Savannah ENDOCRINOLOGY
ISMARY DE CASTRO, MD

Date: _____

Reason for Visit: _____ Referring Provider/PCP: _____

Preferred Pharmacy: _____

Patient's Personal Information Male _____ Female ____ Marital Status: S M D W

Name:_____DOB_____SSN_____

First/ MI/ Last

Address: _____

(Street,City, State, Zip Code)

Phone (H):_____(C):_____E-mail:_____

Guarantor's Personal Information

Name:_____DOB_____SSN_____

First/ MI/ Last

Address:_____

(Street, City, State, Zip Code)

Phone (H):_____(C):_____E-mail:_____

Insurance Information

Primary Insurance _____ Group No _____Policy No. _____

Claims Address _____

Insured Name/DOB: Relationship to Patient: Self /Spouse/Family

_____

Secondary Insurance _____Group No_____Policy No._____

Emergency Contact

Name_____Relationship_____

Address_____ Phone: _____

Authorization and Consent to Treatment

Authorization to Treat and Release

I hereby voluntarily consent to the rendering of such care and treatment as my provider(s), in their professional judgment, deem necessary for my health and well-being. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging to my home/work/mobile phone. These communications may notify me of preventive care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving such communications at any time by notifying my provider(s) staff.

I authorize Savannah Endocrinology to release to, and receive from, any Doctor, Hospital, Clinic, other Healthcare Provider, or Insurance Carrier any medical records/information relating to my health, including without limitation, relating to illness or disease cause, treatment, diagnostic testing including laboratory and/or radiology. The forgoing shall include records and information relating to HIV infection, AIDS, Mental illness and/or use of alcohol or drugs. Your signature below fully authorizes our staff and doctors to perform examinations, diagnostic test and/or treatment, as we may consider it necessary.

Signature:_____Date _____

Assignment of Benefits

We will file your insurance as a courtesy; however, if we have no response from your insurance company within 60 days, the charge(s) will be transferred to your responsibility to pay. I authorize direct payment from my Insurance Company to my provider. I hereby certify that the insurance information I have provided is accurate, complete and current. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment according to my health insurance plan. If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services according to the plan's provisions. I understand that in my failure to do so may result in denial of benefit payments and that I will be responsible for all balances due. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I understand that if my provider does not participate in my insurance plan's network or if I am a self-pay patient, this assignment of benefits may not apply. At any time should I decide that I want to file my own claims, I understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred.

I agree to notify Savannah Endocrinology of any changes pertaining to my address and/or insurance information.

Signature:_____Date _____

Privacy Statement

You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice. By signing below, you acknowledge you have read, understand and agree to the Savannah Endocrinology Office and Financial Policy and our Notice of Privacy Practices. I understand that my provider's Privacy Notice is available at SavannahEndocrinology.com and that I may request a paper copy at my provider's reception desk.

Signature/Parent or
Guardian:_____

Printed Name:_____Date _____

Office and Financial Policy

Welcome and thank you for choosing Savannah Endocrinology. We are committed to providing you with the highest quality medical care possible in a cost-effective manner. We specialize in providing endocrinology care to our patients and therefore we do not provide primary care services, immunizations or vaccinations.

Office Hours: our office is open Monday – Friday, 8:30 am to 5:00 pm

After Hours/Emergencies: Our providers are not available after hours. You may leave a message for non-urgent matters and a staff member will return your call the next business day. If an emergency, please call 911. If you are not sure whether you need immediate assistance, please contact your primary care physician or seek local urgent care for evaluation. If you are experiencing troubleshooting/malfunction on a diabetes technology device such as insulin pump and/or continuous glucose monitoring device, please contact the manufacturer immediately. Notify our office by leaving a message with the concern/incident, and refer to your provider's emergency plan which may entail administration of insulin by self-injection and monitoring of your blood sugar using a glucometer.

Prescription Refills: It is your responsibility to keep up with your medications. You can expect a 24-48 hour turn-around time for prescriptions to be sent to your pharmacy. Do not wait until the last minute to request medications. Request for medications made after NOON on Friday may not be addressed until Monday. Savannah Endocrinology specializes in endocrinology care and such chronic disease management. We will NOT refill medications prescribed by another physician for the treatment of depression and/or pain. If you have not been seen by the office recently and not following the treatment and follow up plan as set by your provider, Savannah Endocrinology will NOT refill your medication for your safety and the good faith practice of medicine.

