DIABETES, THYROID & ENDOCRINE ASSOCIATES

PATIENT INFORMATION

Name: _____ Date of Birth: _____/_____/_____ Age: _____

Place of Birth: _____ Marital Status: _____ Social Security #:_____

Address: _____ Home Phone: _____

City:_____ State:_____ Zip Code: _____ Cell Phone:_____

Email Address:_____ Occupation:_____

Primary Language Spoken:_____ Name of Employer: _____

How do you hear about us: _____ Ethnicity: American Indian, Alaska Native, Asian, White, African American, Hawaiian, Hispanic or Other

Have you travelled outside of the US in the last six months? If Yes, where to: _____

Health Insurance Information

Name of Primary Insurance: _____ Policy#: _____

Name of Secondary Insurance: _____ Policy#:_____

Name of Subscriber: _____ Date of Birth:_____ Relationship:_____

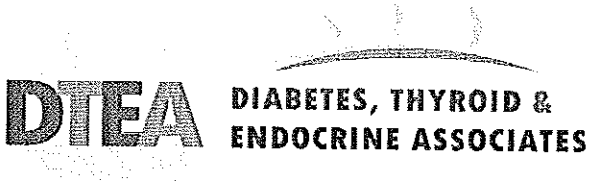
Emergency Contact/ Authorization to Discuss Your Health Information

Name of Relative:_____ Relationship:_____ Phone: _____

Please read and sign the following

1. Payment for services is expected at time of visit
2. Your insurance is filed, I authorize benefits to be paid directly to Diabetes, Thyroid & Endocrine Associates, LLC
3. I am responsible for the balance on my account, regardless, of insurance coverage. My failure to pay off outstanding balances may result in collection procedures.
4. I authorize Diabetes, Thyroid & Endocrine Associates, LLC to release any information requested in regards to the processing of my medical claims.

Patient Signature:_____ Date: _____



DIABETES, THYROID & ENDOCRINE ASSOCIATES LLC

George Vargas, MD, FACP, FACE **Vitra Gosine, MD, FACP, FACE**

17901 NW 5th Street, Suite 103, Pembroke-Pines, Fl 33029 (Tel- 954-538-0022) (Fax- 954-538-0028)

Authorization for Release of Confidential Medical Information

I hereby authorize and request release for the following:

_____ a copy of the most recent doctors notes, laboratory results, scans.
_____Complete chart including reports, laboratory results, scans and medication.

MEDICAL RECORDS FROM:
Name of Facility or Primary Care Doctor:

_____

Address:

_____

City, State, Zip Code: _____

RELEASE MEDICAL RECORDS TO:
DIABETES, THYROID & ENDOCRINE ASSOCIATES LLC
ADDRESS: 17901 NW 5TH STREET, SUITE 103, PEMBROKE-PINES, FL 33029

TO RECEIVING PARTY: This information is disclosed to you from records whose confidentiality is protected by law. Redisclosure is prohibited without the written permission of the patient/client/legal representative listed above.

NOTE: PATIENT /REPRESENTATIVE MUST INITIAL APPLICABLE AREAS FOR RELEASE:
Psychiatric/psychological information _____ (Initial)
Alcohol /drug/chemical information _____ (Initial)
HIV Tests and information pertaining to tests/treatment _____ (Initial)

Patient's Name (printed) :

_____

Address: _____ Date: _____

Patient/Guardian Signature: _____ Medical Record # _____

Witness: _____ Date: _____

DTEA DIABETES, THYROID & ENDOCRINE ASSOCIATES

Patient Financial Responsibility Agreement

A. **Financial Responsibility.** In consideration of DTEA providing me with health care services, I agree as follows:

1. I will be responsible, either personally (for services not covered by my insurance) or through my insurance coverage, for payment to DTEA for all services provided to me by DTEA.
2. I hereby assign payment by any third party, including private insurance and credit card companies, for all services provided to me by DTEA, directly to DTEA. I understand and agree that I remain liable for all charges and/or applicable co-payments, co-insurance and deductibles not covered by this assignment.
3. For services not covered by my insurance, I agree to pay DTEA within seven (7) days of the date of any invoice.
4. I understand that after 30 days of non-payment of any DTEA invoice that DTEA may, in its sole discretion, stop providing services to me.
5. If my current insurance policy prohibits direct payment to DTEA, I hereby authorize and instruct my insurance carrier to mail directly to DTEA any check for any payment of benefits due to me.
    a. Immediately upon DTEA's request, I will endorse such payment(s) over to DTEA.
    b. This is a direct assignment of my rights and benefits under my insurance policy.
    c. Any payment made pursuant to this assignment will not exceed my indebtedness to DTEA but I hereby agree to pay, in a current manner, any balance due to DTEA over and above any insurance benefit payment received by DTEA.
    d. For purposes of carrying out the provisions of this assignment, a photocopy of this Agreement shall be treated as an original.
    e. I hereby authorize DTEA to initiate, on my behalf, any action it deems necessary to enforce the provisions of this assignment of benefits, including, but not limited to submitting a complaint to the appropriate Insurance Commissioner.
6. If I receive any payment of insurance benefits for services provided to me by DTEA, I will immediately forward any and all such monies, along with the explanation of benefits, to DTEA.
7. I will notify DTEA immediately upon my dis-enrollment from my current insurance carrier or any other change of benefit that could affect payment to DTEA for its services.
8. I acknowledge that it is not the insurance company's responsibility to inform DTEA of any change in my coverage, and the insurance company will not pay for non-covered services or for services I receive after I am no longer covered.
9. I understand that I will be held liable for payment if I fail to notify DTEA if I dis-enroll from or become ineligible for coverage under my current payer(s).
10. DTEA will charge, and I agree to pay, a 1.5% monthly finance fee on all outstanding balances over 30 days and, if necessary, collection and attorney's fees.

11. I must provide at least 24 hours' advance notice of cancellation of any appointment by calling 954-538-0022 or such other number as DTEA mandates. DTEA may charge me a $50 cancellation fee if I do not cancel in a timely manner as required by this Agreement.
12. I also agree to pay DTEA $30.00 for any checks returned unpaid for any reason.

B. **Release of Information.** I authorize:

1. any health care insurer with whom I have or may have coverage to disclose to DTEA any information regarding my coverage and any payments made directly or indirectly for services rendered to me by DTEA;
2. any credit card company to which I charge fees for services provided to me by DTEA to disclose to DTEA any information regarding my account and any fees charged for services rendered to me by DTEA;
3. DTEA and its designees, to release to any public or private regulatory entity, accrediting entities and to any third party insurer or other person or entity which provides insurance on my behalf or for my benefit, information concerning my medical history, condition, lab and test results;
4. DTEA and its designees, to conduct any credit and financial history check, inquiry or information gathering activities it feels, in its sole discretion, is or are necessary to verify my ability to pay for products or services provided by DTEA.

I hereby release DTEA, its designees and any person or entity providing information as contemplated above from any and all liability in connection therewith.

I have read and understand the provisions of this Agreement, I have had a chance to ask questions about the Agreement and I agree and acknowledge that I am financially responsible for services received from DTEA. I acknowledge that this Agreement binds me and my heirs, executors, administrators and assigns. I am signing this Agreement of my own volition with full understanding of its meaning.

Credit Card Number: _____

Expiration Date: _____/_____

Security Code: _____

Patient Name:_____

Patient Signature:_____

Date:_____