PATIENT REGISTRATION

Diabetes & Endocrine Specialists, PLLC
330 Townepark Circle, Suite 100
Louisville, KY 40243

(502) 245 – 8988 Phone Number
(502) 489 – 5227 Fax Number
Dr. Nisha Roy Varghese

Referring Physician ______________________ Family Physician ______________________

Dear Patient: As a part of our services to you, insurance claims will be filed directly to your insurance company or employer. Many claims are submitted electronically for quicker processing. Please assist us by clearly and correctly completing the following information.

Last Name ______________________ First Name __________________ Middle Initial ______

Patient's Sex ____ Male ____ Female Date of Birth ___________ Race ________

Street Address ________________________________City____________Zip___________

Home Number ______________ Cell Number ________________ Work Number ___________

Social Security Number ___________________ Employer ______________________________

Employment Status Full-time ____ Part-time ____ Retired ___ Unemployed _____
Marital Status Single_____ Married_____ Separated_____Widowed_____ Divorced_____

Alternate Contact's Name & Number ____
Pharmacy name, number and zip code

AUTHORIZATION (Authorization and Appointment Cancellation Detail on Back of This Page)

DATE ____________________ Signature ____
Patient (Parent/Guardian if Minor)

PRIMARY INSURANCE COVERAGE

Primary Insurance Coverage ______________________________ ID Number __________________

Group Number ____________________ Name of Policy Owner _____________________________

Birth Date of Policy Owner _____________________ Social Security Number ________________
Policy Holder's Sex ____ Male ____ Female Phone Number _________________________
Patient's Relationship to Policy Owner Self _____ Child _____ Spouse _____ Other _____

THE ABOVE SUBSCRIBER HEREBY AUTHORIZED HIS/HER INSURANCE COMPANY TO ISSUE INDEMNITY CHECKS TO THE ABOVE LISTED MEDICAL PROVIDER FOR SERVICES RENDERED.

DATE ____________________ Signature ____
Patient (Parent/Guardian if Minor)

SECONDARY INSURANCE COVERAGE

Secondary Insurance Coverage ______________________________ ID Number ________________

Group Number ____________________ Name of Policy Owner _____________________________
Birth Date of Policy Owner _____________________ Social Security Number ________________
Policy Holder's Sex ____ Male ____ Female
Patient's Relationship to Policy Owner Self _____ Child _____ Spouse _____ Other _____

THE ABOVE SUBSCRIBER HEREBY AUTHORIZED HIS/HER INSURANCE COMPANY TO ISSUE INDEMNITY CHECKS TO THE ABOVE LISTED MEDICAL PROVIDER FOR SERVICES RENDERED.

DATE ____________________ Signature ____
Patient (Parent/Guardian if Minor)

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PATIENT AUTHORIZATION

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to my insurance carrier. I authorize any holder of medical or other information about me to release to insurance carriers or the Health Care Financing Administration and its agents or the Social Security Administration or its intermediaries or any agency, group, or person(s) necessary to secure payment any information needed for this or related claim(s). "For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. The patient or his/her representative recognizing the need for health care, consents to the above listed medical provider rendering service as ordered by the physicians, including medical or surgical treatment, laboratory procedures, or other services rendered under the instructions of the physician. I certify that the information given by me in applying for payment under Title XVII of the Social Security Administration Act is correct.

APPOINTMENT CANCELLATION

A 24-hour advanced notice of appointment cancellation is appreciated by our staff as well as our patients. Repeated occurrences may be subject to a "cancellation" or "No Show" charge of **$75.00**.

We look forward to meeting you!

Financial Policies

Diabetes & Endocrine Specialists, PLLC, welcomes you as a patient. We will make every effort to work with you and your insurance company to maximize your health care benefits. It is your responsibility to immediately inform us of any changes in your insurance coverage or carrier. We are dedicated to providing the best quality care and services to you and regard your complete understanding of your financial responsibilities as and essential element of your care and treatment. To avoid problems and to expedite the services you may require, please bring your insurance identification card to each visit. Our patient registration will verify coverage on file, each visit.

CO-PAYS: All co-pays are due at the time of registration. If you are unable to pay at the time of service, your appointment will be rescheduled.

DEDUCTIBLES AND CO-INSURANCES: Your insurance benefit information is verified prior to your visit. Any co-pay, deductibles or co-insurance amounts will be collected at the time of check-in. As a patient, you are expected to pay any patient due balances each appointment. If you are unable to pay the balance in full, you will be required to set up a payment plan, on a case by case basis.

