



ENDOCRINE & ONCOLOGIC SURGICAL ASSOCIATES

SPECIALIZING IN DISORDERS OF THE THYROID AND SURGERY FOR CANCER

NEW PATIENT INFORMATION

Name: _____

Last

First

Middle

Date of Birth: _____

Social Security Number: _____

Address: _____

Cell: _____ Alternate Phone Number: _____

Email: _____

Emergency Contact: _____

Name

Relationship

Phone

Primary Care Provider/Family Doctor: _____

Referring Physician: _____

Endocrinologist: _____

Which doctor do you wish records sent? _____

Reason for Today's visit: _____

When would you estimate your problem began/ was discovered: _____

Ethnicity and Preferred Language: _____

Preferred Pharmacy: _____

****There will be a \$50 Cancellation fee for all No Call No Show Appointments ****

In general, the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternate means, such as sending correspondence to the individual's office.

I wish to be contacted in the following manner (check all that apply)

CELL PHONE

- ___ O.K. to leave detailed message
- ___ Leave message with call back number only

WRITTEN CORRESPONDENCE

- ___ O.K. to leave detailed message
- ___ Leave message with call back number only

EMAIL

- ___ O.K. to leave detailed message
- ___ Leave message with call back number only

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I hereby grant permission to Dr Carolyn Garner, staff and contracted agencies to openly discuss my healthcare information with the following persons. I understand this authorization may only be revoked in writing. (*This section MUST BE COMPLETED in order to discuss care with anyone other than you, including spouse, children, parents, etc*)

Name	Relationship	Phone
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Name	Relationship	Phone
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PLEASE SIGN HERE Signature of Patient or Guardian



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AUTHORIZATION TO RELEASE INFORMATION

Endocrine and Oncologic Surgical Associate is authorized to release or request from any hospital or insurance company having coverage on me, any other physician involved in my care, or to the employer if coverage is under a group insurance plan, any medical records or insurance information pertaining to my treatment. Any copy of this authorization shall be considered as effective and valid as original.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to Endocrine and Oncologic Surgical Associates all rights, title and interest in benefits payable for services rendered by Endocrine and Oncologic Surgical Associates in any policy presented. Said irrevocable assignment and transfer shall be the recovery on said policy(ies) of insurance but shall not be construed to be an obligation of Endocrine and Oncologic Surgical Associates to pursue any such rights of recovery. Provided, however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I hereby authorize the insurance company(ies) presented to pay directly to Endocrine and Oncologic Surgical Associates for all charges incurred or alternatively, for all charges in excess of sums actually paid pursuant to said policy(ies). Any copy of this authorization shall be considered as effective and valid as the original.

**I HAVE BEEN PROVIDED WITH THE OFFICE POLICY INFORMATION PACKET
AND HAVE AGREED WITH THESE POLICIES BY SIGNING BELOW.**

SIGNATURE OF PATIENT OR GUARDIAN

DATE



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MEDICATIONS LIST	DOSAGE
MEDICATION ALLERGIES	

**PLEASE BRING THIS SHEET TO RECEPTIONIST IMMEDIATELY PRIOR TO
COMPLETING REST OF PAPERWORK**

Endocrine and Oncologic Surgical Associates

Carolyn Garner MD FACS

3502 Corinth Parkway Suite 100

Corinth, TX 76208

OFFICE POLICY INFORMATION

Endocrine & Oncologic Surgical Associates is committed to providing you & your family the best possible care. We take it as a compliment that you chose our practice as your ally in the search for quality healthcare.

If you have medical insurance, we are equally committed to helping you receive the maximum benefits allowable under the terms of your policy. In order to achieve these goals, we need your cooperation and assistance.

We are a private practice ruled by the laws of any business; we collect fees to pay salaries, office space, and all other business expenses.

We require that any deductible and /or coinsurance for surgery be paid 2 business days prior to surgery.

