8200 E Belleview Ave., Suite 510-E
Greenwood Village, CO 80111
Phone: (303) 783-3883 Fax: (303)783-3800
www.denverpedendo.com

NEW PATIENT REGISTRATION FORM:

Date:_____ Reason for Visit:_____
Physician (Please Circle One): Clifford A. Bloch, MD Alicia G. Marks, DO Sunil N. Nayak, MD

PATIENT INFORMATION:

Patient's Legal Name: Last_____First_____Middle_____
Patient's Preferred Name:_____Sex: _____ Date of Birth:___/___/____
Patient's Address:_____City_____St._____Zip Code_____
Patient's Phone #:_____
Primary Care Physician:_____Phone #:_____
Street Address: _____City_____St._____Zip Code_____

PARENT/GUARDIAN INFORMATION:

Mother's Name:_____ Father's Name:_____
Phone #:_____ Phone #:_____
Address for Mother (if Different from Patient's Address):_____
Address for Father (if Different from Patient's Address):_____
Preferred E-Mail Address: _____

PRIMARY INSURANCE:

Insurance Co. Name:_____ Name of Policy Holder: _____
Policy #:_____ Policy Holder DOB:_____
Group #:_____ Specialty Visit Co-Pay:$_____
If policy holder's address is different from the above provided address, please list here:
_____

SECONDARY INSURANCE:

Insurance Co. Name:_____ Name of Policy Holder: _____
Policy #:_____ Policy Holder DOB:_____
Group #:_____ Specialty Visit Co-Pay:$_____
If policy holder's address is different from the above provided address, please list here:
_____

POLICY ACKNOWLEDGEMENT AND AGREEMENT:

I certify that the above information is correct, and hereby authorize payment directly to Pediatric Endocrine Associates PC (PEA). Although every attempt will be made to bill insurance directly, I understand that I am financially responsible to PEA for any co-payments, co-insurance or charges not covered by insurance including failure to obtain insurance authorization. I acknowledge that I have read and agree to adhere by all office policies including release of information, missed appointments, consent for care, insurance information, payment information, and VAULT policy. **Please be aware that we will vault your credit card and bill the card directly after your appointment for the remaining balance not covered by insurance.**

_____ _____
Signature of Insured Person or Authorized Rep. Date

_____
Printed Name of Insured Person or Authorized Rep.

POLICY AKNOWLEDGMENT AND AGREEMENT

AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY PRACTICES

I authorize the release of information from the above named patient's medical record that may be necessary to make reimbursement for any of all of the services rendered. I further understand that Pediatric Endocrine Associates, P.C. cannot be held responsible for the subsequent passage of information that might occur by the third parties themselves. I acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

MISSED APPOINTMENTS

I understand that I am responsible for being on time for my appointments. **Failure to cancel an appointment 48 hours before the date will result in being billed a $50.00 "missed appointment fee" and $100.00 for a missed stimulation test.** If I am more than 15 minutes late for an appointment, it will be regarded as a missed appointment.

CONSENT FOR CARE

On behalf of the above named patient, I do hereby apply for and voluntarily consent to outpatient care for my child ordered by Clifford Bloch, MD; Sunil Nayak, MD; Alicia Marks, DO; Rebecca Somershoe, CNP; or Lisa Farr, RD, CDE.

INSURANCE INFORMATION

Please note: If your insurance plan requires a referral, you are responsible for ensuring the referral is available at the time of the appointment. Please present your insurance card at the time of the patient's appointment and be prepared to pay any necessary co-payment. Co-payments are due at the time of service (cash, check, Visa, MasterCard, Discover accepted).

PAYMENT INFORMATION

All patient account balances are payable within 30 days of the date of the billing statement. They are payable to Pediatric Endocrine Associates, P.C., PO Box 710043, Denver, CO 80271-0043. If you have an outstanding balance, we will make arrangements with you at your visit to collect the balance, either in full or via a payment plan with automatic monthly billing to your credit card. In addition, all co-pays are due at time of service.

VAULT Policy:

All patients will be asked to provide us with a valid HSA, credit, or debit card to store in our secure gateway card system. PEA has partnered with Retriever Medical to securely store patients' card information. Retriever Medical provides encrypted and secure storage of patient credit/debit card information in strict accordance with the Payment Card Industry Data Security Standards (PCI DSS). These are global standards for transmission and storage of financial data. For more information, please go to https://www.pcisecuritystandards.org. By initiating this new policy, PEA will be following the community standard that you may already be familiar with. This system is a convenient and efficient way for both our providers and your child to make payments in a timely matter. After each visit, we will submit a claim to your insurance carrier for the services you received. Once the claim is processed, you will receive an Explanation of Benefits (EOB) from your insurance provider detailing the exact amount that is your responsibility. We will receive the same EOB and will review it carefully. Then we will charge your stored credit card and you will receive an email notifying you of the charge. You will not be notified of the charge prior unless it exceeds $150.

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AUTHORIZATION TO LEAVE MEDICAL INFORMATION AND TEXT MESSAGE REMINDERS

I _____, parent/representative of _____, D.O.B. _____, give Pediatric Endocrine Associates the authorization to text the primary number for text message appointment reminders and to leave medical information including but not limited to lab results, medication information, etc. on any of the following voicemails:

Primary Phone Number:_____

Secondary Phone Number:_____

Signature:_____ Date:_____

RELEASE OF HEALTH INFORMATION FOR PATIENTS OVER 18 YEARS OLD

I _____, D.O.B_____, am 18 years or older. I give permission to Pediatric Endocrine Associates to release my health information to the following people at the following numbers:

Name/Relationship:_____ Phone Number:_____
Name/Relationship:_____ Phone Number:_____
Date:_____

E-PRESCRIBING SYSTEM

Please provide your preferred pharmacy below:

Local Pharmacy:	Mail Order Pharmacy (If Applicable):
Name:_____	Name:_____
Address:_____	Address:_____
Phone:_____	Phone:_____