ASSOCIATED ENDOCRINOLOGISTS

Patient Name _____ Date of Birth _____ Gender F M Marital Status M S W

Home Address _____City_____State_____Zip_____

Main Phone Number (Test Results/Reminder Calls): (_____)_____Texting Ability? Yes / No

Alternate Phone Number _____ Main E-mail Address_____

Employer _____ Occupation _____

Referred By _____ Primary Care Physician _____

EMERGENCY CONTACT INFORMATION

Last Name: _____First Name:_____Relation:_____

Phone (_____)_____ □Cell □Home □Work

Guarantor Name:_____Relationship: _____ Last 4 of SS _____

Address (if different from above): _____

Phone (_____)_____ □Cell □Home □Work

□Yes □No Initial:_____ Is this individual authorized to receive protected health information?

Primary Insurance Subscriber Name _____ Subscriber Date of Birth _____

Primary Insurance Company _____ Contract Number _____ Group _____

Employer _____ Employer Phone Number _____

Secondary Insurance Subscriber Name _____ Subscriber Date of Birth _____

Secondary Insurance Company _____ Contract Number _____ Group _____

Employer _____ Employer Phone Number _____

Initial: _____ By initialing, I give permission to leave medical information on my answering machine.

Initial: _____ By initialing, I give permission to discuss my healthcare with family members.

By signing below, I acknowledge that I have reviewed the NOTICE OF PRIVACY PRACTICES from Associated Endocrinologists/MHP.

_____ (initial)

I hereby authorize my insurance benefits to be paid directly to the above physician, realizing I am responsible to pay Non-covered services as well as an assignment of the right to pursue payment, other alleged ERISA violations, and the right to pursue all causes of action, including, but not limited to the right to pursue payment and other ERISA claims.

_____ (initial)

Signature (Authorized Representative) _____ **Date** _____

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGMENT

On (date) _____ (name of employee) _____ presented this Acknowledgment of Receipt of Notice of Privacy Practices Form to (patient's name) _____.

The patient refused _____ or could not _____ provide a signature when requested. _____ (initial)