Thyroid and Endocrine Center of South Texas

Patient Insurance Information Form

PATIENT INFORMATION: **Todays Date:**

Name: **Date of Birth:** MM/DD/YY: AGE

Address: **Social Security #:**

Marital Status: □ Married □ Single □ Divorced □ Widowed

City, State, Zip: **Sex:** □ Male □ Female

Phone (home): **Employment Status:** □ Employed □ Unemployed □ Retired

Phone (Cell) **Employer:**

Although we do not participate in your insurance partnership, information is required for any lab requests from our office.

PRIMARY INSURANCE:

Carrier: **Policy Group:**

Insurance ID#: **Insured Name:**

FINANCIAL AGREEMENT

I understand my insurance is a contract between myself and my insurance company. I understand that I am responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by my insurance company. I agree to pay at the time of service. I understand that I am ultimately responsible for any balance on my account.
choose to extend payments over time.

Patient printed name/Date Patient Signature

RELEASE OF INFORMATION

I hereby allow the **Thyroid and Endocrine Center of South Texas** to furnish any information pertaining to my medical treatment to my insurance carrier, attorney or other providers of service as necessary when **I, the patient, request in writing.** _____ (Initial)

CONSENT FOR TREATMENT

I hereby authorize the **Thyroid and Endocrine Center of South Texas** to examine, treat and perform diagnostic tests and office procedures that the provider deems necessary. If we cannot leave messages we may not be able to contact you regarding followup appointments test results etc. May leave messages on her answering machine regarding her care. **Yes/ No**

PRIVACY PRACTICES

The Thyroid and Endocrine Center of South Texas is required by law to maintain the privacy of a patient's protected health information. In addition we are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. You must list any restrictions on the release of your protected health information:

Check one: □ No restrictions □ Restrictions

If it applies: I am 18 years or older and authorize release of this information to my parents: □ Yes □ No

I have read and agree to the Financial Agreement, Release of Information, Consent for Treatment and Disclosure as listed above. My signature below indicates that I have also received a copy of the **Thyroid and Endocrine Center of South Texas's** Notice of Privacy Practices and I have indicated any restrictions on my protected health information above. Scanned signatures suffice as originals.

Patient or responsible party signature: Date:

Person signing on behalf of patient (print name): Relationship to patient: