



New Patient Registration Form

ACCOUNT #

Patient Information

Last Name		First Name		Middle Name
Address(Street or Box)		City	State	Zip
Cell Phone #		Home Phone #		Sex (Check One) <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	Age	Social Security #		Driver's License #
Marital Status (Check One) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Email		
Insurance Name		Occupation /Employer Name		
Primary Care Physician Name		Referring Physician Name		
How did you hear about Austin Thyroid & Endocrinology?				
<input type="checkbox"/> Family/ Friend <input type="checkbox"/> Hospital <input type="checkbox"/> Insurance <input type="checkbox"/> Internet/Website <input type="checkbox"/> Location/Drive By <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Google Search <input type="checkbox"/> Physician Referral <input type="checkbox"/> Magazine				

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**. If you would like to add additional contacts (other than the patient or legal guardian) that Austin Thyroid & Endocrinology (ATE) is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like (ATE) to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

_____	_____	_____
Contact Name	Relationship to Patient	Contact Phone Number
<input type="checkbox"/> Billing Account Information	<input type="checkbox"/> Medical Condition Information	<input type="checkbox"/> Emergency Contact
_____	_____	_____
Contact Name	Relationship to Patient	Contact Phone Number
<input type="checkbox"/> Billing Account Information	<input type="checkbox"/> Medical Condition Information	<input type="checkbox"/> Emergency Contact

My preferred method of communication regarding my **medical conditions** is indicated below (**check multiple**):

Cell Phone Home Phone Online Portal

If the above method of communication is by phone, please check the appropriate box below (**check one**):

Leave a confidential message with detailed information.

Leave a message with a call-back number only.

My preferred method of **appointment reminders**: (**Check One**) _____(initial)

Phone Call Text Email

V8 8/7/18

Patient Signature

Date

Patient Information

Due to the many changes in healthcare and our ability to comply with those changes and the growth in our practice, we have designed the following policies and procedure for our office.

Appointments

New appointments are scheduled by phone or by making a request on our website. Return visits are scheduled at the end of your visit at checkout. You will receive a reminder 7 days ahead via phone, text, or email, followed by a second one the day before your appointment. Please call us at least 48 hours ahead to cancel your appointment. If you miss three appointments in a row, you may be discharged from our practice since we cannot provide proper healthcare without you. No shows and late cancellations (made less than 48 hours prior to the appointment) are charged \$25.

Lab reporting and Review

When labs or imaging studies are ordered at the new patient visit, they will be discussed 7 to 14 days later at a face-to-face visit in our office. This allows us to discuss treatment options and formulate a plan for patient care. Labs ordered at a routine follow-up visit will be reported to you only if they are abnormal, in which case the contact will be through the portal or by phone with instructions. Test results are confidential medical records and will only be given to the patient. If you would like to designate another person to receive your test results, please ask the receptionist for a HIPAA consent form. Please allow 2 weeks for the processing and review of abnormal labs. Please note that we will not contact you for normal labs. We will not review labs done outside and reviewed by another physician by phone; you will be asked to schedule a visit to discuss the labs.

Nurse Call Backs

To avoid phone tag, the best way to contact our nurses is on the patient portal. Nurses are in clinic from 8:00am-noon and 1pm-4pm. Please leave a phone message if there is no answer. Messages are checked in the morning and after lunch, and we make an effort to reach you the same day or the next business day.

Prescriptions/Refills

Refills will be done at the time of your office visit. We will provide 30 and/or 90 day prescriptions at the time of the visit. We utilize electronic prescriptions, so if you are using a mail order company, please notify them when you like your prescriptions filled and shipped. If you need a refill between visits, please do not contact our office. Contact your pharmacy, they will send a refill request on your behalf. Please allow 48 hours for processing of these refills. If your insurance changes and your prescriptions need to be rewritten, there will be a \$25 charge. This is not a covered insurance benefit and will be due at the time of pickup or mailing. We will not sign for generic substitutions between visits. All prescription functions must be taken care of at the time of your visit.

Medical Records/Completion of Forms/Letters

We require signed consent to release medical records. A fee is associated with copying of records. Records sent to another provider are sent free of charge in accordance with HIPAA covered entity exclusion. Records may be requested by insurance companies and disability providers; these are released with the consent you have provided to these agencies. If you are requesting the physician to fill out a form for you, a fee of \$25 is charged.

