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
## PATIENT INFORMATION - PLEASE PRINT

<table>
<thead>
<tr>
<th>SOC SEC #: __<strong><strong><strong><strong><strong><strong>-</strong></strong>____<strong><strong>-</strong></strong></strong></strong></strong></strong></th>
<th>MRN#: __________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: __________________________________________</td>
<td>Home Phone: __________________</td>
</tr>
<tr>
<td>Last First Mid Initial</td>
<td>Work Phone: __________________ Ext: ______</td>
</tr>
<tr>
<td>Address: _______________________________________</td>
<td>Cell Phone: __________________</td>
</tr>
<tr>
<td>City: __________________________________________</td>
<td>Date of Birth: <strong><strong><strong>-</strong>__-</strong></strong> Age: ____ yrs</td>
</tr>
<tr>
<td>State: ___________ Zip Code: ________________</td>
<td>Employer: __________________</td>
</tr>
<tr>
<td>SEX: ☐ Male  ☐ Female</td>
<td>Work Address: __________________</td>
</tr>
<tr>
<td>MARITAL STATUS: ☐ Married  ☐ Single  ☐ Divorced</td>
<td>City: ___________ State: _____ Zip: _____</td>
</tr>
<tr>
<td>☐ Partner  ☐ Widowed  ☐ Separated</td>
<td>Occupation: __________________</td>
</tr>
<tr>
<td>PRIMARY CARE PHYSICIAN: _________________________</td>
<td>Email: _____________________ @ ______</td>
</tr>
</tbody>
</table>

### REFERRAL

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

- ☐ Washington Regional Medical Center
- ☐ Community or Company Health Fair
- ☐ Treated by Physician in hospital
- ☐ Employer
- ☐ Recommended by friend or family member
- ☐ Internet
- ☐ Phone Directory (Yellow pages)
- ☐ Employer
- ☐ Drove by Location of Clinic
- ☐ Insurance Plan Directory
- ☐ 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: ____________________________

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: ____________________________

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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation to Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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:** __________________________

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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: ________/_______/_______