Diabetes and Endocrinology
CLINICAL CONSULTANTS OF TEXAS

PATIENT DEMOGRAPHICS

DATE: _____

Legal Name: First _____ **MI** _____ **Last** _____ **Preferred Name:** _____

Parent / Legal Guardian Name: _____ **DOB:** _____ **Mobile:** _____

SS#: _____ **DOB:** _____ **Legal Sex:** ❑ **M** ❑ **F**

Do you have any Sexual Orientation or gender preferences you would like us to consider? ❑ **Yes** ❑ **No**

Is your Legal Sex different from your Sex at Birth? ❑ **Yes** ❑ **No**

If you answered yes to either of these questions, additional information will be collected from you later.

Address: _____ **Apt#** _____ **City** _____ **State** _____ **Zip** _____

Phone: Home _____ **Work** _____ **Mobile** _____

Email _____ ❑ **No Email**

GENERAL INFORMATION

Marital Status ❑ **Divorced** ❑ **Legally Separated** ❑ **Married** ❑ **Significant Other** ❑ **Single** ❑ **Widowed**

Need Interpreter ❑ **Yes** ❑ **No** **Preferred Language** _____ **Written Language** _____

Race: ❑ **Asian** ❑ **Black** ❑ **Native American** ❑ **Native Hawaiian/Pacific Islander** ❑ **Two or More Races** ❑ **White**

Ethnicity: ❑ **Hispanic** ❑ **Non-Hispanic**

ADDITIONAL DEMOGRAPHICS

Preferred Communication Method: ❑ **No Preference** ❑ **Mail** ❑ **Email** ❑ **Online Portal** ❑ **Accept Text Messages**
By checking one of the boxes for Preferred Communication Method, I agree to receive correspondence from DECCT.

Do you have any communication difficulties / special needs? Visually Impaired: ❑ **Y** ❑ **N** **Hearing Impaired:** ❑ **Y** ❑ **N** **Special Needs:** ❑ **Y** ❑ **N**

If yes, please list: _____

PCP

Primary Care Physician _____ ❑ **No Primary Care Physician**

EMERGENCY CONTACTS

Name _____ **Relationship to Patient** _____ **Home Phone** _____ **Mobile** _____

Name _____ **Relationship to Patient** _____ **Home Phone** _____ **Mobile** _____

EMPLOYMENT

Employer Name _____ **Employment Status:** ❑ **Disabled** ❑ **Full Time** ❑ **Part Time** ❑ **Retired** ❑ **Student** ❑ **Unemployed**

FOR OFFICE USE ONLY:

Patient Name _____
MRN _____

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

I authorize Diabetes and Endocrinology Clinical Consultants of Texas 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 Diabetes and Endocrinology Clinical Consultants of Texas of changes or updates. I also authorize Diabetes and Endocrinology Clinical Consultants of Texas to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my insurance or test results.

❑ **Only Release Information to Patient**
If *no* answer, may we leave a message on your: Home Phone ❑ Y ❑ N Work ❑ Y ❑ N Mobile ❑ Y ❑ N

Name _____ **Relationship to Patient** _____

Home Phone _____ May We Leave a Message? ❑ Y ❑ N Mobile _____ May We Leave a Message? ❑ Y ❑ N

You may release the information regarding the following services to the person named above: ❑ **Appointments** ❑ **Billing** ❑ **Medical Care**

Name _____ **Relationship to Patient** _____

Home Phone _____ May We Leave a Message? ❑ Y ❑ N Mobile _____ May We Leave a Message? ❑ Y ❑ N

You may release the information regarding the following services to the person named above: ❑ **Appointments** ❑ **Billing** ❑ **Medical Care**

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 _____

FINANCIALLY RESPONSIBLE PARTY - GUARANTOR

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

Name: First _____ MI _____ Last _____ DOB _____

Relationship (Please circle): Spouse Father Mother Other (Please Specify) _____

Address: _____ Apt# _____ City _____ St _____ Zip _____

Phone: Home _____ Cell _____ Work _____

Employer Name _____ **Employment Status:** ❑ Student ❑ Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

INSURANCE INFORMATION

PRIMARY INSURANCE _____ **ID** _____ **GRP#** _____

Subscriber Name _____ **Sex:** ❑ M ❑ F Patient Relationship to Subscriber _____

Subscriber DOB _____ **Phone:** Home _____ Cell _____ Work _____

Employer Name _____ **Employment Status:** ❑ Student ❑ Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

SECONDARY INSURANCE _____ **ID** _____ **GRP#** _____

Subscriber Name _____ **Sex:** ❑ M ❑ F Patient Relationship to Subscriber _____

Subscriber DOB _____ **Phone:** Home _____ Cell _____ Work _____

Employer Name _____ **Employment Status:** ❑ Student ❑ Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

FOR OFFICE USE ONLY:

Patient Name _____
MRN _____

HOW YOU HEARD ABOUT US

❑ Family Friend ❑ Email ❑ Newspaper/Magazine Ad ❑ Organization Website ❑ Internet Search ❑ Television Commercial ❑ Organization Newsletter
❑ Other _____ ❑ Referring Physician _____ ❑ Coach _____ ❑ Trainer _____

FINANCIAL AND PAYMENT GUIDELINES

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

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 responsibiity (or guarantor) to obtain the referral prior to your appointment.

- I authorize direct payment of my insurance benefits to Diabetes and Endocrinology Clinical Consultants of Texas for services rendered to myself or dependents.
- Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.
- Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.
- Out-of-Network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.
- Diabetes and Endocrinology Clinical Consultants of Texas, or its authorized agent, will provide medical information to the insurance company as required for payment of claims for services rendered.
- 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 my telephone number provided during my registration process. I understand that these collection attempts could be performed by Diabetes and Endocrinology Clinical Consultants of Texas, or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.

Lab / X-Ray / Diagnostic Services:

- I understand that I may receive a separate bill if my medical care includes lab, x-ray, or any other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.

RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

- I authorize the release of all medical records to specialists and/or consulting physicians 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 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 Diabetes and Endocrinology Clinical Consultants of Texas.

Authorization to Treat a Minor (Ages 0-18th Birthday)

❑ **Not Applicable (Patient is an Adult)**

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers of Diabetes and Endocrinology Clinical Consultants of Texas to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to Diabetes and Endocrinology Clinical Consultants of Texas or update. I authorize Diabetes and Endocrinology Clinical Consultants of Texas 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.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

PRIVACY PRACTICES

Diabetes and Endocrinology Clinical Consultants of Texas offices, physicians, and staff are commited to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.

ACKNOWLEDGEMENT

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

Patient Name _____ Signature _____ Date _____