

Appointment Date/ Time: \_\_\_\_\_



**82 W. Sunbridge Drive  
Fayetteville, AR 72703  
479-463-7400**

***Consent for Treatment***

I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of Endocrinology Clinic as many in their professional judgment be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment.

***Assignment of Insurance Benefits***

Patient-Physician Agreement: I, the undersigned, authorize Endocrinology Clinic to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that the medical insurance I possess may not completely cover the fee(s) for professional services rendered me; hereby agree that I am responsible for said fee(s). I authorize payment directly to me for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

***Authorization to Release Information***

I authorize Endocrinology Clinic to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services on this or a related date of service.

***Guarantee of Payment***

I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that Endocrinology Clinic does not accept any insurance policy assignment as a guarantee of full payment.

Patient Signature:

X \_\_\_\_\_

\_\_\_\_\_  
(Patient or Parent/Guardian if under 18 years of age)

\_\_\_\_\_  
Relationship of Guardian

\_\_\_\_\_ **DATE**

Date



**PATIENT INFORMATION- PLEASE PRINT**

SOC SEC #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

MRN#: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Mid Initial

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ yrs

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_

SEX:  Male  Female

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

MARITAL STATUS:  Married  Single  Divorced  
 Partner  Widowed  Separated

Occupation: \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

**REFERRAL**

Who referred you to our clinic? (PLEASE CHECK BOX)

- Washington Regional Medical Center
- Newspaper or Magazine
- Recommended by friend or family member
- Drove by Location of Clinic
- Community or Company Health Fair
- Treated by Physician in hospital
- Internet
- Phone Directory (Yellow pages)
- Referred by a Physician: \_\_\_\_\_
- Employer
- Insurance Plan Directory
- Return Patient/ Not Applicable
- Other: \_\_\_\_\_

**SPOUSE / PARENT – INFORMATION Please circle one**

Spouse/Parent Name: \_\_\_\_\_

Cell: \_\_\_\_\_

Employer: \_\_\_\_\_

Work: \_\_\_\_\_ Ext: \_\_\_\_\_

Work Address: \_\_\_\_\_

Spouse/Parent SEX:  Male  Female

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse/Parent Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation: \_\_\_\_\_

Social Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Emergency contact: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

# PRIMARY INSURANCE

Patient's Relationship to Main Policy Holder:  Myself  Spouse  Child  OTHER: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company's Phone Number: \_\_\_\_\_

Main Holder's Name: \_\_\_\_\_

Main Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Main Holder's Address: \_\_\_\_\_

Main Holder's Soc Sec#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

# SECONDARY INSURANCE

Patient's Relationship to Main Policy Holder:  Myself  Spouse  Child  OTHER: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company's Phone Number: \_\_\_\_\_

Main Holder's Name: \_\_\_\_\_

Main Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Main Holder's Address: \_\_\_\_\_

Main Holder's Soc Sec#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

## GENERAL INFORMATION

Who is responsible for Payment?:  Myself  Other: \_\_\_\_\_ (FILL OUT BELOW)

Responsible Party Name: \_\_\_\_\_ Responsible Party DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  OTHER SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics?  Yes  No  
If Yes, When?: \_\_\_\_/\_\_\_\_/\_\_\_\_ Where?: \_\_\_\_\_

## RELEASE OF INFORMATION (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**Preferred Language:**  English  Spanish  Marshallese  Arabic  DECLINE OTHER: \_\_\_\_\_

**Race:**  White  African American  Asian  Native Hawaiian/Other Pacific Islander  
 Native American Indian/ Alaskan  Hispanic  Unknown  DECLINE

**Ethnicity (Origin):**  Not Hispanic or Latino  Hispanic or Latino  Unknown  DECLINE

**Preferred Communication Method:**  Print  Save to Flash Drive  DECLINE

**Reminders:**  Mail  Cell Phone  Home phone  Work Phone  DECLINE

**Contact Preference:**  phone ( cell or home )  e-mail  both phone & e-mail  Do not Contact

Circle one

**PREFERRED PHARMACY:** \_\_\_\_\_ **LOCATION:** \_\_\_\_\_

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X \_\_\_\_\_  
Signature (Patient or Parent/Guardian if minor)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_