Hancock Diabetes & Endocrine Center, PLLC
Update

Today's Date: _____

PERSONAL INFORMATION:

(Mr., Mrs., Ms., M.D.)
NAME: _____
FIRST MIDDLE LAST

_____
STREET/MAILING ADDRESS CITY STATE/ZIP

(_____)_____ (_____)_____ (_____)_____ _____
HOME TELEPHONE CELL PHONE WORK PHONE DATE OF BIRTH

WHERE DO YOU PREFER TO RECEIVE CALLS? _____ Email Address: _____

_____ _____ _____
SOCIAL SECURITY NUMBER PRIMARY CARE PHYSICIAN OFFICE NUMBER

MARITAL STATUS _____ PREFERRED LANGUAGE _____ RACE _____
ETHNICITY: HISPANIC OR NON-HISPANIC DOMINANT HAND: RIGHT/ LEFT GENDER: MALE/FEMALE TOBACCO USE: YES/NO

In the event of an emergency please contact:
Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____

Insurance information: (Please provide copy of insurance card)

PRIMARY INS CO: _____ SECONDARY INS CO: _____

ID# _____ GROUP# _____ ID# _____ GROUP# _____

INSURED'S NAME: _____ INSURED'S NAME: _____

INSURED'S DOB: _____ SSN: _____ INSURED'S DOB: _____ SSN: _____

RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD

PHARMACY: _____ **LOCATION:** _____

PLEASE LIST ALL MEDICATIONS, STRENGH AND HOW OFTEN YOU TAKE THE MEDICATION: (YOU MAY PROVIDE A LIST IF AVAILABLE)

NAME:	STRENGTH:	TIMES PER DAY:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Lloyd D. Hancock, MD. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.

_____ _____
Patient's signature (Parent's signature if under 18 years old) Date

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Financial Policy

Here at Hancock Diabetes & Endocrine Center, PLLC, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

As a courtesy, our office will file insurance claims for reimbursement for all rendered services. Actual benefit payments are determined only when the claim is processed by your insurance company. Therefore, it is the insurance company that makes the final determination of benefits. If the insurance payment does not fully reimburse for the treatment rendered, the financially responsible person is the responsible for the remainder of the balance.

Payment for service is due at the time services are rendered. We accept cash and most major credit cards.

Copayments: Your insurance company requires co-payments, deductibles, and co-insurance to be paid in full at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Referrals: If your insurance company requires a referral, it is **YOUR** responsibility to obtain the referral. Failure to obtain the referral and/or prior authorization for treatment may result in rescheduling of your appointment and/or a lower payment of denial from the insurance company.

Self-Pay Patient's: You are responsible for all charges incurred at the time of service.

Financial Agreement:

Your Insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. To enable our office to file your insurance, you must provide accurate information at each visit.

Not all services are a covered benefit in all contracts – Some insurance companies will not cover certain services (i.e., I131 foot exams, extremity services, biopsies, ultrasounds and CGMS, etc.).

Due to timely file limits for insurance companies, you have 30 days from the date of services rendered to provide our office with updated insurance information. If the correct information is not received within 30 days, you will be responsible for the charges.

All charges are your responsibility from the date services are rendered.

- I authorize Hancock Diabetes and Endocrine Center, PLLC, to release to all of my insurance companies any information necessary including but not limited to the diagnosis and records of any treatment and examination or procedure rendered to me.
- I understand that all charges are my responsibility from the date that services are rendered.
- I also understand that all services may not be covered by my insurance company, but I am responsible for the cost of all services that are rendered.
- If I am a self-pay patient, I understand that I am responsible for all charges incurred at the time of service, and that payment is due in full at the time services are rendered.
- I understand that this is an acknowledge of financial responsibility for the cost of services received.

There will be a $25.00 Charge for any missed appointments and cancellations made within 24hrs of your appointment.
Also a $25.00 Charge for medical records released to you and FMLA/form completion will apply.

We must emphasize that as your Endocrinology provider, our relationship and concern is with You not the insurance company.

I, as the patient, am the financially responsible person and/or guardian for this account, certify that I have read, understood, and agreed to this financial policy.

HIPAA Medical Information Release Form

I, _____, give permission for the following list of people to obtain any medical information regarding my care at Hancock Diabetes and Endocrine Center, PLLC. By signing this release, I hereby understand that any information regarding my health may be discussed with the person(s) listed below. My personal code is _____, and I understand that any person listed must have this code to obtain **ANY** information about me. We stand firm with the HIPAA laws and strive to ensure your confidentiality as a patient at our office.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

**A copy of the HIPAA Privacy Act and/or Patient Guide is available at the front desk at our office. If you would like a copy, let us know and we will gladly provide you with a copy.

Patient Name (printed)	Patient Signature	Date
_____	_____	_____

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