SOUTH FLORIDA ENDOCRINE CENTER PATIENT REGISTRATION

Name_____ Sex M/F Date_____ SS_____

Address_____ City_____ State_____ Zip_____

Other Address_____Email_____

Date of Birth: _____ Age: _____ Martial Status S / M / D / W Race:_____ Language:_____

Ethnicity_____ Employer_____ Occupation _____ Retired Y / N Disabled Y / N

REFERRING PHYSICIAN: _____ PCP: _____ Phone: _____

EMERGENCY CONTACT: _____RELATIONSHIP_____ PHONE_____

********SOUTH FLORIDA ENDOCRINE CENTERS REQUIRE TWO PHONE NUMBERS AND CONFIRMATION OF APPOINTMENTS MADE WITHIN 24 HOURS OF APPOINTMENT TO AVOID CANCELLATION********

PHONE NUMBER 1_____ PHONE NUMBER 2_____

INSURANCE INFORMATION

PRIMARY INS_____POLICY HOLDER NAME_____DOB: _____ SS _____

SECONDARY INS _____ POLICY HOLDER NAME_____ DOB: _____SS_____

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT; I HEREBY AUTHORIZE SOUTH FLORIDA ENDOCRINE CENTER OR ANY OTHER PHSYCIAN DESIGNATED BY HIM, PROVIDING CARE TO THE PATIENT TO RENDER SUCH CARE INCLUDING DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT AS THEY MAY DEEM TO BE NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND TREATMENT OF THE PATIENT, AND, I DIRECT SOUTH FLORIDA ENDOCRINE CENTER, ITS AGENTS, AND EMPLOYEES, TO FOLLOW HIS/HER INSTRUCTIONS AND DIRECTIONS. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO RESULTS OF TREATMENTS AND/OR EXAMINATION. I ALSO UNDERSTAND THAT MEDICAL CARE REQUIRES MY COOPERATION AND IF I MISS MORE THEN TWO APPOINTMENTS, I MAY BE DISMISSED FROM THE PRACTICE AND BE SUBJECT TO CHARGES. I WILL ADVISE THE PRACTICE DURING BUSINESS HOURS **24** OR MORE HOURS IN ADVANCE. IF NO CANCELLATION NOTICE WAS RECEIVED **A SERVICE CHARGE OF $30.00 PER NO SHOW** MAY BE APPLIED AND DUE AND PAYABLE IMMEDIATELY.

FINANCIAL AGREEMENT: THE UNDERSIGNED AGREES WHETHER HE/SHE SIGNS AS AGENT OR AS PATIENT, THAT IN CONSIDERATION OF THE SERVICES RENDERED TO THE PATIENT, HE/SHE OBLIGATES THEMSEVLES TO PAY THE ACCT OF SOUTH FLORIDA ENDOCRINE CENTER IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF SOUTH FLORIDA ENDROCINE CENTER. IF MEDICARE AND/OR YOUR INSURANCE COMPANY DENY PAYMENT, I AGREE, TO BE PERSONALLY RESPONSIBLE FOR PAYMENT INCLUDING ALL DIAGNOSTIC TESTS ORDERED BY SOUTH FLORIDA ENDOCRINE CENTER. IT IS ALSO MY UNDERSTANDING THAT ALL ADDRESS, PHONE NUMBER, AND INSURANCE UPDATES ARE MY RESPONSIBILITY TO PROVIDE. SHOULD THE ACCOUNT BE REFERRED TO A COLLECTION AGENCY AND/OR ATTORNEY FOR COLLECTION, THE UNDERSIGNED SHALL PAY ALL REASONABLE ATTORNEY FEES AND/OR COLLECTION EXPENSES AND ANY RETURNED CHECK FEE. THE CHARGE FOR A NON SUFFICIENT FUNDS CHECK IS **$40.00.**

PATIENT SIGNATURE: _____ DATE _____

PATIENT AGENT OR REPRESENTATIVE: _____ DATE_____