Appointments: Please arrive for your appointment 15 minutes early. When you arrive, please inform the front desk of any changes in demographics (phone no., address, insurance, etc.). If you are not able to arrive on time for unforeseen circumstances, please notify the office immediately to avoid a NO SHOW Fee and cancellation of visit. Missed appointments are subject to a $25 NO SHOW Fee. Please note the staff prepares ahead of time for your appointment, and therefore if you are not able to keep your scheduled appointment a 24-hour advanced notice is required to avoid a $25 LATE CANCELLATION Fee.

Insurance: It is your responsibility to know your insurance benefits. Savannah Endocrinology is contracted with several insurance companies. We will verify your insurance coverage at each visit to help ensure your coverage is active. Notify the office if you have a change in address or insurance coverage. We offer a reasonable discount to self-pay patients. Payment is due at time of service. Any outstanding balance over 60 days due will be referred to an outside collection agency and may be subject to a 10% collection fee. Any returned check will be charged a $25 bank fee.

Medication Formulary Status/Medical Prior Authorizations/Appeals/Diabetes Technology Device/Diabetes Testing Supply:

Your healthcare plan will have specific preferred covered medications often referred to as a list of formulary medications. If you are diabetic, we recommend you obtain and bring in a list of preferred/formulary diabetic medications from your prescription drug plan on the day of your appointment. In the event the medication prescribed to you is not preferred and/or requiring a prior authorization for use, the provider will permit pharmacy to change the medication to accommodate your specific healthcare plan unless you have documented failure or side effect of alternative medication. Please note completion and submittal of a prior authorization request does not guarantee your medication will be covered.

If you are enrolled in Medicare, it is your responsibility to identify a pharmacy or supplier participating in Medicare Part B for your diabetes testing supply. Documentation of use/frequency of blood sugar monitoring will be recorded and documented at time of visit. Please bring your meter and/or logbook to every visit. Continuous glucose monitors require additional time for interpretation and reporting in support of your prescription and/or coordination with your durable medical equipment supplier.

Administrative Fee: Completion of special forms such as FMLA, disability, workers compensation, letters for employers/school, other not provided at time of appointment etc. require time away from patient care and day to day business operations, and therefore we will charge an administrative fee of $10 per form.

I acknowledge that I have received and read a copy of the Savannah Endocrinology Office and Financial Policy

_____ _____

Signature/Name Date

PERSONAL PRIVACY NOTICE

Savannah Endocrinology is committed to serving our patients with professionalism and always ensuring to protect the privacy and security of all protected health information.

During serving your interests we give you, our patient, the opportunity to specify any persons, i.e., family members, friend, caretaker, with whom we may discuss your medical condition or your financial records with this practice.

Other than the reasons listed, on our privacy practice notice, we will not discuss your information with any person(s) other than the person(s) you list on this form.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

_____

Signature of Patient/Guardian Date

Witnessed By: _____

CREDIT CARD AUTHORIZATION FORM

We will file your insurance as a courtesy; We understand you may have a deductible, co-pay or additional out-of-pocket requirements before your health care plan assigns payment for our services. Your insurance may issue a notification of your patient responsibility after the claim has been processed. If we have no response from your insurance company within 60 days, the charge(s) will be transferred to your responsibility to pay.

As a courtesy we provide a secure and convenient non-obligatory payment feature of "Card on File." Please note any patient responsibility balance will be communicated in the form of a patient statement. You may then elect to submit payment by "Card on File". Charges will only be submitted after your notification and verbal consent.

After notification of my patient responsibility, I authorize Savannah Endocrinology, LLC, to process additional payment due determined as "patient responsibility" from my credit card on file. I agree to notify Savannah Endocrinology of any changes pertaining to my address, credit card and/or insurance information.

Signature:_____Date _____

Print Name _____

_____ I **agree** to maintain my credit card on file

_____ Thank you but I **decline**

Card #:_____CVV#_____Exp Date:_____