PATIENT INFORMATION

Please answer all questions fully

Date: ____________________

REGENCY ENDOCRINOLOGY
752 Stirling Center Place
Suite 1008
Lake Mary, FL 32746
(407) 333-1212

PATIENT

Name (Last, First, MI)		Social Security	Birth Date	Sex
Mailing Address	City		State	Zip Code
Home #	Work #		Marital Status	
Email		Ethnicity		
Employer		City	State	Zip Code

RESPONSIBLE PARTY OR POLICY HOLDER (Please indicate which one)

Name (Last, First, MI)		Social Security	Birth Date	Sex
Mailing Address		City	State	Zip Code
Home Number	Work Number		Marital Status	
Employer		City	State	Zip Code
Referring Physician		**Primary Care Physician**		

INSURANCE

Primary Insurance	Subscriber's Name	Policy and Group Number
Secondary Insurance	Subscriber's Name	Policy and Group Number

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

Signature: ______________________________ Date: ____________________
(Signature of insured or authorized patient or parent of a minor)

OVER

REGENCY ENDOCRINOLOGY

MAHA ANSARA, M.D., P.A.
RICHARD WHETZEL-SCHILL, APRN, C-BC
ADRIEL PEREZ, APRN, FNP-C
752 STIRLING CENTER PLACE, SUITE 1008
LAKE MARY, FLORIDA
(407) 333-1212

OUR FINANCIAL POLICY

THANK YOU FOR CHOOSING US AS YOUR ENDOCRINE SPECIALIST. WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE MEDICAL CARE. IN ORDER TO ACHIEVE THIS GOAL, WE NEED YOUR ASSISTANCE AND YOUR UNDERSTANDING OF OUR PAYMENT POLICY. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, WHICH WE REQUIRE YOU TO READ AND SIGN PRIOR TO ANY TREATMENT.

- ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORM BEFORE SEEING THE DOCTOR.
- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/AMERICAN EXPRESS
- RETURNED CHECKS ARE SUBJECT TO A $29.00 SERVICE CHARGE

HEALTHCARE INSURANCE PLAN OBLIGATION:
REGENCY ENDOCRINOLOGY, DIABETES & METABOLISM MAINTAINS A LIST OF THE HEALTH CARE SERVICE PLANS WITH WHICH IT HAS CONTRACTED TO PROVIDE MEDICAL SERVICES. WE HAVE AGREED TO BILL THOSE INSURANCE CARRIERS FOR ALL SERVICES RENDERED. AUTHORIZATION FROM YOUR INSURANCE DOES NOT ALWAYS GUARANTEE PAYMENT. THE UNDERSIGNED AND/OR PATIENT SHALL REMAIN RESPONSIBLE FOR ALL CHARGES, APPLICABLE CO-PAYMENT AND DEDUCTIBLES. IF YOUR INSURANCE HAS NOT RESPONDED TO OUR CLAIMS SUBMITTAL WITHIN 60 DAYS, PAYMENT FOR SERVICES INCURRED AND CLAIM STATUS FOLLOW-UP WITH THE INSURANCE CARRIER BECOMES THE PATIENT'S RESPONSIBILITY.

NON-PARTICIPATING INSURANCE:
ALL FEES ARE DUE IN FULL AT THE TIME OF SERVICE. A RECEIPT IS PROVIDED WHICH DETAILS ALL SERVICES AND PAYMENT FOR THE VISIT. A COPY OF THE RECEIPT CAN BE SUBMITTED TO YOUR INSURANCE CARRIER FOR PAYMENT.

PPO/HMO/MEDICARE/TRADITIONAL INSURANCE WAIVER REGARDING NON-COVERED PATIENTS:
MEDICARE, UNDER SECTION 1862 (A) (1) OF THE MEDICARE LAW AND SOME HEALTH INSURANCE PLANS WILL ONLY PAY FOR SERVICES THAT DETERMINES TO BE **'REASONABLE & NECESSARY"**. IF MEDICARE DETERMINES THAT A PARTICULAR SERVICE IS NOT REASONABLE AND NECESSARY UNDER THE MEDICARE PROGRAM STANDARDS; OR YOUR INSURANCE DETERMINES THAT A SERVICE OR SERVICES WERE UNAUTHORIZED OR NOT A COVERED BENEFIT UNDER YOUR PLAN, MEDICARE AND OR OTHER INSURANCE PLANS WILL DENY PAYMENT FOR THESE SERVICES. WE BELIEVE THAT ACCORDING TO YOUR INSURANCE/ MEDICARE PLAN, PAYMENT IS OFTEN DENIED FOR THE FOLLOWING SERVICE(S).

