SAN MIGUEL ENDOCRINE, INC

Patient Information: Please print. All information will be strictly confidential.

Patient Last Name _____ First Name _____ Middle Name/Initial _____

Address _____ City _____ State _____ Zip Code _____ Home Phone # _____ Cell Phone # _____

Date of Birth _____ Social Security Number _____ HDL Number _____ email address _____

If patient is a child, who may authorize treatment? _____ Relationship _____ Sex: □ Male □ Female Marital Status: □ Married □ Single

Referring M.D. _____ Primary Care Physician _____

Employer Information:

Name of Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip Code _____ Work Phone # _____

Emergency Information:

(Do you authorize release of your medical information to anyone besides your insurance carrier or doctor? i.e. reminder appointments, lab results, etc.) □ Yes (Please list below)
□ No ___ (please initial that you have read and understand above statement)

Contact Name	Relationship	Phone (land and/or cell)

Do you have an answering machine or voice mail? □ Yes □ No
If so, may we leave messages (i.e. reminder appointments, lab results, etc) on your answering machine or voice mail? □ Yes □ No

Responsible Party (If other than patient):

Last Name _____ First Name _____ Middle Name/Initial _____

Address _____ City _____ State _____ Zip Code _____

Relationship _____ Home Phone # _____ Work Phone # _____ Cell Phone # _____

600 Kapiolani Blvd., Ste 210
Honolulu, HI 96813

Insurance Information:

Primary Carrier:	Secondary Carrier:
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: ____ Zip: _____	City: _____ State: _____ Zip: _____
Name of Insured: _____	Name of Insured: _____
Date of Birth of Insured: _____	Date of Birth of Insured: _____
Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other _____	Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other _____
Insurance ID # _____	Insurance ID # _____
Group # _____	Group # _____

Acknowledgement of Receipt of Notice of Uses and Disclosures Of Protected Health Information
Authorization for Treatment, Release of Information, Assignment of Benefits and Acknowledgement of Responsibility for Payment for Physician Services

- I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from your receptionist. I hereby acknowledge that I received from San Miguel Endocrine, Inc, a copy of the Notice.
- I hereby give consent to San Miguel Endocrine, Inc. to provide whatever treatment is deemed necessary.
- I authorize any holder of medical information to release to my insurer and its agents, physicians, hospitals and other medical providers any information needed to determine benefits payable for these and related services.
- I allow fax transmittal of my medical records, if necessary.
- I request that payment of authorized Medicare and other insurance benefits be made to me or on my behalf to the physician of San Miguel Endocrine, Inc. for any services furnished me. This assignment will remain in effect until revoked by me in writing.
- I understand that payment of charges (i.e. co-pays, balance after insurance payment received, etc) incurred is due at time of service unless other definite financial arrangements have been made prior to treatment.
- I understand that a late monthly fee of 1.5% or 50 cents minimum will be charged to all accounts past 60 days. I understand that I am financially responsible for all charges incurred and, in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted, I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

I have read and fully understand the above consent for treatment, financial responsibility, release of information and insurance authorization. I also acknowledge receipt of Notice of Uses and Disclosures of Protected Health Information.

Signature: _____ Date: _____

Witness: _____ Date: _____