David R. Brown, M.D., Ph.D., P.A.

Endocrinology, Diabetes, Metabolism, Lipids, Obesity, and Osteoporosis

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PATIENT REGISTRATION, AUTHORIZATION FOR TREATMENT,
RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES
AND AGREEMENT FOR BILLING AND INSURANCE PAYMENT

Date: _____

Patient's Name: _____

Patient's Address: _____

_____

Patient's Telephone Contact Numbers: **Daytime:** _____

Evening: _____ **Cell:** _____

Patient's E-mail: _____

Patient's DOB: _____

Male ___ Female ___ Single ___ Married ___ Significant Other _____

Patient's Employer: _____

Emergency Contact: _____ **Telephone Number:** _____

Responsible Party: Patient ___ Spouse ___ Parent ___ Other _____

Responsible Party's Name: _____

Responsible Party's Address: _____

Responsible Party's Telephone Number: _____

Health Insurance: _____ **Type:** _____

Insured Party: Name: _____ **DOB:** _____

Policy Number: _____ **Group Number:**

Secondary Health Insurance: _____ **Type:** _____

Insured Party: Name: _____ **DOB:** _____

Policy Number: **Group Number:** _____

Clinical Services: Preferred Laboratory: _____

Other Allowed Laboratory: _____

Preferred Pharmacy (name, ID no.): _____

(TEL no.): _____

(FAX no.): _____

Initials: _____

AUTHORIZATION FOR TREATMENT

On behalf of myself or the patient for whom I am the Responsible Party, I authorize Dr. Brown to perform routine examinations, testing, evaluations, diagnosis, prescriptions and clinical procedures that do not involve major risk on the basis of Dr. Brown's oral explanations. In the event that a treatment or procedure would involve significant risks or the possibility of complications, my consent will be documented along with a confirmation that I was provided with an adequate explanation of the treatment or procedure and expressly consented on the basis of that information. I understand that it is my responsibility to ask any question that I may have regarding the care to be rendered by Dr. Brown and to seek whatever explanation is required so that I can make an informed decision.

RESPONSIBILITY FOR PAYMENT

I agree that I am responsible to pay for all care and treatment rendered by Dr. Brown to me or to the patient for whom I am the Responsible Party. I understand that payment is due at the time of service.

I am informed that Dr. Brown charges fees for special services and procedures that may not be covered by my insurance policy. Fees for these services include but may not be limited to:

1. **Returned check $25**
2. **Missed appointment without 24 – hour notification $100**
3. **Telemedicine Consultations**
4. **Photocopying charges per Maryland State guidelines.**

Initials: _____

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION FOR BILLING AND OTHER PURPOSES

I authorize Dr. Brown's office to release or transmit information regarding my health or treatment rendered to me (or to the patient for whom I am the Responsible Party), as required or requested by any party liable to pay for health care services rendered to me (or to the patient for whom I am the Responsible Party) for the purpose of obtaining payment. This authorization includes a discussion or transmittal of health information for the purpose of obtaining approval for payment prior to the performance of services, documentation of the kind or extent of services rendered and information relative to past or current care and treatment that Dr. Brown has received from other providers of health services.

I authorize Dr. Brown's office to confer with and provide medical record information to other physicians and health care providers regarding my care and treatment. I authorize Dr. Brown to inform family members and other persons responsible for my personal care and welfare (or that of the patient for whom I am the Responsible Party) of health information necessary and appropriate so that those persons can provide nutrition, personal comfort, medications and other care relative to an illness or injury, including information regarding possible complications or the need to contact a physician or secure urgent or emergency care.

I specifically authorize the following persons to receive my health care information:

_____

_____

_____

_____

I do not want any health care information regarding me or the person for whom I am the responsible party to be disclosed to:

_____

_____

_____

_____

(spouse, employer, children, siblings, insurance company, lawyer, etc.)

Initials: _____

AUTHORIZATION FOR TELEPHONE AND FAX USE

I authorize Dr. Brown's office to use the following contact numbers for the purpose of communicating to me (or to the patient for whom I am the Responsible Party) medical record information.

Telephone number:_____ Fax Number:_____

I authorize Dr. Brown's office to leave messages on my telephone answering machine for confirmation of my appointments and for the purpose of communicating to me (or the patient for whom I am the Responsible Party) medical record information.

☐ **YES** ☐ **NO**

* * * * * * * * * * * * * *

This is to confirm that I have completed the Patient Registration information in an accurate manner, to the best of my knowledge.

I have read and agree with the Authorization for Treatment, Responsibility for Payment and Authorization to Release Medical Records.

Dr. Brown's office welcomes the opportunity to answer any questions you may have regarding this document.

Signature of Patient or Responsible Party: _____

Date: _____

Initials: _____