Patient Registration Form Comprehensive Endocrinology

Last Name	First Name	SSN	Marital status
Date of Birth			Language
Street	City	Zip	State
Phone Numbers: please check preferred	Cell	Home	
Email address			
Preferred Contact Method: please check box	Phone	Text	Email
Who referred you?			
Driver's License #	Expiration Date	State	
Primary Insurance Company	Policy Number	Group Number	Effective Date
Secondary Insurance Company	Policy Number	Group Number	Effective Date
If you are covered under the policy of a spouse, parent, or legal guardian please tell us about them:			
Name		Phone Number	
Emergency Contact Information: Name and Phone Number			

Medications you are taking	Dose	Frequency
Allergies (sesonal and medications)		
Known Medical Diagnoses and Surgeries:		

Comprehensive Endocrinology Telemedicine Patient Consent Form

I (name of patient or parent/guardian):

agree to participate in a telemedicine evaluation. By signing this agreement, l authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical care. [Note: The likelihood of this transmission being intercepted by people other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard from other people. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that electronic medical records of telemedicine services will
be kept at Comprehensive Endocrinology.

Signature of patient (or parent/guardian): Date:

I have chosen not to participate in this telemedicine evaluation.

Signature of patient (or parent/guardian) Date:

Comprehensive Endocrinology Patient Portal Authorization Form

Patient Name:

E-mail Address:

By signing this form, I authorize Comprehensive Endocrinology to communicate via personal, secure access Patient Portal with me for my medical care and treatment. Comp Endo will provide notices via your personal e-mail that information can be found in your Patient Portal. No personal health information is transmitted via or in your personal e-mail. I understand the following types of protected health information may be used, disclosed and retained by health care providers of Comp Endo because of the communications:

1. my personal health information
2. laboratory test results
3. pathology reports
4. other medical records

The portal is not intended for "web visits" or new problems. If a message takes a long time to write, it's probably better done in person at an office visit.

Signature: Date:

Once you have signed up you can access the site through our website or at www.gotomyclinic.com/comp-endo

Username:

Privacy Policy and Terms of Services
Usage of SMS/Texting for communication

Comprehensive Endocrinology uses text messaging to communicate with patients. This service is voluntary.
Patients have to opt-in to receive messages and can opt-out at any time by notifying Comprehensive Endocrinology.

Phone number:

I hereby agree to receive text messages to remind me of upcoming appointments and to receive reminders of pending payments. My opt-in information will never be shared with third parties for marketing purposes.
Terms of Services:
Text messages will only be used for reminders of appointments and outstanding balances. To opt out of this service please contact Comprehensive Endocrinology by written notice through the Patient Portal. Message and Data rates may apply. This Privacy and Terms of Serviced can be reviewed at www.comp-endo.com

Patient Name: Date:

Signature:

Comprehensive Endocrinology Financial Policy

This is an agreement between Comprehensive Endocrinology, PC, a Colorado Professional Corporation, as creditor, and the Patient/Debtor named on this form. By executing this agreement, you agree to pay for all services rendered by our office and employees thereof.

Insurance:

We do not accept insurance payors except for Medicare. We will provide patients with a superbill which the patient can use to seek reimbursement by their insurance company as out of network medical service.

Payments:

The patient is responsible for paying the fee for a visit on the day of service in full. Please see the Credit Card and Payment Policy for more details.

Returned checks:

There is a fee ($25) for any checks returned by the bank ("bounced checks").

Charges to Account:

We shall have the right to cancel your privilege to incur charges against your account at any time. All future visits would then need to be paid at the time of service.

Payment plans:

If a payment plan agreement is arranged and signed, payments are expected each month by the arranged due date. You will continue to receive a monthly statement. If you default on the agreed payment plan and the account becomes past due, any courtesy discounts will be rescinded, and your account assigned to our collection agency, for the full amount, as described in the section Payments.

Missed appointment fee:

Patients who do not show up for an appointment or cancel with less than 24 hours' notice will be charged $100. This fee must be paid in full before a new appointment is scheduled. Patients with two missed appointments will be asked to transfer their records to another doctor.

Waiver of confidentiality:

You understand if this account is submitted to an attorney or collection agency, if this account requires litigation in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring Records:

You will need to request in writing and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to release all relevant patient and account information, including your payment history.

Co-signature:

If this or an additional Financial Policy for this patient account is signed by another person, that co-signature remains m effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date:

Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name:

Signature: Date:

Credit Card and Payment Policy of Comprehensive Endocrinology

Healthcare benefits and coverage options have become increasingly complex. To make this process more cost-effective for everyone, we have the following policy:

1. You will be asked to pay at the time of your visit.
2. We require all patients to provide us with a credit card at the time of service. The information is encrypted and securely stored with our payment gateway company, which is 'payment card industry' (PCI) complaint. This is like the process that all hotels, mail order pharmacies.

This policy will be an advantage to you, since you will not have to come in or call in with the credit card information or bring in cash to pay the bill. It will be an advantage to us, as it will significantly reduce our time/costs associated with sending out statements from the office as well as collection attempts.

The combination will benefit everyone in helping to keep the cost of healthcare down. As a small medical practice operating with fixed/decreasing reimbursements and rising expenses, we must do everything possible to allow our medical practice to maintain its professional standard of service. Thank you for your cooperation and understanding.

Authorization to charge my credit card for all patient responsibilities:

Patient's name:

Signature: Date:

Comprehensive Endocrinology:
Notice of Privacy Practices and Terms and Conditions

THIS NOTICE DESCRIBESHOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULL.Y

Uses and Disclosures
Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Comprehensive Endocrinology. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. ·

law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited from using or disclosing your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.