FINANCIAL DISCLOSURE

Dr Garner has a partial ownership in Medical City Denton Day Surgery Center.

Financial Policy

Please Initial EACH:

__ **PAYMENT:** All current balances, copayments, co-insurance and deductibles are due and payable PRIOR to services being rendered and are requires by your insurance to be paid at each visit. We accept cash, check, Visa, MasterCard, Discover, And American Express.

__ **PAYMENT:** If you have a plan that requires a referral, you will need a referral from your primary care physician as noted on your card from your insurance company. If your insurance requires a referral that is generated through them, you must reach out to your primary care physician for them to call your insurance. Since we are a specialist, we cannot generate a referral ourselves. If we have not received this referral prior to your arrival at our office, your appointment will be either rescheduled or you will be responsible for the entire bill. It is your responsibility to know if your insurance requires a referral and to obtain one.

__ **INSURANCE BENEFITS:** Please be aware that when a patient requires a visit to a specialist there are diagnostic procedures required for appropriate care that cannot be done by a primary care physician. These procedures may be done during the normal course of exam by the specialist. Although necessary as part of routine exams, insurance companies often categorize theses as procedures. The possible procedures which are often performed in this practice during your visit include, but are not limited to, ultrasound of the neck and fine needle aspiration. It is important to note that imaging testing done for screening or diagnostic reasons by your referring physician do not replace the need for independent examination by the specialist. Depending on your insurance policy provisions, these procedures and other may fall under a separate benefit other than your office visit copay; such as deductibles and co-insurance. IN most cases exact insurance benefits cannot be determined until the insurance company receives the claim. Therefore, any estimate for services will be considered an estimate only and any payment will be considered a partial payment only until such time that the insurance company processes your claim. Your insurance is a contract between you and your insurance carrier; payment for services is ultimately your responsibility.

__ **NO SHOW/ CANCELLATION COURTESY:** We are committed to making you an appointment at your earliest convenience; likewise, we require a call at least 24 hours in advance if you are unable to keep your appointment to allow for other patients to be seen. If you “no show” for your appointment or cancel with less than 24 hour notice, you will be charged a \$50.00 fee. Multiple missed appointments or chronic rescheduling of appointments may result in our request for you to find another specialist.

__SURGERY RESCHEDULING: We ask that you be firmly committed to your surgical date and time when scheduling. If you anticipate any personal or financial barriers to keeping your surgery date, we ask that you hold off on selecting the date until those issues are resolved. While we understand that emergencies happen, rescheduling and shuffling of a surgery schedule can be extremely disruptive to other patients. There will be a \$100 Cancellation fee for any surgery booked & then cancelled.

__SURGERY DEPOSIT: If surgery is recommended, you will be required to pay your deductible and or coinsurance no later than 48 hours prior to the date of surgery, excluding the need for emergent procedures or next day surgery. Any quote received for surgery will be considered an estimate only and any payment will be considered a partial payment only until such time as the insurance company processes the claim. If you cancel your surgery for any reason, the deductible will be refunded. Any requests for a payment plan will need to be discussed with our surgical coordinator with signed terms of that plan on file, any payment plans will be arranged prior to date of service. It is important to understand that our office will inform you of expected charges from our professional fee's only. We are happy to assist if there are questions related to the billing practices of the surgical center or hospital, anesthesia or pathology, but those are billed separately through those entities and our office is responsible only for billing as it relates to the surgeon.

__PATIENT BALANCE POLICY: After filing with the insurance company on file, we will promptly mail you a statement. Payment in full is due upon receipt of this statement and is a courtesy from our office. If you have any questions or dispute the balance it is your responsibility to contact our office within 30 days. If you are unable to pay balance in full, please contact our surgical coordinator to discuss a payment schedule or arrangements.

**PATIENT'S
NAME** _____

IF Minor—Signature of parent or guardian:

PATIENT'S SIGNATURE (if NOT minor):

DATE:
