Pediatric Endocrine
ASSOCIATES

Patient name:_____ **Circle**: Male / Female **Race**: _____
Date of Birth _____**Preferred Language:** _____
Address_____**Apt**_____
City _____ **State** _____ **Zip**_____-_____
Phone to receive calls, messages and texts 1. ( ) _____
2. ( )_____
Email to receive messages and appointment reminders: _____
Parent(s)/Guardian(s) Name/Date Of Birth:_____

Insurance Information:
1. Primary Insurance: _____ Member ID _____Group_____
2. Secondary Insurance: _____ Member ID _____
(Please note that we will bill your secondary insurance ONCE on your behalf as a courtesy. Payment is your responsibility.)
Policy Holder's Information:
Name: _____Social Security: _____
Date of Birth: _____ Relationship to patient: _____

Primary Care Provider:
Name: _____ Phone_____ Fax_____

Pharmacy Name: _____Street Name: _____Phone _____
I understand that I am responsible for providing the office with the correct information.
I agree that all the information provided above is correct.
By signing my name, I authorize the medical information to be released to my insurance for billing purposes and for medical care of the patient. I also authorize payment of medical benefits of the above patient to Pediatric Endocrine Associates for services received.
By signing my name, I take legal responsibility of providing correct insurance information to Pediatric Endocrine Associates for the service delivered. Any parent or legal guardian (regardless of marital status) who brings a minor in for treatment is, and hereby agrees to be responsible for paying the minors account in full. If the information provided is incorrect or incomplete; I will be responsible for covering the charges on the date the services were rendered**.** If patient account is sent to *collections*, patient(s) will also be *discharged from this practice.*
By signing below, I also have legal permission to consent to treatment and exam, including pelvic exam defined in SB 698. My signature provides this written legal consent.

Signature: _____ **Date:** _____

Print Name: _____**Relationship to patient:** _____
Please note that those patients who **DO NOT CALL OR EMAIL TO CANCEL AN APPOINTMENT** within 24 hours **WILL BE CHARGED a $25 FEE**. This is a **NON-COVERED** service and as such is not payable by insurance. Thank you for your understanding in this matter.

Signature: _____ **Date:** _____

FUTURE APPOINTMENTS ONLY

I agree that the above information (insurance, address, telephone# and PCP) is still correct and complete as of today's date.
1.Date:_____ Signature:_____No changes to primary/secondary insurance. I consent to an exam.

2.Date:_____ Signature:_____No changes to primary/secondary insurance. I consent to an exam.

3.Date:_____ Signature:_____No changes to primary/secondary insurance. I consent to an exam.

4.Date:_____ Signature:_____No changes to primary/secondary insurance. I consent to an exam.

THIS FORM EXPIRES ONE YEAR FROM FIRST SIGNATURE

Revised 2020