PATIENT REGISTRATION - Rochester Endocrinology and Diabetes Center

NAME:_____ **SEX:**_____ **MARITAL STATUS**_____
(LAST) (FIRST) (INITIAL) (M/F) (S/M/D/W)

ADDRESS:_____
(STREET) (APT) (CITY/STATE) (ZIP)

PHONE NUMBERS: _____-_____ _____-_____
(PRIMARY) (CELL)

BIRTHDATE:____/____/____ **EMPLOYER:**_____ **SSN:** XXX-XX- __ __ __ __

EMAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____

SUBSCRIBER'S NAME:_____ **BIRTHDATE:**____/____/____

EMERGENCY CONTACT:_____ **RELATIONSHIP:**_____ **PHONE:**_____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to *Rochester Endocrinology & Diabetes Center* for all insurance benefits otherwise payable to me for service rendered. I understand that I am financially responsible for all charges, whether or not paid by insurances, and for all services rendered on my behalf or my dependents. I authorize any provider and/or supplier of services in this office to release any information required in securing the payment of benefits. I authorize the use of this signature on all insurance submissions. **I understand I will be subjected to a $30 service fee if my check is returned unpaid or $50 if 24 hour prior to my scheduled appointment I fail to notify the office I will not be keeping my scheduled appointment.**

Signature of Responsible Party:_____ **Date:**_____

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

Rochester Endocrinology & Diabetes Center will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information. You have the right to review and retain a copy of this notice prior to signing this acknowledgement. The terms of the notice may change with time and we will always post the current notice at our facilities and have copies available for distribution. You may ask us to restrict the use and disclosure of your personal health information.

□ I would like a copy of Notice of Privacy Practice.
□ I have read and understand the PCMH Agreement

SIGNATURE:_____ **DATE:**_____

You may give Medical & Billing info to the following: _____ / _____
(NAME) (RELATIONSHIP)

You may leave a message on answering machine or voicemail if unavailable. YES / NO

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