MR#: _____

MR# to be entered by the practice

ENDOCRINOLOGY CONSULTANTS
OF EAST TENNESSEE
Balanced Care. Better Life.

Date Completed:	

PATIENT INFORMATION

Patient Name			**SSN#**	**Birthdate**	**Gender**
First	M.I.	Last			☐ Male ☐ Female

Mailing Address			
Street	City	State	Zip

Primary Phone	**Secondary Phone**	**Email Address**

Employer Name	**Occupation**	**Work Phone**

Marital Status	**Student Status**	**Veteran?**
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	☐ N/A ☐ Full-Time ☐ Part-Time	☐ Yes ☐ No

Race	**Ethnicity**	**Primary Language**
☐ White ☐ African American/Black ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown/Other _____ ☐ Prefer Not to Report	☐ Hispanic ☐ Non-Hispanic ☐ Prefer Not to Report	☐ English ☐ Spanish ☐ Prefer Not to Report ☐ Other _____

LEGAL GUARDIAN

If patient is a minor or requires a guardian, provide the information requested below; otherwise leave blank

First	M.I.	Last	Relationship	Primary Phone	Secondary Phone

RESPONSIBLE PARTY/GUARANTOR INFORMATION

If guarantor (individual responsible for fees not paid by insurance) is not the patient, provide information below; otherwise mark "SAME AS PATIENT"

Guarantor Name ☐ SAME AS PATIENT			**SSN#**	**Birthdate**	**Gender**
First	M.I.	Last			☐ Male ☐ Female

Mailing Address			
Street	City	State	Zip

Primary Phone	**Secondary Phone**	**Relationship to Patient**

INSURANCE INFORMATION

If insurance policy holder is different from patient, provide policy holder information; otherwise mark "SAME AS PATIENT" for policy holder name

PRIMARY	Insurance Company Name		Insurance Plan Name (if known)		Insurance Plan/Group ID (if known)
	Policy Holder Name ☐ SAME AS PATIENT	Birthdate	SSN#		Relationship to Patient
	Policy Holder's Address			Policy Holder's Phone	
SECONDARY	Insurance Company Name		Insurance Plan Name (if known)		Insurance Plan/Group ID (if known)
	Policy Holder Name ☐ SAME AS PATIENT	Birthdate	SSN#		Relationship to Patient
	Policy Holder's Address			Policy Holder's Phone	

MR#: _____

CARE TEAM INFORMATION	
Primary Care Physician	**Referring Provider (i.e. who sent you to our office?)**

Other Medical Providers (List name and specialty if known)	
Name	**Specialty**

APPOINTMENT REMINDERS
It is the patient's responsibility to keep track of appointments and notify us in advance of cancellations. As a courtesy, you may receive a reminder notification in advance of your appointment. You may opt out of this service if you do not want to receive appointment reminders. If no preference is specified, reminders will be communicated via the primary phone number provided in the Patient Information section.
I would like to receive appointment reminders as follows (please specify your preferred option):
☐ Primary Phone (a voicemail message will be left if call is picked up by an answering machine or voicemail system)
☐ Text Message (a text message will be sent to the mobile phone number we have on file)
☐ Opt Out – I do not wish to receive appointment reminders
PATIENT PORTAL
☐ Yes, I would like to be enrolled on your patient portal (email address must be provided on front side of form)
☐ No, please do not enroll me in your patient portal; I understand and accept my communication options might be limited

OTHER INFORMATION		
WORKMANS COMP	Are you here under workman's compensation? ☐ Yes ☐ No	Date of Event (if applicable)
ADVANCED DIRECTIVES AND POA	Do you have any advanced directives (e.g. Living Will or Advanced Care Plan)? ☐ Yes ☐ No Do you have a Power of Attorney? ☐ Yes ☐ No ***If you answered yes to either of the above questions, please make sure we have a copy for your medical record.***	

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PATIENT REGISTRATION AGREEMENT AND CONSENTS

1. CONSENT TO MEDICAL CARE AND TREATMENT

The below-signed individual hereby authorizes Endocrinology Consultants of East Tennessee (the Practice) and its associated professionals to furnish medical treatment and services to the patient and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees. Such consent includes:

a. consent to photographic/video documentation of patient's medical treatment as the patient's treating professional finds medically necessary; and
b. consent to the electronic viewing/downloading of prescription histories maintained by any e-prescription network (e.g. SureScripts) in order to maintain an accurate medication list