INSURANCE CLAIMS: Patients will become responsible for any charges if the insurance information give to our office at the time of service does not result in payment within 45 days.

COLLECTIONS: If your account becomes delinquent with our office, our billing department will make several attempts to secure the balance in full or set up a payment arrangement. If the attempt to secure the balance or the payment arrangement fails, the undersigned agrees that if this account is not paid when due, and Diabetes and Endocrine Specialists PLLC, should retain an attorney or collection agency for the collection, the undersigned agrees to pay all costs of collection including court costs, reasonable interest, reasonable attorney's fee and reasonable collection agency fees at the maximum rate of 33 1/3%. This contract shall cover all medical treatment and services until revoked by either party in writing.

APPOINTMENTS: Our office will call approximately two business days prior to your appointment date to remind you of the appointment. It is the patient's responsibility to remember the appointment and to supply this office with **a 24 hour notice** if you must cancel. We have a 24 hour cancellation access extension: (502) 245-8988 Ext. 21. **Our office will extend a $75.00 service charge for all missed appointments that must be paid prior to scheduling your next appointment.**

MEDICAL RECORDS: Our office will provide you with one free copy of your medical records according to Kentucky law. You will be required to sign a release and pick up the copy at our office, as they will not be faxed or emailed directly to the patient. Additional copies are charged at $1.00 per page with a postage and handling fee if required.

Lab order forms given to patients are the patients responsibilities and requests to fax or mail misplaced lab slips may incur a fee to cover staff time spent in doing so. The completion of any form such as disability, FMLA or other forms will be subject to a **$50.00** fee paid at the time of the form completion.

RETURNED CHECKS: There will be a **$50.00 charge** for any check returned to our office for insufficient funds. Cash, credit card, or money orders must then pay the balance.

I, the undersigned, hereby agree that I have read and understand all of the Financial Policies stated above. If I have any financial questions or concerns, I will contact the billing department. Otherwise, I agree to be financially responsible for the full treatment I will receive by Diabetes & Endocrine Specialists, PLLC.

Patient Signature _______________ Date _______________

AGREEMENTS, AUTHORIZATIONS, AND CONSENTS

I HEREBY CONSENT AND CERTIFY THE FOLLOWING

A.**CONSENT TO TREATMENT:**The undersigned grants authority to Dr. Nisha R. Varghese and her office staff to perform those procedures and treatments deemed necessary for this patient that are generally used in care for patients. It is understood that the patient or his/her agent also consent to the performance of special diagnostic studies and/or surgical procedures deemed necessary.

B.**ASSIGNMENT OF BENEFITS:**I assign all rights and privileges and authorize payment directly to Dr. Nisha R. Varghese for any claim filed on my behalf for surgical and/or other medical insurance filed now or in the future including disability, no fault and liability benefits. I agree this assignment given after this date including any cost relative to attorney fees.

C.**GUARANTEE OF PAYMENT:**I agree to be responsible to Dr. Nisha R. Varghese for charges resulting from services rendered. I agree all bills are due in full upon demand. Should I fail to honor this agreement, I agree to pay any collection costs, court costs, or attorney fees resulting from the collection of my accounts. This is a guarantee of payment not a guarantee of collection.

D.**RELEASE OF INFORMATION:**I authorize Dr. Nisha R. Varghese and her office staff to release information from all or part of my medical or financial record may be disclosed to any corporation, person or agency that Dr. Nisha R. Varghese and her staff has good cause to believe will be involved in treatment, payment, or healthcare operations.

E.**PROCUREMENT OF INFORMATION:**The undersigned designates and authorizes Dr. Nisha R. Varghese to be his/her agent for the purpose of rendering such consent to other physicians, hospitals, or clinics as may be necessary to obtain from them such previous or current records, as are needed for the patient's current medical care.

CERTIFICATION: The undersigned certifies that he/she has read the foregoing and/or that he/she understands the nature and purpose of these consents to his/her satisfaction, and that he/she is the patient or is duly authorized by the patient's general agent to execute the above and accept its terms.

