LUCAS RESEARCH

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PATIENT

Name _____ **Primary Care Physician** _____
First Middle Last

Mailing Address _____
Street City State Zip

Home Address _____
Street City State Zip

Male ☐ **Female** ☐ **Marital Status**: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Language Spoken: English ☐ Spanish ☐ Other _____ **Ethnicity** (optional)**:** _____

Social Security # _____**Date of Birth**_____ **Home Phone**_____

Cell Phone _____ **Spouse Name**_____

E-mail _____ ***PLEASE PRINT CLEARLY***

Emergency Contact _____ **Phone** _____

EMPLOYMENT

Employer_____ **Work Phone** _____

Employer's Address _____

RESPONSIBLE PARTY (If patient is under 18, we must have person legally responsible)

Name _____ **Relationship**_____

Address _____ **Home Phone** _____

Employer _____**Work Phone** _____**SS #**_____

REQUIRED

INSURANCE INFORMATION	PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insurance Co.		
Policy #		
Group#		
Policy Holder/Subscriber		
Date of Birth of Policy Holder		
Social Security # of Policy Holder		
Employer of Policy Holder		

PREFERRED PHARMACY AND PHONE #_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Lucas Research, Inc. to furnish information to any doctor, hospital, or insurance carriers pertinent to my medical care, which may include treatment for physical/emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS or AIDS related information. I assign payments to Lucas Research, Inc./ Diabetes & Endocrinology Consultants, PC from contracted insurance companies and networks for medical services rendered to myself or my dependents.

_____ _____
Patient's Signature or Responsible Party **Date**

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Financial Policy for Clinical Research Volunteers

We often find ourselves in the awkward position of discussing finances with patients at the time of their visits. We feel that the better you understand our policies, the better we will be able to serve you.

The financial policies for clinical research volunteers fall into one of two categories. With very few exceptions all expenses paid by the sponsoring pharmaceutical company and are at no cost to you.

1. Category #1 is people we are seeing to get ready for a study. These patients are not in a study yet. We call these volunteers **DSNY** patients; that stands for **D**rug **S**tudy **N**ot **Y**et patient.
    a. For DSNY patients, all expenses for medical services provided in our office (appointments, labs, and procedures) directly related to study preparation are paid by Lucas Research.
    b. Medical services not provided by Lucas Research will be the financial responsibility of the patient. The most common example of this is laboratory expenses by an outside laboratory like LabCorp. That bill will come directly from LabCorp. We will file your insurance for you.
    c. Medical services completely unrelated to the study are the patient's responsibility. This is a rare situation. For example, if we are managing your healthcare in preparation for a diabetes study and one of our providers also sees you for a totally unrelated condition, that expense might be your responsibility. This is rare and never a surprise.
        i. We will obtain your insurance information before or at your first visit and file your insurance claim for these third-party expenses. Please bring your insurance card(s) for us to copy.

2. Category #2 is people who have already qualified for a clinical research study.
    a. After you qualify for a study all expenses directly related to your participation in clinical research are paid by the sponsoring pharmaceutical company and are of no cost to you. This includes all office visits, study medication, study supplies, and study labs.

Financial Policy Non-Clinical Research Patients

We often find ourselves in the awkward position of discussing finances with patients at the time of their visits. We feel that the better you understand our policies, the better we will be able to serve you.

Please bring your insurance card(s) for us to copy. Payment for all co-pays, deductibles and any other charges are due at the time your check-in for your visit. We accept cash, personal checks, and most credit cards. Please make certain that you bring one of these forms of payment with you each time you visit our office. **To speed the check-out process, we collect co-payments at check-in time.**

As a service to our patients, we will file insurance claims for almost all insurance companies once you have provided your complete insurance information. We apologize that we cannot participate with every form of insurance for all of our patients. We do have contracts with

- Medicare (and "automatic" secondary crossovers),
- N.C. & Federal Blue Cross/Blue Shield Plans,
- Atlantic Integrated Health (AIH)
- Tricare Prime (you still need to get an authorization for Tricare)
- Tricare Select

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You are financially responsible for the portion of the bill your insurance company does not pay.

Please remember, your insurance coverage is a contract between you and your insurance company. We will do everything possible to expedite your claim with proper filing and forms; however, you are responsible for all fees. Please also advise our office if there is any change in your insurance plan or benefits. Please remember, most of our policies are based on those of YOUR insurance provider.

ACKNOWLEDGMENT OF FINANCIAL POLICY

I, the undersigned, acknowledge the Financial Policies of Diabetes & Endocrinology Consultants and Lucas Research. I understand that I am financially responsible for all charges relating to co-payments, deductibles and non-covered services at the time of my visit. I authorize my insurance benefits to be paid directly to Diabetes & Endocrinology Consultants or Lucas Research. I acknowledge that if I have insurance coverage other than those listed above, or if I am uninsured, that I am responsible for all charges incurred in this office at the time of service. I understand that all unpaid balances that are 90 days past due are sent to a collection agency, and I will be discharged from Lucas Research, Inc. unless prior arrangements have been made with a billing administrator.

_____ _____

Patient's Signature or Responsible Party **Date**

ONE TIME AUTHORIZATION FOR MEDICARE ONLY

I authorize any holder of medical or other information about me to release to the Social Security Administration Health Care Financing Administration or its intermediate or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Diabetes & Endocrinology Consultants or Lucas Research, a participating provider in the Medicare system. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Patient's Signature or Responsible Party **Date**

APPOINTMENT REMINDER CALLS, NO-SHOW FEE, & E-VISIT SERVICE CHARGES

Please provide as much notice as possible if unable to keep your appointment. You should receive an appointment reminder card and a text message when your appointments are made in our office. You should also receive an appointment check-in text message and e-mail two days prior to your appointment. **You will be charged for the office visit if you fail to cancel in a timely manner and do not keep your scheduled appointment. If you fail to keep 3 appointments without giving us proper notice, you will be discharged from the practice. The new patient (and patients not seen in over a year) no-show fee is $50. The regular "recheck" office visit no-show fee is $25.** We do not want your no-show fee; we want you to keep your appointment or call ASAP to make the time available for another patient. **No-show fees are donated to diabetes related charities.**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned hereby acknowledges receipt of a copy of the Notice of Privacy Practices of Lucas Research, Inc./Diabetes & Endocrinology Consultants, PC.

I authorize Lucas Research Team Members to leave medical or account information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes. If neither the YES or NO selection is marked, we will consider YES to be your selection.

Home answering machine	Yes □	No □	Work telephone	Yes □	No □
Cell phone	Yes □	No □	Voice mail	Yes □	No □
Other_____	Yes □	No □	E-mail	Yes □	No □

Please list names of authorized people and their relation (such as spouse, parent, etc.) and contact number.

Name:_____ Relation:_____ Phone Number:_____

Name:_____ Relation:_____ Phone Number:_____

Name:_____ Relation:_____ Phone Number:_____

_____ _____

Patient's Signature or Responsible Party **Date**

_____

Print patient's name here