There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees the Practice and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

2. CONTACTING PATIENT AND DISCLOSURE OF DIAGNOSTIC RESULTS

The undersigned authorizes the Practice to communicate information related to their treatment and diagnostic test results as specified below:

ALTERNATE CONTACTS FOR EMERGENCY/MEDICAL/FINANCIAL:

Practice may contact any of the individuals listed below and speak to them about an emergency situation, treatment/medical information, and/or financial/billing information as designated in the "Authorizations Granted" column. Please specify at least one emergency (ER) contact below. **NOTE: This does not authorize these individuals to receive the patient's medical record. To release a medical record to another recipient, patient must complete an Authorization for Release of Medical Records in accordance with Practice's Privacy Practices.**

Name	Relation to Patient	Phone	Authorizations Granted		
			ER	Medical	Financial
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

VOICEMAIL AUTHORIZATION:

If Practice is unable to contact me directly, Practice may leave information related to my treatment/diagnostic test results and/or financial obligations with any voicemail system that answers at my designated primary phone number. Please specify either "Yes" or "No."

MEDICAL (Treatment/Diagnostic Results): ☐ Yes ☐ No **FINANCIAL (Billing Obligations):** ☐ Yes ☐ No

NO AUTHORIZATION:

If voicemail authorization is not given above and no alternate contacts are identified, Practice will only speak directly with the patient.
NOTE: Messages will still be left about appointments unless patient has opted out of this service on their Patient Registration Form.

3. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and as authorized or permitted by federal or state law.

Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

4. PATIENT IDENTIFICATION

The undersigned acknowledges that the Practice may request to take a photograph of me upon my admission for the sole purpose of patient identification, and I consent to the taking of my photograph for this purpose. I understand that the photograph will be maintained in a secure manner and will not be released except upon written authorization from me or my authorized representative or as required or permitted by law.

5. PERSONAL PROPERTY AND VALUABLES

The undersigned agrees that the Practice is not responsible for loss, theft, or damage of any money, personal property, or other valuables.

MR#: _____

6. CONSENT TO COMMUNICABLE DISEASE TESTING

The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge to the patient.

7. CALCULATION AND PAYMENT OF CHARGES

The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following:

a. The Practice's charges are set out in a charge master, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the charge master. Charges on the patient's account are calculated based on charge master rates in effect as of the date services are accrued.
b. The patient is liable for the uninsured portion of the Practice bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient or designated guarantor.
c. Any specimens (e.g. blood, urine, or biopsy) collected for tests not performed by the Practice's lab may be sent to hospitals or outside laboratories. Insurance information is provided to such outside entities for the purpose of billing the patient and/or their insurer for these services.
d. The undersigned acknowledges receipt of the Practice's Payment Policies, which is incorporated into this Agreement by reference, and understands the Practice may charge a "no show" or "late cancellation" fee to any patient that fails to show up (no shows) for their appointment or cancels their appointment with less than twenty four (24) hours of notice. The patient will not be able to have their appointment rescheduled until such fee is paid in full. The Practice reserves the right to modify its payment policies at any time and will make every reasonable effort to inform the patient (e.g. posted at check-in/check-out desks, posted on web site, etc.) of these changes; however the patient agrees to abide by the Practice Payment Policies as long as they are receiving services from the Practice.
e. After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

8. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS

The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice billing such payers for items and services furnished by the Practice. The undersigned hereby irrevocably assigns to Practice all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to Practice all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section 7 (CALCULATION AND PAYMENT OF CHARGES) or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers do not pay. Any sums not paid by a third-party payer are the patient's obligation. The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as non-covered or excluded items or services. If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

9. HEALTH PLAN NOTIFICATION/AUTHORIZATION

If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals may order (e.g. lab services). The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

10. AMENDMENTS

Revisions to this Agreement are not effective or enforceable unless accepted in writing by an authorized agent of the Practice.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

Signature of Patient or Legal Representative	Date

Printed Name	Patient Name (if signed by representative)	Relationship to Patient