PATIENT INFORMATION

Last Name: _____ First: _____ MI: _____

Address: _____ City: _____ State: _____Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____ Email: _____

SSN#: _____-_____-_____ Date of Birth: _____/_____/_____ Gender: M ____ F_____

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Minor_____

Ethnicity: American Indian/Alaska Native_____ Asian _____ Black/African American _____
Native Hawaiian/Pacific Islander _____ White_____ Other_____

Patient's Employer: _____ Work Phone: ( ) _____-_____

Address: _____ City: _____ State: _____Zip: _____

If patient is a minor – Parent or Legal Guardian:

Last Name: _____ First: _____ MI: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____ Email: _____

Employer Name: _____ Address: _____

City: _____ State: _____ Zip: _____Work Phone: ( ) _____-_____

Communication or Message Preference:

Phone messages can be left on: home phone ____ work phone ____ cell phone____.

Preferred method of communication: phone ____ mail ____ email____.

Emergency Contact:

1. Name: _____Relationship to patient: _____

   Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

2. Name: _____Relationship to patient: _____

   Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Insurance Information: **(After you complete this information, please give your card(s) to the front desk to scan.)**

Primary Insurance Company: _____Effective Date ____/____/____

Insured Name: _____Date of Birth _____/_____/_____

Policy or ID Number: _____ Group Number: _____

Relationship to Patient: _____

Do you have additional insurance? If so, please complete the following:

Secondary Insurance Company: _____Effective Date ____/____/____

Insured Name: _____Date of Birth _____/_____/_____

Policy or ID Number: _____ Group Number: _____

Relationship to Patient: _____

Tertiary Insurance Company: _____Effective Date ____/____/____

Insured Name: _____Date of Birth _____/_____/_____

Policy or ID Number: _____ Group Number: _____

Relationship to Patient: _____

Authorization & Release:

I authorize release of any information concerning my (or my child's) healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to John Woody Sistrunk, M.D.

I give my permission to Jackson Thyroid & Endocrine Clinic to administer treatment and perform necessary minor procedures, lab work and diagnostic tests to diagnose and treat my condition.

Signature: _____Date: _____/_____/_____
(Signature of patient (parent/guardian if patient is a minor)

Whom may we thank for referring you to our clinic? _____

Acknowledgement of Receipt of Privacy Practices:

I, the Patient or Guardian/Legal Representative of Patient, acknowledge that I have received a copy of or have read the Notice of Privacy Practice Policies of Jackson Thyroid and Endocrine Clinic.

Signature: _____Date: _____/_____/_____
(Signature of patient (parent/guardian if patient is a minor)

Protected Health Information:

I authorize release of my PHI to the following individuals (family members or friends) as it may become necessary:

Name: _____Relationship to patient_____

Name: _____Relationship to patient_____

Name: _____Relationship to patient_____

Signature: _____Date: _____/_____/_____

(Signature of patient (parent/guardian if patient is a minor)

Financial Policy:

Although Dr. Sistrunk participates in several healthcare networks, including Medicare, it is *your responsibility* to inform us if your insurance program is affiliated with a network. It is also *your responsibility* to let us know if a referral or preauthorization is required. You must present your insurance card so we may determine benefits and you should keep us informed of any changes in coverage. ***All portions of any deductible, co-pay, or co-insurance are due at the time of service.*** If Dr. Sistrunk is not a member of your network (out of network), you will be responsible for any portion your insurance does not pay.

We routinely file secondary insurance, but if we have not received a response within 45 days the balance will be transferred to the patient's responsibility.

Please remember that your insurance policy is a contract between you and your insurance company. We will file your claim(s), but it is your responsibility to follow-up to ensure *your* claim(s) are paid in a timely manner. Should problems arise with your insurance company, we will gladly assist you in determining what steps need to be taken. ***You are always responsible for your account, regardless of insurance coverage.***

We make every effort to work with our patients regarding their accounts and we encourage you to keep us informed of any special circumstances. However, it is sometimes necessary to rely on an outside agency to assist us in collections. Once an account is sent to collections, your balance will need to be resolved prior to any return appointments and a 40% collection fee will be added to your account balance.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED AS A RESULT OF DIAGNOSIS OR TREATMENT AT JACKSON THYROID AND ENDOCRINE CLINIC. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL STATEMENTS, COLLECTION FEES AND/OR ATTORNEY FEES THAT MAY BE ADDED TO MY ACCOUNT DUE TO MY FAILURE TO PAY MY ACCOUNT IN FULL OR IN A TIMELY MANNER.

I HAVE READ THE FINANCIAL POLICY OF JACKSON THYROID AND ENDOCRINE CLINIC AND AGREE TO THE ABOVE CONDITIONS.

_____ Date: _____/_____/_____

(Signature of Responsible Party)