BS ID #: **DEC** Online Patient Registration

Name:(Last)	**(First)**	**Middle Initial**	**Sex:** M or F
Street Address:			
City:	**State:**	**Zip:**	
Home Phone:	**Work:**	**Other/Cell:**	
Date of Birth:	**Social Security Number:**		
PCP:	**PCP address:** **Phone:** **FAX:**		
Name & Phone # of Emergency Contact:	**Preferred Pharmacy:** **Phone:**		

Name of Primary Insurance Company:		
Billing Address:		
Name of Insured:	DOB:	SSN:
Policy #:	Group #:	
Relationship of Patient to insured:		

I authorize Diabetes & Endocrinology Consultants to furnish information to insurance companies, and/or other Hipaa covered entities, concerning the illness or medical treatment of myself, and herby assign to the provider(s) all insurance payments for medical services rendered to me or my dependent.

Patient / Guarantor Signature: ______________________________ **Date:**_______________

My signature below acknowledges that all information supplied above is correct, I have been given a copy of the financial policy, and I understand that I will be responsible for payment of all medical services rendered to me by Diabetes & Endocrinology Consultants, and any other fees outlined in the financial policy.

Patient / Guarantor Signature: ______________________________ **Date:** _______________

Medicare Patients: I authorize any holder of medical or other information about me to release to the social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Medicare Patient Signature: ______________________________ **Date:** _______________

Receipt of Notice of Privacy Practices:

_______________ I acknowledge that I have received the Community Hospitals of Indiana, Inc. and The Indiana Heart Hospital Notice of Privacy practices.
(Patient's Initials)
(If patient did not sign, give reason and initial.) ______________________________

Release of Information: PLEASE CIRCLE YES OR NO AND PROVIDE OTHER INFO AS INDICATED.

1. Is there anyone you would like to authorize the staff of DEC to discuss medical information and/or the results of laboratory tests? **YES / NO**
Name: ______________________________ Relationship _______________ (*your initials_________*)

2. Is it okay to leave medical information on your answering machine or voicemail? **YES / NO** (*your initials___________*)

3. May we contact you via Secure E Mail?
YES / NO
Email address: ______________________________ (*your initials ________*)