NOTICE OF PRIVACY PRACTICE OF NORTH RALEIGH ENDOCRINOLOGY & THE DIABETES CENTER

A DIVISION OF ALVI PRIME TIME CLINICS, PLLC

PATIENT REGISTRATION FORM

Welcome to our practice. To help us meet your health care needs, please fill out this form completely and accurately in ink. If you have any questions or need assistance, please do not hesitate to ask us, and we will be happy to assist you in any way we can.

Name _____ Nickname_____
Last First Middle

Maiden Name_____ Birth Date _____ Gender M/F SS#_____

Marital Status S/M/W/D Drivers License #_____ Expires_____ State_____

Phone (cell) _____ (home) _____ (work) _____

Address _____ Apt#_____ City_____ State____ Zip_____

Email address_____

Primary Insurance Card Holder _____ Self _____Spouse _____Parent

Insurance Company_____ Address_____

Guarantor (Main Policy Holder) _____ DOB _____

Employer_____ Group#_____ Policy#_____

For your privacy, please answer the following:

- You may leave a message regarding my medical care/billing on my home phone **Y/N**
- You may leave a message regarding my medical care/billing on my cell phone **Y/N**
- You may send information regarding my medical care/billing to the email address provided **Y/N**
- You may leave a message regarding my medical care/billing with:
  Name_____ Relationship_____ Phone_____

I have read and understood the policies set forth on the back of this form and agree to adhere to your policies. I have also been provided an opportunity to review or have received the notice of privacy practices.

Patient Signature_____/_____ Date_____
(Guardian signature for minor) (Relationship)

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PLEASE CAREFULLY READ OUR OFFICE POLICY
PLEASE ASK ANY QUESTIONS IF YOU NEED CLARIFICATION

Consent for Treatment: I hereby authorize consent to the examination and treatment of the patient by the provider and clinical staff and the performance of any surgical and/or diagnostic procedure deemed necessary.

Authorization to Release Information: I hereby authorize North Raleigh Endocrinology & the Diabetes Center to release any information, including the diagnosis and records or any treatment(s) or examination(s) rendered to my child or me to my insurance company(s) or Worker's Compensation carrier necessary to process claims. I also authorize and request my insurance company(s) to make payment of any medical benefits directly to the physician or North Raleigh Endocrinology & the Diabetes Center. I also authorize North Raleigh Endocrinology & the Diabetes Center to release any information, including the diagnosis and records of any treatment(s) or examination(s) rendered to my child or me, to specialty physicians when necessary to assist in my treatment or care.

Financial Responsibility: I understand that I am responsible for payment when services are rendered, including previous balances, copayments, coinsurance, deductibles, or services not covered by my insurance plan. I acknowledge that I have provided current and accurate insurance information to enable timely reimbursement for medical services. If the insurance information cannot be verified or if I do not have health insurance coverage, I will pay in full at the time of service by credit card, cash, or check. I understand that any balance after my insurance company has paid is due within 30 days of receipt of the billing statement. I understand that accounts not paid after 90 days from the service date will be turned over to a collection agency and reported to the credit bureau.

Cancellation Policy: I understand if I cannot keep a scheduled appointment. I must notify the office at least 24 hours before the appointment time. I know I will be charged a $50.00 cancellation fee if I do not provide 24 hours notification or do not show up for a scheduled appointment.

Laboratory Tests: I understand that, if necessary, an outside laboratory may process blood and tissue specimens taken during my visit. These services will be billed separately by the lab. I am responsible for contacting the lab with any questions or concerns regarding their bill.

Minor Patients: I understand that as the adult accompanying the minor, I am responsible for any payment amount due for services rendered, regardless of the responsible party or insurance policy holder. I will be provided with a receipt for my personal reimbursement.