# Academic Endocrine Metabolism & Nutrition, Inc.

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**Patient's Name** ______________________________ **SSN #** ____________________

Birth Date ____________________ Gender____________ Marital Status S M D W

Street Address ______________________ City ______________ Zip Code ________

(Area Code) Home Phone ________________ Work Phone ________________ Ext ______

Present Employer ____________________________________________________

Referred By ________________________________________________________

Primary Care Physician _______________________________________________

Address ___________________________________________________________

**<u>Party Responsible for Patient's Insurance</u>**

Name ________________________________________ SSN #____________________

Street Address _______________________________________________________

City/State ___________________________________________ Zip Code __________

Present Employer _____________________________________________________

Insurance Company __________________________ Plan # ____________________

As a courtesy to our patients, claims are filed on your behalf. It is your responsibility to give us accurate insurance information. You are responsible for paying your co-pay at the time of service. If a temporary insurance lapse necessitates a period of self-pay, payment in full is due at the time of service. **<u>In cases of HMO coverage, a form authorizing treatment must be brought to the office for every visit. This referral is your responsibility. Please call your insurance company and/or primary care physician ahead of time to determine if this is needed.</u>** If you do not have your referral form with you, you accept responsibility for payment for services rendered for every visit and/or procedure and are prepared to pay the fee at the time of the visit.

Professional services are rendered and charged to the patient, not to the insurance company. Insurance forms will be filed for you if you give us all of the necessary information. You will receive a statement from our office every month, which will show any insurance payments made and the balance due. If a payment on a claim is denied, reduced, or delayed beyond 90 days, you will be responsible for settling your balance with us. Payment in full is expected at that time.

As our patient, your signature is required to indicate acceptance of our office policies and to acknowledge that you have been advised of them. In addition, your signature will serve as our authorization to release to your insurance company information regarding only the services rendered. Your signature will also serve as an authorization for your insurance company to pay us directly, if we have filed your claims. Thank you. We look forward to serving you and your family.

Signature of Patient or Responsible Party ________________________ Date __________________