Insurance Companies

We are in-network providers for many insurance companies. Insurance companies make changes frequently, so to ensure coverage, please contact your insurance company prior to your visit to determine network status. It is your responsibility to ensure that you are covered before your appointment. You are financially responsible for all charges incurred during your office visit. If your insurance does not cover your visit, you will be billed. If your account is put into collections for non-payment, you will be expected to make a payment on your account prior to scheduling an appointment. All co-pays, co-insurance & deductible payments are due at the time of service.

Letters

If you request that we generate a letter or any document on your behalf, your account will be charged \$25. The fee is due when the request is made. This is not a covered insurance benefit and will be billed directly to the patient.

Lost Items

Should you misplace any items generated by this office there will be a \$10 charge for replacing them. This is not an insurance benefit and is due at the time of the request. This includes lost prescriptions, labs requisitions, and physician orders for testing.

Financial Policy

Thank you for choosing us to assist you in managing your healthcare. We are committed to providing you quality healthcare and ask that you acknowledge and respect our financial policies as stated below:

- Payment is due at the time of service. We accept cash, checks, Visa, MasterCard, American Express, and Discover.
- Copays, deductibles, and non-covered procedures must be paid at the time of service, per your contract with the insurance company. Copay, coinsurance, and deductible are determined by your insurance company.
- Referrals. If your insurance company requires a referral from your primary care physician, you are responsible to obtain one. If a valid referral is not on file, you need to sign a referral waiver on the appointment day. If we do not receive your referral within 5 days of your appointment, you will be responsible for the cost of services rendered.
- As a courtesy, we will submit a claim to your insurance on your behalf. Please understand that your insurance policy is a contract between you, your employer, and the insurance company. **We are not a party to that contract.** Our relationship is with you, the patient. We cannot become involved in disputes between you and your insurer regarding deductibles, co-insurance, non-covered charges, secondary insurance and “usual and customary” charges.
- We are contracted with certain managed care and preferred provider plans. We are contracted to follow the guidelines for reimbursement and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
- All charges are your financial responsibility. Not all services are benefits. It is your responsibility to verify coverage prior to the appointment. Payments for non-covered services are expected at the time services are rendered.
- If you have not received your insurance explanation of benefits within 30 days of your appointment, please contact your insurance company to expedite payment. Unpaid claims are your financial responsibility. If you insurance company has not paid within 45 days, you may be billed for the charges.
- Outstanding balances, insurance co-pays, co-insurances, and yearly deductible not met will be collected prior to your visit.
- If you have a balance on your account, you will receive a patient statement. A second one follows at 3 weeks, a third one at 6 weeks. If you have not paid your balance after the third statement, your account is sent to collections, and a \$25 collection charge is added to your account.
- Returned checks are assessed a \$25.00 fee per check. We may convert this to an electronic transaction to recoup.
- Missed appointments are charged a \$25.00 no show fee. Late cancellations, that is, cancelling an appointment less than 24 hours ahead, are also charged a \$25 no show fee. Stress tests, FNA, and Echos are assessed a \$75.00 fee for no shows or late cancellations.
- As with many medical offices ATE and Dr Scumpia have possible financial interest in some products, labs and procedures offered here including but not limited to Metagenics, Ideal protein, Synergist, Rise and others You have the option to use a healthcare facility or laboratory other than those listed without being treated any differently. If you have any questions regarding this notice, ask Dr. Scumpia.

I have read and understand the financial policy and agree to its terms. I understand that the practice may amend these terms from time to time. I hereby assign all medical and surgical benefits to which I am entitled to Austin Thyroid & Endocrinology. I hereby authorize my insurance carriers (Medicare, Tricare, and other public or private insurance or health plan) to issue payment directly to Austin Thyroid & Endocrinology for medical services rendered to me and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Austin Thyroid & Endocrinology to release any information needed to insurance carriers regarding my illness and treatment, process insurance claims for diagnosis and treatment, and allow a copy of my signature to be used by insurance companies for processing claims. This authorization will remain in effect until revoked by me in writing.

Patient Signature

Date

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

