ALLIANCE ENDOCRINOLOGY

NEWPATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS DATE: _____

Legal Name: First _____MI _____ Last _____DOB: _____

Address: _____City: _____State_____Zipcode: _____

SS# _____Sex: □ M □ F E-mail: _____

Phone: Home _____Work:_____Mobile: _____

Marital Status: □ Married □ Single □ Widowed □ Divorced Occupation:_____

Spouse's Name: _____Phone:_____

Emergency contact: _____Relationship: _____Phone:_____

Referring physician: _____Phone number: _____

Primary Care physician: _____Phone number: _____

FINANCIALLY RESPONSIBLE PARTY – GUARANTOR

□Same as Patient Information (If different, please complete section below)

Name: First _____MI_____ Last _____DOB_____

Relationship: Spouse Father Mother Other: _____Employer Name_____

Address(if different):_____City _____State _____Zip _____

Phone: Home _____Cell _____work_____

INSURANCE INFORMATION

Primary Insurance:_____Policy/ID#_____

Name of Policy Holder: _____DOB _____Group #_____

Employer: _____Employer Address: _____

City _____State_____Zip Code _____Work #_____

Secondary Insurance: _____Policy/ID# _____

Name of Policy Holder:_____ DOB _____Group#_____

Employer:_____Employer Address:_____

City:_____State: _____ Zip code: _____Work#_____

PATIENT PORTAL

The Patient Portal is internet based and used at a personal computer. The Patient Portal is a secure way to:

- Send secure messages to your doctor
- View test results
- Request appointments
- Renew Medication

Please provide your email address below to obtain access to the Patient Portal.

Email Address: _____Signature: _____

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

I authorize Alliance Endocrinology and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Alliance Endocrinology of changes or update. I authorize Alliance Endocrinology to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

If no answer, may we leave a message for you: Home Phone: □ Y □ N Work: □ Y □ N Mobile: □ Y □ N
□ Only Release Information to Patient

Discuss your personal information, including appointments and treatments with someone other than yourself?
Name: _____Relationship to Patient: _____
Home Phone: _____May We Leave a Message? □ Y □ N Mobile:_____ May We Leave a Message? □ Y □ N

Discuss your personal information, including appointments and treatments with someone other than yourself?
Name: _____Relationship to Patient:_____
Home Phone: _____May We Leave a Message? □ Y □ N Mobile:_____May We Leave a Message? □ Y □ N

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise below. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the Internet.

Initials_____

CLINIC GUIDELINES & CONSENT TO TREAT

I have reviewed the clinic guidelines policy and consent to it. Initials:_____

I hereby authorize employees and agents of Alliance Endocrinology (including physicians, physician assistants, and nurse practitioners, and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that in connection with the patient's treatment, photos or videos may be taken.
The duration of this consent is indefinite and continues until revoked in writing.
I understand that by not signing this consent, the patient will not be provided medical care except in the case of emergency.

Patient Name: _____Signature: _____Date: _____

RELEASE OF INFORMATION, AUTHORIZATION, ASSIGNMENT OF BENEFITS

- I authorize the release of all medical records to other physicians and/or specialists if applicable to my care and condition.
- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- I further authorize and request that insurance payments be directed to Alliance Endocrinology.

PRIVACY PRACTICES : Alliance Endocrinology is committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy policy.

ACKNOWLEDGMENT

I have read, fully understand and agree to the above release of medical information to others, financial and payment guideline, clinic guidelines, release of information & assignment of benefits, and privacy practices. I also certify that all of the information, provided is complete and accurate.

Patient Name: _____Signature: _____Date: _____

ALLIANCE ENDOCRINOLOGY

Health Information Exchange Authorization

ALLIANCE ENDOCRINOLOGY participates in health information exchanges.
Frequently Asked Questions document which may be revised at any time.

A Health Information Exchange (HIE) is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. A Health Information Exchange is an electronic health information system that stores your patient health information from multiple healthcare providers participating in the HIEs. It allows your otherhealth care providers to view your past health information for continued care and other uses included in the provider's Notice of Privacy Practices. Your information will be stored within the HIEsystem, but it will not be visible to or able to be used by providers unless you opt-in toparticipate.

I understand that my medical records are confidential and cannot be disclosed without my written authorization except when otherwise permitted or required by law.I understand that my medical information may include communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune DeficiencySyndrome (AIDS), records related to mental health treatment and alcohol and substance abuse diagnosis or treatment, and I authorize release of that information as part of my medical record. Providers will attempt to exclude clearly identified mental health and substance abuse health information from the HIEs, however some information may beincluded.

I authorize the above provider to disclose my medical information described above to the HIEs in which Alliance Endocrinology participates. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by other providers and such information may no longer be protected.

I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time exceptto the extent that action has been taken in reliance upon this authorization. I may submit a revocation request to the above provider for processing. This authorization will remain in effect indefinitely, unless I revoke it in writing.

The HIE is not able to manage restrictions on disclosure of your health information. A restriction is a request by the patient to not disclose certain information tocertain people or companies. If the restriction is or was agreed to by us or other participating HIE healthcare providers, then you must elect to opt-out of the HIE in order to protect your restriction. This must be done at each HIE participating provider you visit.

I authorize release of my medical information to the Health Information Exchanges in which Alliance Endocrinology participates:
___YES ___NO

Acknowledgement:
I, the undersigned, certify that I have read and fully understand the information in this Health Information Exchange Authorization form. I understand that if I need to change any information I have provided on this form, I will notify a staff member promptly.

_____ _____ Print _____
Patient's Name Date of Birth Address

_____ _____ _____
Signature of patient or authorized representative Relationship to patient or self Date

A "legally authorized representative" is; 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian or a minor, or 6) a person authorized under the Texas Consent To Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy. Written evidence of legally authorized representative status must be presented to the clinic prior to release ofany information.

ALLIANCE ENDOCRINOLOGY

Explanation of Patient Financial Responsibility

We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time. Your clear understanding of our Financial Policy will enhance our professional relationship. Thank you for your review and acceptance of this policy.

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.

We accept cash, checks, debit cards and all major credit cards. If you are unable to pay the full copay, you will be asked to reschedule your appointment. Returned checks will be subject to a $30 charge.

Please remember that our relationship is with you, not with your insurance company.
Your insurance policy is a contract between you and your insurance company. Please provide your health insurance information at the time of the visit. As a courtesy, we will file your claim to your health insurance(s)/ Medicare. Insurance will be filed for services rendered.

You are responsible for notifying our office of any changes to demographics or insurance and billing information. Please provide us with details of both primary and secondary insurance. If you fail to provide us with the correct information at the time of services rendered, your insurance may deny the claim and you will be billed the full fees.

Your health plan may refuse payment of a claim for any of the following reasons:
- Diagnosis is a pre-existing illness which is not covered by your plan.
- You have not met your full calendar year deductible.
- The type of medical service or diagnosis is not covered by your plan.
- The health plan was not in effect at the time of service.
- You have other insurance which must be filed first.
- We do not participate in your plan.

Any charges for services not covered by insurance will be the responsibility of the patient. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.
Initial _____

Out of Network services not paid by the health insurance company will be the responsibility of the patient.
Any verification of benefits provided by your insurance carrier is not considered to be a guarantee of coverage. If your health plan denies a claim for any reason, it is your responsibility as a patient to pay the denied amounts in full.

It is your responsibility to keep your account with us current. This includes all outstanding balances due resulting from co-pays, deductibles, non-covered services, billing adjustments, etc. that are reflected in your Explanation of Benefits received from your insurance company and billing statements received from us. You must pay these outstanding balances in full prior to seeing the physician for your next appointment.

I hereby consent to credit bureau inquiries and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process. I understand that these collection attempts could be performed by Alliance Endocrinology or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.

It is required that Self Pay patients with no insurance pay the full amount due at the time of service. If you are unable to pay the full amount at the time of service, we will ask you to reschedule your appointment.

I _____have read and understand the above policies.
(Please print name)

Patient Signature _____Date_____