CAPITAL
DIABETES & ENDOCRINE ASSOCIATES

Diabetes · Endocrinology · Reproductive Medicine
DARSHANA PUROHIT,, M.D. MARIA MENUCCI, M.D.
DANIEL A. GOZZI, M.D. ROMEU M.AZEVEDO, M.D.
5801 Allentown Road suite 500 • Camp Springs, MD • 20746
Phone: 301-899-7713 • Fax: 301-899-9430

Patient Registration Form

PLEASE PRINT

Date: _____ ❒ New Patient ❒ Existing Patient

Primary Care Doctor : _____ Referring Doctor: _____

Name: _____, _____ _____

Last First M.I

DOB: _____ SSN: _____ Gender: ❒ Male ❒ Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Race: ❒ Asian ❒ Black of African American ❒ White ❒ Hispanic ❒ Other ❒ Decline

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ Decline

Emergency Contact: _____ Phone: _____ Relationship: _____

1st Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

2nd Pharmacy Name: _____ Pharmacy Phone: _____

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Pharmacy Address: _____

Insurance Information (Please provide card) if you are <u>NOT</u> the subscriber please provide the following for 1st, 2nd, and 3rd insurance (if applicable):

1st insurance name: _____

2nd insurance name: _____

3rd insurance name: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Assignment of Insurance Benefits

I, _____ hereby authorize my insurance company to pay and assign directly to Capital Diabetes and Endocrine Associates (CEDA) and or the individual provider(s) of CEDA, all benefits otherwise payable to me for his/her services rendered. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information/records, for this or any related claim, to the provider's billing agent and/or insurance companies above. I permit a copy of this authorization to be used in place of the original. **I understand I am financially responsible for charges incurred. I also acknowledge that I have received a copy of the office policies/privacy laws to review and that I agree to abide by such policies.**

_____ _____

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Signature Date

OFFICE POLICIES (THIS IS FOR YOU TO KEEP)

We know that choosing a physician is a very important decision and we thank you for you choosing our office. Please take a moment to read our office policies.

Information Regarding Your Insurance Coverage

You must be informed of an understand the details of your health insurance coverage and fulfill any associated requirements (e.g., pre-certification, obtaining referrals). **Service may be denied if you do not have a valid referral at the time of your visit.** Your insurance coverage is a contract between you and your insurance carrier and you are responsible for resolving any issues with your insurance carrier regarding coverage for services. It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to provide assistance and/or information to our billing office. If your failure to provide this information results in a denial of coverage, you may become responsible for paying for the services.

Participating Provider and Covered Benefits

If we participate with your health insurance carrier and the services sought are covered services under your health insurance plan, then we will directly bill your health insurance carrier. **Under your plan, you may be responsible for paying certain amounts (co-payments, co-insurance, deductibles, and non-covered services), which are due at the time of service. Failure to provide co-payment or pay balances over $100.00 at the time of visit will result in the rescheduling of appointment.**

Non-Participating Provider or Non Covered Benefits

If we do not participate with your health insurance carrier, or if the services provided are not covered under your plan, then you are responsible for paying for all services at the time of service. We can provide a statement for your records or reimbursement purposes. In certain circumstances, we may directly bill your insurance carrier as

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an out-of-network provider. If we do, you agree to assign your payment rights to our office and forward any checks you receive related to the services provided.

Uninsured Patients

If you do not have active health insurance coverage, payment for service performed shall be paid in full at the time of service. We offered a discounted payment plan for those without insurance.

SELF PAY RATE *Office visit codes may change, but payment amount will say the same.*

CODE	DESCRIPTION	COST
99203	New Patient Office Visit Amount	$ 225.00
99212	Established Patient Office Visit Amount	$ 100.00

Types of Payment; Dishonored Checks

Our office accepts cash, personal checks, MasterCard and Visa. If your check is refused for insufficient funds, you will be required to pay an additional fee of $25.00 along with the original amount of the check.

Collection of Outstanding Balances

All balances shall be due within 30 business days. You are required to pay all past due balances, in their entirety, prior to or at the time of your visit. **Patients owing a balance of $100.00 or more will be required to make at least 50% of the payment prior to services being rendered.** Any balances that remain outstanding for a period of 90 days may be referred to a collection agency or attorney. If your account is referred to an attorney, you will be responsible for paying all the attorney's fees and court costs, in addition to your outstanding balance.

Missed or Broken Appointments

It is important that you appear for all scheduled appointments. By way of courtesy, we try to call to confirm your appointment two days before the scheduled appointment. **Failure to receive a call is not a valid excuse for missing an appointment. You will be responsible for paying a missed/broken appointment fee of $25.00 if you fail to appear for a scheduled visit or have not provided at least 1 business day notice of cancellation. IF YOU**

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FAIL TO KEEP 3 APPOINTMENTS OR GIVE ADEQUATE NOTICE ON 3 OCCASIONS, THE PRACTICE MAY OPT TO DISMISS YOU AS A PATIENT. We recognize the fact that there may be circumstances which may not permit you to give us advanced notice, but such circumstances are exceptional and shall be considered on a case-by-case basis.

Practice Dismissal

We at CEDA care about the safety of our patients, providers, and staff and we hold a high standard of professionalism, safety, and conduct from staff members as well as patients. Failure to adhere to office policies and code of conduct can and result in immediate dismissal from the practice. These include but are not limited to the following:

1. Frequent missed appointments, late arrivals, or rescheduling of appointments (totaling up to 3) in a 90 day time frame.
2. Any foul language or disruptive behavior directed at staff, providers, or other patients.
3. Threats of bodily injury or harm to staff, providers, or patients.
4. Any acts of physical violence directed at staff, providers, or patients.
5. Any sexual harassment or inappropriate contact of any kind directed at staff, providers, or patients.
6. Patient non-compliance to medical directives.

Release of Medical Records and Information and Privacy

You authorize the release of any necessary information regarding your medical condition and treatment to any third party covering your medical services, health care professionals and institutions involved in the delivery of your health care, authorized private review of entities, billing or collection agencies, employees and/or agents of the practice, and any other government agency or as required by law or subpoena. You have the right to be notified in the event of a breach or your protected health information and you have the right to restrict disclosure of certain information to a health plan if you pay out of pocket in full for your visit.

Medical records created by our office shall only be released pursuant to your expressed written authorization in accordance with HIPAA or required by law. In accordance with Maryland law, we charge a fee of $0.10 cents per page, $22.88 handling fee (this is for insurance and attorney companies that request your records), and postage.

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Patient Privacy Act

Capital Diabetes and Endocrine Associates adheres to the Patient Privacy Act. Know your rights. Please refer to the following website at **HHS.gov**

https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html