DIAETA CLINIC
We care.

DIAETA CLINIC Patient Registration Form Date:

PERSONAL INFORMATION			
Name (Last, First, M):			Sex: M F
Date Of Birth:	SSN:	Marital Status:	
Address (Street, City, ST, ZIP):			
Home Phone:	Cell Phone:		
Ethnicity: CAUCASIAN AFRICAN-AMERICAN ASIAN LATINO OTHER DECLINE			

INSURANCE INFORMATION	
Do You Have Insurance? YES NO	
Primary Insurance:	Subscriber Name:
ID#:	Group#:
Relationship to Subscriber:	Subscriber DOB:
Subscriber Address:	Subscriber SSN:
Secondary Insurance:	Subscriber Name:
ID#:	Group#:
Relationship to Subscriber:	Subscriber DOB:
Subscriber Address:	Subscriber SSN:

I have received NOTICE OF PRIVACY AND PRACTICES – public law 104-191. I understand that I am responsible for any services rendered by DIAETA CLINIC – WE CARE LLC and authorize DIAETA CLINIC – WE CARE LLC to release any medical information necessary to process medical claims. I agree to authorize payment of medical benefits directly to DIAETA CLINIC – WE CARE LLC as may be required by insurance contracts.

Please be advised that this office is not responsible for bills incurred for failure to advise the proper outpatient facility and/or failing to obtain a required authorization, as may be required by your insurance, prior to outpatient testing. Co-pay may be due at the time of your visit. You may be billed an additional fee to cover processing, postage, and billing for failure to pay the correct co-pay. You will be responsible for applicable bank fees as well as fees paid to agencies for unpaid balances on your account.

You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which may result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that the practice/office may contact me/us as described above.

Patient Signature:	Date:
Guardian Signature:	Date:

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Relationship to Patient:	