ACKNOWLEDGEMENTS:I acknowledge that I have received a notice of Privacy Practices. When providing information to me, information may be transmitted to me by any or all of the following means (initial all that apply):

_______Telephone messages on answering machine

_______Messages to the following family members or friends:

_______E-mail to the following address: ________________________________

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have had the opportunity to place special restrictions upon the consent hereby given:

____

Special Restrictions:

____

____

This consent is valid form the date executed until revoked in writing by the patient:

Signed: ________________________________

Date:________________________________

Witness:________________________________

HISTORY Questionnaire *Completed by:* [   ] [staff] [patient] [physician] on : __/__/__

Name: [Male] [Female] **Age:** **DOB**

Reviewed last-date/by

SOCIAL

Martial Status: [single] [married] [widowed ___/ ___/ ___] [divorced ___/ ___/ ___] ____________

Occupation: [retired] [active] ____________

Do you: *{Please circle No or Yes and explain if Yes}*

Live w/ others	[no]	[yes]	⇒	who: ____________
Have children	[no]	[yes]	⇒	# living ___ , # deceased ___ ⇒from: ____________
Get exercise	[no]	[yes]	⇒	hours per wk: ____________
Use illegal drugs	[no]	[yes]	⇒	____________
Use alcohol	[no]	[yes]	⇒	oz's per day ____________
Smoke	[no]	[yes]	⇒	ppd stopped

PAST MEDICAL

Have you ever had:

Surgery	[no]	[yes]	⇒	date: ________ hospital: ____________ for: ____________
Blood transfusion	[no]	[yes]	⇒	date: ________ hospital: ____________ for: ____________
An Illness	[no]	[yes]	⇒	date: ________ hospital: ____________ for: ____________

Problems for which you have seen a physician or have been treated for:

				Medications prescribed and dose		**Currently** taking	
Diabetes	[no]	[yes]	⇒	____________	⇒	[no]	[yes]
KIDNEY STONES	(NO)	(YES)		____________			
Cancer	[no]	[yes]	⇒	____________	⇒	[no]	[yes]
Tumor/lesion	[no]	[yes]	⇒	____________	⇒	[no]	[yes]
COPD	[no]	[yes]	⇒	____________	⇒	[no]	[yes]
Blood pressure	[no]	[yes]	⇒	____________	⇒	[no]	[yes]
Heart problem	[no]	[yes]	⇒	____________	⇒	[no]	[yes]
Infections	[no]	[yes]	⇒	____________	⇒	[no]	[yes]
Pain	[no]	[yes]	⇒	____________	⇒	[no]	[yes]
Nervousness	[no]	[yes]	⇒	____________	⇒	[no]	[yes]
Arthritis	[no]	[yes]	⇒	____________	⇒	[no]	[yes]
Others: ________			⇒	____________	⇒	[no]	[yes]
________			⇒	____________	⇒	[no]	[yes]

Do you have any allergies / reactions to:

Food(s)	[no]	[yes]	⇒	____________
Medicines	[no]	[yes]	⇒	____________
Others			⇒	

FAMILY

Do any of your blood relatives have or have had any of these diseases or
Do any other problems run in the family:

Diabetes	[no]	[yes]	⇒ Type ________	TB	[no]	[yes]
Cancer	[no]	[yes]	⇒ Location: ________	Thyroid disease	[no]	[yes]
Tumor/lesion	[no]	[yes]	⇒ Location: ________	High blood pressure	[no]	[yes]
Heart problem	[no]	[yes]	⇒ Type: ________	Stroke	[no]	[yes]
Others ____________				____________		

Your Father: [living] [died] ___/___/___ ⇒ of ____________

Your Mother: [living] [died] ___/___/___ ⇒ of ____________

Your Brothers: [# ___ living] [# ____died] ⇒ of ____________

Sisters: [# ___ living] [# ____died] ⇒ of ____________

PATIENT SIGNATURE____________________________

Name: ______________________________

Date of Birth: _____/_____/______

Please include all prescription medications, vitamins, supplements, and over the counter medications.

Medication	Dose & Directions

Office Directions

Our office is located on 330 Townepark Circle, Suite 100, Louisville KY 40245

From I-64 E / 64 W
Take Exit 19B onto Gene Snyder Freeway North (I 265N) and take Exit 27 (Shelbyville Road, Middletown, US 60 W) take a left off the ramp at the light. At the 5th traffic light, take a left onto Townecreek Road and immediate left onto Townepark Circle. We will be located on the left. Our office is the only building beside the American Flag.

From I-65
Proceed to Gene Snyder Freeway North or I64 East and follow above directions.

From I 71 N/S
Take Gene Snyder to Middletown Exit, make a right off the ramp at the light. At the 5th traffic light, take a left onto Townecreek Road and an immediate left onto Townecreek Circle. We will be located on the left. Our office is the only building beside the American Flag.

Telephone Number (502) 245-8988
Fax Number (502) 489-5227

Patient Hours Monday – Thursday CLOSED ON FRIDAYS
8:10 AM to 4 PM

Copays/Deductibles are due at visit.
24-hour notice of cancellations are appreciated.