# Sansum Diabetes Research Institute

## PATIENT REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ Primary Care Physician_____

## PATIENT INFORMATION

| Patient's Last Name | First | Middle | ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. | Marital Status (Circle One) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former Name) | Birth Date / / | Age | Sex ❑ M ❑ F |
|---|---|---|---|---|---|

| Street Address | City | State | ZIP Code | Social Security | Home Phone No. ( ) |
|---|---|---|---|---|---|

| P.O. Box | City | State | ZIP Code |
|---|---|---|---|

| Occupation | Employer | Employer Phone No. ( ) |
|---|---|---|

Chose Office Because/Referred to Office by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

## INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

| Person Responsible for Bill | Birth Date / / | Address (if different) | Home Phone No. |
|---|---|---|---|
| Is this person a patient here? | ❑ Yes ❑ No | | ( ) |

| Occupation | Employer | Employer Address | Employer Phone No. ( ) |
|---|---|---|---|

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

| Subscriber's Name | Subscriber's S.S. # | Birth Date / / | Group # | Policy # | Co-Payment $ |
|---|---|---|---|---|---|

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

| Name of Secondary Insurance (if applicable) | Subscriber's Name | Group # | Policy # |
|---|---|---|---|

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

## IN CASE OF EMERGENCY

| Name of Local Friend or Relative (not living at same address) | Relationship to Patient | Home Phone No. ( ) | Work Phone No. ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sansum Diabetes Research Institute or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT CELL PHONE NUMBER:_____

**Sansum Diabetes Research Institute**
2219 Bath Street, Santa Barbara, CA 93105

# Protected Health Information Release Form:

Patient Name: _____ Date: _____

(1) Concerning matters of my health, I give permission for SDRI or a member of the SDRI staff to speak with:

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

2) I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

_____

_____

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

_____

_____

Signature of patient: _____

Witness: _____

# Financial Policy and Signature on File

I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to SDRI.

I understand that I am financially responsible for all services rendered and for the following reasons:

If: 1) I do not have the proper referral at the time of service 2) My referral is invalid/expired 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company *(This applies to present and future visits).*

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account.

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Patient or Responsible Party Signature_____Date_____

## HIPAA COMPLIANCE STATEMENT

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

At SDRI, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

### UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to: plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care.

### YOUR RIGHTS

Although your paper chart belongs to our practice, the information contained in the chart is yours. You have the right to: inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information.

## OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information; send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

## EXAMPLES OF HOW YOUR INFORMATION IS USED

Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

## OTHER NOTICES

We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

FOR MORE INFORMATION OR TO REPORT A PROBLEM If you have concerns or would like additional information, you may contact SDRI at 805-682-7638.

Signature_____ Date_____