PALM BEACH DIABETES & ENDOCRINE SPECIALISTS, P.A.

William A. Kaye, M.D., F.A.C.P.
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Gary M. Pepper, M.D., F.A.C.P.
Shital R. Patel, M.D.
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Maria E. Gutierrez, M.D.
Kathleen Kurit, MSN, FNP-C
Stephanie Devaney, MSN, FNP-C

****Please Provide ALL Information Requested****

PATIENT INFORMATION

Name:_____ SSN:_____/_____/_____
Last First MI

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Employer:_____

Sex:_____ Age:_____ Race:_____ Marital Status_____ Birthday:_____/_____/_____ Occupation:_____

Referring Doctor:_____ Which doctor are you seeing today?_____

Emergency Contact Name:_____ Phone:_____ Relationship:_____

Email Address:_____ Cell Phone:_____

PRIMARY INSURANCE INFORMATION

Name of insured as it appears on card:_____ Sex:_____
Last First MI

Relation to patient:_____ SSN:_____/_____/_____ Birthday:_____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Employer:_____

PRIMARY INSURANCE COMPANY NAME:_____

ID#:_____ Group/Control #:_____ Copayment:_____

SECONDARY INSURANCE INFORMATION

Name of insured as it appears on card:_____ Sex:_____
Last First MI

Relation to patient:_____ SSN:_____/_____/_____ Birthday:_____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Employer:_____

SECONDARY INSURANCE COMPANY NAME:_____

ID#:_____ Group/Control #:_____ Copayment:_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____
Name of Insurance Company(ies)

and assign directly to Palm Beach Diabetes and Endocrine Specialists, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature:_____ Date:_____

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☐ 1515 N. Flagler Drive, Suite 430 • West Palm Beach, FL 33401 (561) 659-6336 Fax 659-9353
☐ 6056 Boynton Beach Blvd., Suite 245 • Boynton Beach, FL 33437 (561) 659-6336 Fax 659-9353
☐ 550 Heritage Drive, Suite 150 • Jupiter, FL 33458 (561) 659-6336 Fax 659-9353
☐ 1041 State Road 7, Suite 1 • Wellington, FL 33414 (561) 659-6336 Fax 659-9353

NO SHOW & FORMS POLICY

In an effort to address this concern and continue to meet the needs of our patients, we have developed the following **"NO SHOW POLICY".**

1. Unless there is an unforeseeable emergency, we request at least 48 hours advance notice when canceling your appointment.

2. There is a $50 fee for appointments canceled with less than 24 hours notice to cover administrative expenses.

3. Patients who do not reschedule within 30 days or have a history of repeatedly not showing may be subject to dismissal for "non-compliance."

We believe this policy will result in improved patient care, and we appreciate your understanding in this matter.

Name:_____

Date:_____

There will now be a $25.00 charge for completion of all:

Disability Forms	Handicap Permit Forms
FMLA Forms	DOT Forms
Life Insurance Forms	Wellness Forms
Return to Work Forms	FAA Forms

The forms will be completed within 48 hours and the fee is to be paid when dropping off the forms.

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Designation for Release of Medical Information to a Family Member, Friend or Legal Representative

Introduction:

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Privacy Statement of Palm Beach Diabetes & Endocrine Specialists, P.A. ("PBDES") is the basis for how we treat your Protected Health Information. HIPAA allows physicians to use their professional judgment on disclosing certain PHI to family, friends, etc. without an authorization. This form is an aide to the physicians in making a determination on disclosing such information. Drs. Kaye, Horowitz, Pepper, Patel, Steinsapir, Reynolds, Casanova-Romero, Knudson, Kale and Gutierrez realize that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- Only one person can be designated for this role
- The designation is valid until you cancel it in writing
- If you designate no one, PBDES may not be able to release information to any family member or friend.

Designation Statement:

I, _____, designate the following person to be able to speak to a physician at PBDES, a nurse or other staff member, should it be necessary, on my behalf. I hereby give permission to PBDES through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release PBDES, its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: _____

Relationship: _____ Phone Number _____ (home/work)

Patient's Signature: _____

Date: _____ Witness: _____

I decline to designate any person to speak with my physician or clinical staff.

Patient's Signature: _____

Date: _____ Witness: _____

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Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Discover, Mastercard, American Express, and Visa.

Your Insurance:

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment, co-insurance, or deductible at the time of service. This office's policy is to collect when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients:

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____
Printed Name of the Patient

_____ Date _____
Signature of Patient or Responsible party if a Minor