- COPIES OF MEDICAL RECORDS
- CERTAIN LAB TESTS
- OUT OF NETWORK REFERRALS
- PHYSICALS
- PRE-EXISTING CONDITIONS
- WALK-IN WORK-IN APPOINTMENTS

THE UNDERSIGNED AND/OR PATIENT UNDERSTANDS & AGREES TO BE PERSONALLY AND FULLY RESPONSIBLE FOR NON-COVERED SERVICES. OUR PRACTICE IS COMMITTED TO PROVIDING THE BEST TREATMENT FOR OUR PATIENTS.

THERE IS A $50.00 FEE FOR MISSED APPOINTMENTS UNLESS CANCELLED AT LEAST 24 HOURS IN ADVANCE. PLEASE HELP US SERVE YOU BETTER BY KEEPING YOUR APPOINTMENT. SHOULD COLLECTIONS BECOME NECESSARY, THE PATIENT WILL BE RESPONSIBLE FOR ALL COLLECTION COST AND ATTORNEY'S FEES. THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I HAVE READ THIS FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY

____ DATE____________________

SIGNATURE OR PATIENT OR RESPONSIBLE PARTY

Regency Endocrinology

Specializing in Endocrinology, Diabetes and Metabolism

Maha Ansara, M.D., P.A.
Richard Whetzel-Schill, APRN, C-BC
Adriel Perez, APRN, FNP-C

OFFICE POLICIES

***Appointments:**

- Patients arriving 15 minutes or more late to their appointment will be rescheduled.
- Patients should cancel their appointment at least 24 hours in advance to avoid a no-show fee.
- A no-show fee of $50 will be charged for failure to cancel. $25 may be charged if not 24 hours in advance.
- Reminder calls are automated and called 1 week in advance. (Reminders are a courtesy)

***Copays, Deductibles, and Co-Insurances:**

- Copays, deductibles, co-insurances, and past due balances are collected prior to visit.
- If unable to pay monies due at the time of visit, appointment will be rescheduled.
- We are unable to accept bill larger than $20.

***Forms, Referrals, and Records:**

- Insurance forms, disability papers, and handicap permits should be done at the time of your office visit.
- Forms requested will be charged a fee of $25.
- When applicable referrals are to be submitted prior to visit, if we do not have your referral we will request that you reschedule.
- Records request are to be submitted to the office with a signature of release. (**a fee of $1 per first page *1st 25 pages,*** **and $00.25 *for each page thereafter)*** *Please allow 3-5 business days to complete your request*

***Refills:**

- All prescription refills should be done at your office visit. Please bring medicine bottles with you.
- Please contact your Pharmacy for refill requests outside of office visits.
- Refill requests called in by patient outside of office visits are subject to a $10 charge.
- Please allow 2 business days for your request to be completed.
- Refill request will be honored only if visits and labs are up to date.
- We reserve the right to deny or limit refills if you are overdue for follow up or lab work.

***Labs and Tests:**

- Labs should be done 1 week prior to your scheduled office visit.
- If Vitamin D-25 (OH) and /or Vitamin B-12 are listed on your lab requisition, you should have your labs done 10 days prior to your visit.
- If labs are not done prior to your office visit, we reserve the right to reschedule your appointment.
- Labs and Radiology studies (MRI, CT, Ultrasounds, etc) are reviewed at your office visit and not over the phone.
- Lab and test orders are given to you, or sent electronically at your visit. There will be a $5 charge for a replacement order.

*Samples:

- Please note SAMPLES are limited, they are not guaranteed, or meant to replace prescriptions.
- SAMPLES are just that, unfortunately we are unable to supply samples as a means of a prescription for our patients.
- If a sample has been given to begin a new treatment plan and you can't afford the cost of the new prescription, please contact the office immediately so we may determine an alternate medication.

*Reminders:

- Per HIPPA guidelines patients deserve their right to privacy, when you enter the office:
  1. Please sign-in at our kiosk or front desk receptionist.
  2. We ask that you please wait patiently if there is someone ahead of you.
- All patients will be seen by the Physician or Nurse Practitioner, or both.
- Contact us via our patient portal and we will return your call ASAP. We will do our best to return your call on the same day, excluding days our office is closed or after hours. However we request you allow us up to 48 hours to return any message or request.
- Please use only one of the available methods to contact our office as multiple request/voicemails will only delay our response time.

In order to increase quality of care, we are implementing the above office policies. It is our goal to provide quality care and customer service for all our patients. It is necessary that our patients adhere to all policies as this will enhance patient experience and treatment.

