_  
**Patient's Signature or Responsible Party**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Print patient's name here