Website: www.yourdiabetes.net

YOUR DIABETES ENDOCRINE NUTRITION GROUP, INC.

Patient Registration Form

Account Number_____

PATIENT INFORMATION

Today's Date_____

Legal Last Name_____ Legal First Name_____ MI_____

Mailing address_____ EMAIL_____

City_____ State_____ ZIP Code_____

Home Phone_____ Work Phone_____ Ext_____ Cell Phone_____

Date of Birth_____ Employer_____

Gender (Circle) Male Female

Marital Status (Circle) S M D W

Emergency ContactName_____Relationship_____Phone_____

RESPONSIBLE PARTY (person responsible for payment of services) – Usually this is the Policy Holder

Last Name_____ First Name_____ MI____

Mailing Address (if different than patient) _____

City_____ State_____ ZIP Code_____

Home Phone_____ Work Phone_____Ext_____

Date of Birth_____ Gender: Circle: Male Female Social Security #_____

Employer_____ Relation to patient (circle): Self Spouse Father Mother Guardian

PHYSICIAN INFORMATION

Primary Care Physician_____ Physician sending you here: _____

City, State_____Phone_____ City, State_____ Phone_____

INSURANCE INFORMATION

Primary Insurance_____

Secondary Insurance_____

ASSIGNMENT & RELEASE – TREATMENT AND RECORD INFORMATION

I agree to permit authorized personnel of Your Diabetes Endocrine Nutrition Group, Inc., to perform routine medical treatment, examinations, laboratory tests, and emergency procedures as deemed necessary by the doctors assisting in my care. I agree to be contacted about possible clinical research trials that might be of interest to me.

I hereby assign my insurance benefits to be paid directly to Dr. Daniel Weiss. I also authorize Dr, Weiss and his designee to release information acquired in the course of my examination and treatments necessary to process insurance claims and/or provide care.

I agree that this authorization is valid regardless of when services are provided and that I certify that I am the patient or authorized person to sign this document.

SEE NEXT PAGE PLEASE

Your Diabetes Endocrine Nutrition Group, Inc.

FINANCIAL AND INSURANCE POLICY STATEMENT

Thank you for choosing us as your healthcare provider. In order to continue to offer high quality care and services, we will adhere to the following policy: The patient/responsible party assumes the responsibility to ensure that the financial obligation is fulfilled for the services we provide. We ask that you read and sign this Policy Statement prior to seeing your provider.

- Patients with an insurance co-payment are expected to make payment at time of services.
- Patients with insurance are expected to pay any personal balance that is due immediately after their insurance has remitted payment to the provider. If you receive the insurance payment at your home on an outstanding bill with our office, that payment must be forwarded to this office immediately.
- Not all services are covered benefits by all insurance plans. The patient/responsible party is responsible for verification of applicable coverage.
- The patient is responsible for payment of unpaid deductibles, co-insurance, or other known non-covered services at the time services are provided.
- Uninsured patients are expected to make payment at the time of service.
- Patients are requested to provide staff with sufficient notice to complete any referral forms, pre-certifications or other forms required by your insurance company to process payment for services. The patient is responsible for notifying staff of the need for a referral and will be responsible for any financial penalty incurred by failure to secure proper referral for any services.

We accept cash, personal checks and credit/debit and HSA cards. Returned checks will be subject to additional fees.

We understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems with our billing office so that we can assist you in the management of your account.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide you with medical care.

I have available for review Your Diabetes Endocrine Nutrition Group's Notice of Privacy Practices.

I also understand that I MAY be charged $40.00 for failure to cancel or reschedule an appointment at least 48 hours in advance of the time it was scheduled.

Please note that crossing out portions of this statement or altering its content does not change its validity or intent.

I have read, understand, and agree to accept full responsibility as described above.

_____ Date_____

Signature of Responsible Party

Patient Name if different than Responsible Party_____

Do you have an answering machine? Circle one: YES NO

May we leave a detailed message on the machine? Circle one: YES NO not applicable