Thank You,
REGENCY ENDOCRINOLOGY STAFF

Patient Name:______________________________

Patient Signature:______________________________ Date______________

REGENCY ENDOCRINOLOGY
PATIENT MEDICAL HISTORY SUMMARY

NAME ______________________ AGE ______ REASON FOR VISIT ______________________

PHARMACY NAME ______________________ PHARMACY PHONE # ______________________

PHARMACY ADDRESS: ______________________

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY ON

MEDICATION	DOSE/MG	FREQUENCY	REASON

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF SO, PLEASE INDICATE

☐ I HAVE NO ALLERGIES TO MEDICATIONS ☐ I AM ALLERGIC TO THE FOLLOWING:

____

PLEASE LIST ANY MAJOR ILLNES(S)/SURGICAL PROCEDURE(S) PERFORMED

ILLNES(S)/SURGICAL PROCEDURE(S)	YEAR

ARE YOU OR WERE YOU A SMOKER? ☐ YES ______________ PACK(S)/DAY ☐ NO

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

ARE YOU ON ASPIRIN OR BLOOD THINNER (COUMADIN)? ☐ YES ☐ NO

WOMEN DATE OF YOUR LAST MENSTRUAL ______________________

CONTINUED ON BACK!!

PLEASE INDICATE THE HEALTH HISTORY OF YOUR FAMILY MEMBERS

FAMILY MEMBER (Mother, Father, Sister, Brother, etc.)	GOOD	POOR	DECEASED/CAUSE OF DEATH	
____________	☐	☐	☐	____________
____________	☐	☐	☐	____________
____________	☐	☐	☐	____________
____________	☐	☐	☐	____________
____________	☐	☐	☐	____________
____________	☐	☐	☐	____________

PLEASE CHECK IF YOU OR A FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING

	ME	OTHER		ME	OTHER
HEART DISEASE	☐	☐	HIGH BLOOD PRESSURE	☐	☐
STROKE	☐	☐	CANCER	☐	☐
GLAUCOMA	☐	☐	DIABETES	☐	☐
THYROID DISEASE	☐	☐	EPILEPSY/CONVULSIONS	☐	☐
BLEEDING DISORDER	☐	☐	KIDNEY DISEASE	☐	☐
MENTAL ILLNESS	☐	☐	OSTEOPOROSIS	☐	☐
GOUT	☐	☐	HIV/AIDS	☐	☐
GI DISORDER	☐	☐	HEPATITIS	☐	☐
ANEMIA	☐	☐	ASTHMA	☐	☐
DOUBLE VISION	☐	☐	SEXUAL DYSFUNCTION	☐	☐
MIGRAINES	☐	☐	DEPRESSION	☐	☐
GALLSTONES	☐	☐	DIZZINESS	☐	☐
GOITER	☐	☐	LEG PAIN	☐	☐
INDIGESTION	☐	☐	CONSTIPATION	☐	☐
RECTAL BLEEDING	☐	☐	FAINTING SPELLS	☐	☐
FORGETFULLNESS	☐	☐	HOARSENESS	☐	☐
ABDOMINAL PAIN	☐	☐	COLITIS	☐	☐

______________________________ PATIENT SIGNATURE

______________ DATE

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Name:_______________________________ DOB_______________

ETHNICITY: (Circle one)
HISPANIC/LATINO
NOT HISPANIC/LATINO
UNKNOWN

RACE: (Circle one)
AMERICAN INDIAN/ALASKA NATIVE
ASIAN
BLACK OR AFRICAN AMERICAN
NATIVE HAWAIIAN/ PACIFIC ISLANDER
WHITE
OTHER

PREFERRED LANGUAGE: ___________________________________

EMAIL: ____

PHARMACY INFO FOR ELECTRONIC PRESCRIPTIONS

PHARMACY NAME:_______________________________________

STREET:_______________________ CITY: ____________________

PHARMACY PHONE: _________________________

**DO YOU HAVE MAIL ORDER: Yes or No

WHICH ONE? ____

752 Stirling Center Place, Suite 1008 • Lake Mary, FL 32746 • Phone 407-333-1212 • Fax 407-333-1213 • www.regencyendocrine.com

ACKNOWLEDGMENT AND CONSENT FOR PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

In connection with the medical services that I am receiving from Regency Endocrinology, Diabetes & Metabolism, I hereby authorize the group to disclose any/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

A. Any third party payor covering medical services of the patient;
B. Other healthcare professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care sendees and payment for such services;
E. Pharmacies; and
F. Other parties as otherwise required by law.

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 acknowledge that I have received a copy of the practice's privacy notice and had an opportunity to ask questions concerning the Notice of Privacy Practices.

____

Print Patient Name or Personal Representative

____

Signature of Patient or Personal Representative

____

Date

____

Signature of Office Personnel

Restrictions to PHI: ______________________________

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