sheffrin men's health
TESTOSTERONE REPLACEMENT • NUTRITION • FITNESS

Patient Registration, Authorization, Release, Receipt of Privacy Practices & Financial Responsibility

Date _____/_____/_____ Reviewed by: _____ (*employee initials*)

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

LAST NAME_____ **FIRST NAME** _____ **M.I.** _____

Date of Birth _____/_____/_____ SS # _____-_____-_____

Street Address _____ City/State/Zip _____

(H)Phone (_____) _____ (M): (_____) _____ Email: _____

Employer _____ Work Phone (_____) _____

Work Address _____ City/State/Zip _____

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

(H) Phone: (_____) _____ (M)Phone: (_____) _____

INSURANCE INFORMATION

Primary Insurance Company _____ Insured ID # _____

Claims Address _____ Group # _____

Claims City/State/Zip _____ Claims Phone (_____) _____

Name of Insured/Policy Holder _____ Relationship to patient _____

Insured Date of Birth _____/_____/_____ Insured SS # _____-_____-_____

Does this insurance company require a referral? _____ Was this obtained? _____

Secondary Insurance Company _____ Insured ID # _____

Claims Address _____ Group # _____

Claims City/State/Zip _____ Claims Phone (_____) _____

Name of Insured/Policy Holder _____ Relationship to patient _____

Insured Date of Birth _____/_____/_____ Insured SS # _____-_____-_____

AUTHORIZATION, RELEASE, RECEIPT OF PRIVACY PRACTICES, AND FINANCIAL RESPONSIBILITY: As a courtesy to you, Sheffrin Men's Health will file a claim with your primary insurance carrier for service you receive. Please be aware that Sheffrin Men's Health requires payment for all co-pays, deductibles, co-insurances, and medication/supplies your insurance may not cover at the time of service, unless other arrangements have been made with our facility. Sheffrin Men's Health strongly encourages you to check with and question your insurance carrier regarding delays in payment and/or the amounts paid. We will present you with a statement once we receive payments or notifications from your insurance company. We ask that you take care of any payments and/or outstanding balance within 30 days of the date of the statement. In the event your account becomes delinquent, and is therefore in default of payment, you will be responsible for the principal amount owed and all reasonable costs associated with the collection of this debt, including: collection service fees, attorney fees, court costs, and additional legal expenses associated with the recovery of the debt. **I hereby authorize Sheffrin Men's Health or its representatives to release any information acquired in the course of my examination or treatment to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, worker's compensation carriers, adjusters or attorneys. I instruct and direct my insurance carrier(s) to pay Sheffrin Men's Health by check or electronic remittance for services billed to them on my behalf. I agree to pay any portion determined my responsibility by my insurance carrier including but not limited to co-payments, deductibles, and non-covered services/supplies. I assume full responsibility for payment of services not covered by insurance. I have received or reviewed the privacy practice notice (2 pages) for Sheffrin Men's Health, and understand the situations in which this practice may need to utilize or release my medical records. I understand this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy practice statement.**

Patient Signature _____ Date _____

Effective Date: 02/06/2018