**Botts Diabetes and Endocrinology**

Dara Botts, RNC, FNP, ADM-BC

1420 W Baddour Pkwy Suite 200, Lebanon, TN 37087 (615) 444-4126

First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**As it is indicated on insurance card**

\_\_\_\_\_Male \_\_\_\_\_Female Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Marital Status: M S D W

Race: \_\_\_\_\_\_\_\_\_/Declined Preferred Language: English/Other \_\_\_\_\_\_\_\_\_\_Ethnic Group: Hispanic or Latino/Not Hispanic/Other

Phone: H(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ C(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ W(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred method of contact: H C W Email

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(**Must be street address. No P.O. Box**)

Email: (for appointment reminders) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Information:**

Patient’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full Time/Part Time/Student/Other

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_

**Parent or Financially Responsible Party (if under 18) \*\*MUST HAVE PHOTO ID AVAILABLE\*\***

First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Male \_\_\_\_\_Female

Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_Same as Above/ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(**Must be street address. No Po Box**)

Phone: H(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ C(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ W(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full Time/Part Time/Student/Other

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_

**Primary Insurance \*\*MUST PRESENT INSURANCE CARD\*\***

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber: \_\_\_\_\_Self/ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Male \_\_\_\_\_Female Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance \*\*MUST PRESENT INSURANCE CARD\*\***

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber: \_\_\_\_\_Self/ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Male \_\_\_\_\_Female Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a living will, durable power of attorney, or advanced directives? \_\_\_Yes \_\_\_No

If No, would you like information? \_\_\_Yes \_\_\_No

**Insurance information and Billing Practices in addition to the Financial Policy:**

I understand that services rendered to me by Botts Diabetes and Endocrinology (BDE) are my financial responsibility and that the provider will bill my insurance company as a courtesy to me. I authorize my insurance company to pay my benefits directly to Botts Diabetes and Endocrinology, and I understand that I will be fully responsible for any outstanding balance for my dependants or myself. I understand if I have not secured appropriate authorizations and otherwise complied with the terms of my benefit plan, there may be a decrease or no coverage at all for services rendered at BDE. I understand the responsible party will be assessed a fee for all returned checks.

I agree to full compliance with the Financial Policy provided to me.

Any balance is ultimately my responsibility. In the event my balance is transferred to a collection agency or attempts are made to collect a delinquent balance using an outside source, I will be responsible for collection costs, attorney fees, and/or court cost up to and beyond the existing balance incurred.

I understand that if Workers’ Compensation or other third party carrier is liable for my bills, my personal insurance is not responsible for payment.

**I understand that all insurance information must be provided BEFORE time of service. Insurance information provided after services have been rendered will not be utilized. This is a direct assignment of my rights and benefits under this policy.**

**Consent to Treat & Medical Records Release Authorization:**

I authorize BDE providers to provide treatment that they may deem advisable for my dependants and me. I understand that these services are voluntary and I have the right to refuse these services before they are rendered. In the event of a life-threatening emergency, I consent for the provider to administer emergency treatment. I authorize BDE providers to use photography to monitor certain conditions.

I authorize BDE to obtain or send any previous and/or current medical records for my dependants or myself including lab and imaging results, if my providers feel it is necessary for the care of my dependants or me.

**Communication Agreement:**

E-Communication: This policy is intended for patients that have a password protected email and is checked at least 2-3 times per week. BDE will only communicate electronically with the approved email address you have provided. This office will use the provided email address to communicate directly with you. It will not be released to any third party other than for use of treatment, payment and healthcare operations. BDE cannot and does not guarantee the privacy or security of any message sent over the internet. There is the potential that an email sent over the internet can be intercepted and read by others.

Phone: I understand the method of contacting the office, my provider, or any member of the staff must be done via the office number, 615-444-4126, or by responding to an email sent by the office. To contact them by any other number will result in your call not being answered or returned or your needs met. Your information cannot be protected. **I understand that texting my provider or any member of the staff is not protected and will not be responded to.**

**Appointments:**

I understand it is my responsibility to contact the office and schedule an appointment in a timely manner. I understand failure to do this may result in not receiving requested services such as prescription refills or completed documents. I understand walk-in appointments are reserved for urgent care needs only and non-urgent needs such as prescription refills will not be addressed. I understand a $50 fee will be assessed to my account for failure to keep an appointment or to cancel or reschedule 24 hours in advance.

**I have read the above items regarding insurance and financial responsibility, consent and medical records, communication, and appointments and agree to the terms and conditions related to each item.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient or Responsible Party Signature Relationship to Patient Date**