Summit Endocrine & Diabetes, PLLC
550 New Waverly Place
Suite 120
Cary, NC 27518
919-439-0492

TODAY'S DATE_____/_____/_____

PATIENT INFORMATION

LAST NAME_____FIRST NAME_____MI____

DATE OF BIRTH_____/_____/_____SOC. SEC #_____-____-_____GENDER_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE (_____) _____-_____ CELL PHONE (_____) _____-_____

EMAIL ADDRESS: _____

ETHNICITY: NATIVE AMERICAN ☐ WHITE ☐ BLACK ☐ ASIAN ☐
HISPANIC OR LATINO ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐

NEXT OF KIN

LAST NAME_____FIRST NAME_____MI____

ADDRESS _____

CITY_____ STATE_____ ZIP_____

HOME PHONE (_____) _____-_____ REALTIONSHIP:_____

EMPLOYER_____ OCCUPATION_____

ADDRESS,CITY,STATE,ZIP_____

WORK PHONE (_____) _____-_____ EXTENSION: _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

ID #_____ GROUP #_____

POLICY HOLDER_____DATE OF BIRTH____/____/____

SOC. SEC #_____-____-_____ HOME PHONE (_____) _____-_____

ADDRESS_____

CITY,STATE,ZIP_____

EMPLOYER OF POLICY HOLDER_____

EMPLOYER ADDRESS_____

EMPLOYER PHONE (_____) _____-_____

RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE_____

ID #_____GROUP#_____

POLICY HOLDER_____ DATE OF BIRTH____/____/____

SOC. SEC #_____-____-_____ HOME PHONE (_____) _____-_____

ADDRESS_____

CITY, STATE, ZIP_____

EMPLOYER OF POLICY HOLDER_____

EMPLOYER ADDRESS_____

EMPLOYER PHONE (_____) _____-_____

RELATIONSHIP TO PATIENT_____

******IF YOUR INSURANCE REQUIRES A REFERRAL, AND YOU DO NOT OBTAIN ONE FROM YOUR PRIMARY PHYSICIAN PRIOR TO YOUR VISIT WITH US, YOU WILL BE CHARGED FOR THE VISIT******

PHARMACY INFORMATION

PHARMACY NAME, LOCATION & PHONE NUMBER_____

_____

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY, ELECTRONIC SIGNATURE, OFFICE POLICIES

I authorize the release of any medical information about me necessary to process claims for services rendered to me by Summit Endocrine & Diabetes, PLLC. I authorize direct payment to Summit Endocrine & Diabetes, PLLC for any services rendered to me. I understand that I am ultimately financially responsible for all claims that are denied or not covered by my insurance company for any reason and agree to pay any uncovered balances in full. I agree that if Medicare denies any submitted claim for any reason, that my signature below affirms that I agree to pay, in full, any remaining balance for any unpaid services rendered.

In order to limit paper waste and to facilitate the CMS requirement that a summary of my medical information be made available to me, I agree that as a patient at Summit Endocrine & Diabetes, PLLC I will either make my email address available to the company in order to facilitate my access to my personal medical information, or I will permit Summit Endocrine & Diabetes, PLLC to create an email address on my behalf regardless of my intent to access my medical information.

If I do not give Summit Endocrine & Diabetes, PLLC at least 24 hours notice prior to canceling a scheduled office visit, I understand that Summit Endocrine & Diabetes, PLLC has rescheduling fee of $45. I understand that enforcement of such policy is entirely up to the sole discretion of Summit Endocrine & Diabetes, PLLC

I understand that laboratory blood work results are often not forwarded to the ordering physician, and that it is my responsibility to notify Summit Endocrine & Diabetes, PLLC when I have had blood drawn at any outside laboratory facility.

For prescription refills, please ask your pharmacy to send in a request electronically. You can also call the office to request refills. It may take up to 2 business days for refills to be completed.
You may be charged if a routine prescription has to be refilled after hours.

I understand that there may be a fee for all forms filled out by my physician.

We have contracted with an outside vendor Professional Data Management (PDM) for billing services. For any billing and payment related questions, please call 919-751-9120. Extension 101

PDM may collect aggregate patient data, however they have agreed to take all reasonable steps to make sure that PHI is not disclosed.

I understand that the only official means of communication with my physician is during the actual office visit. After normal business hours, Summit Endocrine & Diabetes, PLLC will have a provider on call for emergency calls only. Non urgent messages may be addressed on next business day. We would like to encourage use of the patient portal for non-urgent messages.

For life threatening emergencies, please call 911 or go to the nearest emergency room.

I give Summit Endocrine & Diabetes, PLLC and any subcontractors that they use (including but not limited to billing departments or appointment reminder services, etc) permission to leave the following information including but not limited to: a voicemail or send a text message for appointment reminders, prescription refills, lab results, radiology results, billing information, medical results, etc.

My signature below is my official signature of record. When electronically signing Summit Endocrine & Diabetes, PLLC documents, the electronic signature is equivalent to and as legal and binding as the signature below.

Signature of Patient/Legal Guardian_____**Date**_____

PERMISSION FOR WRITTEN & VERBAL COMMUNICATIONS

To protect a patient's privacy and to ensure that our clinic staff and physicians know whom they have permission to communicate with regarding a patient's protected health information, it is helpful for patients to have a Permission for Written & Verbal Communications form on file at the clinic.

_____
Patient's Name

I permit Summit Endocrine & Diabetes, their physicians, nurses, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, and/or in writing, with the following family members or friends involved in my medical care or payment of my care:

List family members/friends and state the person's relationship to the patient.

Name **Phone Number**
Relationship

1._____
_____

2._____
_____

3._____
_____

****

This authorization is limited to discussions regarding the following medical condition(s):

_____
_____
If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.

****

This authorization is limited to the following timeframe from

_____ (date) to _____ (date).

If no dates are indicated, this form will remain in effect for an unlimited amount of time.

Release of information under this document is for written and verbal discussions with my Health Care Providers.

If, at any time, I do not want written or verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting Summit Endocrine & Diabetes at 919-439-0492.

_____ _____

Patient's Signature Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____ _____

Name of Personal Representative Relationship to Patient

_____

Witness

Summit Endocrine & Diabetes, PLLC
550 New Waverly Place, Suite 120
Cary, NC 27518
Phone: 919-439-0492
Fax: 919-585-1554

Acknowledgement of HIPAA Notification

I acknowledge receipt of the Notice of Privacy Practices from Summit Endocrine & Diabetes, PLLC. I understand that I may request additional restrictions on the use and disclosure of my protected health information or request for additional confidential treatment of communication.

Name _____

Signature _____

Date _____

Summit Endocrine & Diabetes, PLLC
550 New Waverly Place, Suite 120
Cary, NC 27518
Phone: 919-439-0492
Fax: 919-585-1554

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Requesting records from:

Content requested: All Records

Purpose for Disclosure: Continued Medical Care

Records to be forwarded to:
Summit Endocrine & Diabetes, PLLC
Khushbu Chandarana, MD
550 New Waverly Place, Suite 120, Cary, NC 27518
Phone: 919-439-0492
Fax: 919-585-1554

I hereby authorize the release of the above requested medical records to the above noted recipient and to no other party.

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or HIV.

This authorization expires on: _____ (date or "never")

_____

Patient Name

_____ _____

Patient Signature **Date**