

Specializing in adult and pediatric lipid disorders. Diplomate: American Board of Clinical Lipidology

PATIENT INFORMATION SHEET

Patient Legal Name:		DOB:		
		Marital Status:		
Social Security #:		S M W D	Male / Female	
Race: (Please check one)	□American Indian or Alaska Native □	∃Asian □White	e □Hispanic	
	□Black or African American □Native Hawaiian or Other pacific Islander			
	□Other Race □Other Pacific Islander □Refuse to Report			
Ethnicity:	□Hispanic or Latin □Not Hispanic or Latin □Refused to report			
Phone:	(H) (C)	(W)	
Street Address:				
City:		State:	Zip:	
Email:				
Primary Care Physician:		Phone:		
	Phone:			
*Advanced Directive				
	(Power of Attorney): YES or NO Name: Phone: Phone:			
	Priorie Cross streets:			
	INSURANCE INFORMATION	ON		
Primary Insurance:				
Name of Guarantor:		ID#:		
Group #:		DOB:		
Relationship to Patient:				
Secondary Insurance:				
Name of Guarantor:		ID#:		
Group #:		DOB:		
Relationship to Patient:				
Patient Signature / Paren	t or Guardian]	Date	



Specializing in adult and pediatric lipid disorders. Diplomate: American Board of Clinical Lipidology

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S FULL NAME:		
ADDRESS:		
DATE OF BIRTH:	PHONE NUMBER: _	
THIS AUTHORIZES:		
1	Lee R. Goldberg, M.D. ● Stanley Goldb	perg, M.D.
	Joseph DeBoe, DNP ● Jennifer Ward	d, DNP
3955 E	E. Fort Lowell Rd, Suite 113 • Tucson, A	NZ 85712
RELEASE INFORMATION TO: (F	PRIMARY CARE, OTHER PROVIDERS	S, FAMILY MEMBERS)
Jennifer Ward, DNP AND ANY INFORMATION CONTAINED IN PERSON, OR DISTRESS ANY Goldberg, M.D., Joseph DeBo	SES Lee R. Goldberg, M.D., Stanley Go STAFF, EMPLOYEES AND AGENTS SUCH RECORDS RELEASED IN CAS TYPE CAUSED TO ME OF OTHER De, DNP, WILL NOT BE HELD L E INFORMATION CONTAINED HEI	OF ANY RESPONSIBILITY FOR E OF LOSS OR THEFT FROM MY, Lee R. Goldberg, M.D., Stanley IABLE FOR ANY MISUSE OF
I AUTHORIZE THE RELEASE COMMUNICABLE DISEASE REL	E OF ALL MY MEDICAL RECORD ATED INFORMATION.	DS, INCLUDING ALL HIV AND
Patient Signature, Parent or Guar	rdian	Date
Signature of Witness		Date

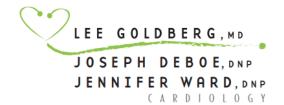


Specializing in adult and pediatric lipid disorders. Diplomate: American Board of Clinical Lipidology

PRACTICE GUIDELINES AND PATIENT FINANCIAL POLICIES

1. **INFORMATION**: You agree to provide your correct name, current and correct address, cellular or other phone number,

	insurance information, Social Security number, driver's license, or picture identification at the time of registration, or as requested by the practice, and additionally as any of the above information changes at any time.
	Initials
2.	FINANCIAL RESPONSIBILITY : By these initials and your signature below, you accept financial responsibility for all charges for services rendered to you. If a minor or under guardianship, the parents or guardian accompanying the patient assumes this liability.
	Initials
3.	PAYMENT METHODS : We accept cash, check, and several major credit cards. Front office staff may be contacted regarding credit cards accepted or insurance companies in which the practice participates with.
	Initials
4.	APPOINTMENTS : Our office will schedule appointments as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen; unless special arrangements have been made with the office. We require a minimum of 48 hours (or the Friday before a Monday appointment) notice of cancellation, as a courtesy to other patients seeking services. A fee of \$50.00 will be charged for non- cancelled and missed appointments. A pattern of non- cancelled, and or missed appointments may result in discharge from the practice.
	Initials
5.	FORM FEES: Our office charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change: (a) FMLA, immigration, disability, and drivers license's forms-\$25.00
	Initials
6.	MEDICAL RECORDS: The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. We will charge a fee of \$25.00 for copies of your medical records.
	Initials
7.	INSURANCE CO-PAYMENTS, DEDUCTIBLES, AND CO-INSURANCE: Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, and coinsurance, or non-covered services are to be paid in a timely fashion according to office policies. All copayments, deductibles, and coinsurance for testing, are to be paid at time of services rendered to you.
	Initials



Specializing in adult and pediatric lipid disorders. Diplomate: American Board of Clinical Lipidology

8.	These agencies charge fees. In the event a lawsuit is nece	days old are subject to transfer to an outside collection agency. ssary for collection, prevailing party is awarded attorney's fees. annot be cashed. You agree to be liable for all such fees with a			
	Initials				
9.	PATIENT DISCHARGE: The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your practitioner.				
	Initials				
10. INSURANCE CLAIMS: If applicable, our office will submit insurance claims. You agree to allow our practice to assignment" of benefits and receive payment directly from your insurance company. In the event your insured payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillmen amounts due within 10 days of postmark.					
	Initials				
	read and understand all the terms of this policy and be tand each item and agree to the terms above.	y my initials and my signature below, I attest that I fully			
Patient Signature, Parent/Guardian		Date			
Printed Name		Date			
Witness	Signature	 Date			



You may refuse to Sign this Acknowledgement

·Advanced Lipidology· Stan Goldberg, M.D.

Specializing in adult and pediatric lipid disorders. Diplomate: American Board of Clinical Lipidology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

have received a copy of the office's Notice of Privacy Practices. (Please print name) Signature: ____ Date: For Office Use Only We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: Individual refused to sign o Communication barriers prohibited obtaining the acknowledgement o An emergency situation prevented us from obtaining acknowledgement Other (please specify): _____