THE CENTER FOR DIABETES & ENDOCRINE CARE

JELLINGER & LERMAN, M.D., P.A.
3107 Stirling Rd, Suite 300, Ft Lauderdale, FL 33312
Tel: 954-963-7100 Fax: 954 981-0446

PERSONAL INFORMATION

SOCIAL SECURITY NO	MARITAL STATUS	RACE	ETHNICITY	NATIONALITY

LAST NAME	FIRST NAME	MI	BIRTH DATE	AGE

ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELLPHONE

FAX	E-MAIL

NAME OF REFERRING PHYSICIAN	☐ CHECK IF SELF-REFERRED	PRIMARY (FAMILY) PHYSICIAN

MEDICAL REASON FOR REFERRAL

EMPLOYMENT STATUS:
EMPLOYED ◯ UNEMPLOYED ◯ STUDENT ◯

OCCUPATION / PROFESSION

MEDICARE NUMBER	MEDICAID NUMBER

NAME OF INSURANCE CARRIER	INSURANCE PLAN NUMBER

NAME OF INSURED	RELATIONSHIP TO YOU	DATE OF BIRTH OF INSURED

PHARMACY NAME	PHARMACY PHONE NUMBER	PHARMACY LOCATION

PHARMACY (2) NAME	PHARMACY PHONE NUMBER	PHARMACY LOCATION

PHARMACY (3) NAME	PHARMACY PHONE NUMBER	PHARMACY LOCATION

I AUTHORIZE payment of Insurance benefits be made to the medical practice of Drs. Jellinger & Lerman M.D., P.A. for all laboratory, medical services and procedures that are provided to me by the doctors and their staff.

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Signature _____ Date:_____

PAUL S. JELLINGER, M.D., M.A.C.E.
MITCHELL M. JACOBSON, M.D.
SHARON D. LAMKIN, PA-C (PA 9102859)

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CONSENT FORM

In connection with the medical services that I am receiving from the above named physician group, I hereby authorize the above-named group to discuss and/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records:

A. Any third party payor covering the medical services of the patient.
B. Other health care professionals and institutions involved in the deliver of health care to the patient.
C. The proponent of any legally sufficient subpoena, or in response to a court order.
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services.
E. Pharmacies and other parties as otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given:

Special Restriction:
_____
_____
_____

The consent is valid from the date executed until revoked in writing by the patient

Print Name: _____ Date: _____

Signature: _____ Witness: _____

GENERAL MEDICAL INFORMATION

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DIPLOMATES, AMERICAN BOARD
OF INTERNAL MEDICINE
DIPLOMATES, SUBSPECIALTY BOARD OF
ENDOCRINOLOGY AND METABOLISM

ENDOCRINOLOGY
DIABETES-METABOLISM
LIPID DISORDERS
OSTEOPOROSIS

THYROID & PARATHYROID ULTRASOUND
FINE NEEDLE THYROID & LYMPH NODE BIOPSY
THYROID CANCER LYMPH NODE MAPPING
RADIOACTIVE IODINE (1-131) THERAPY
BONE DENSITOMETRY

CLINICAL RESEARCH

PLEASE READ, SIGN, AND DATE

We care about our patients! Our medical practice understands the difficult process of trying to comply with the complicated rules and regulations of your insurance company. We will strive to keep you informed of your medical choices and the mandate of your insurance carrier.

LIFETIME SIGNATURE AUTHORIZATION

1. I acknowledge that it is my responsibility to understand and adhere to the rules and policies of my medical insurance carrier.
2. I must provide all necessary insurance referral and authorization paperwork to the doctor's office within the time frame mandated by my policy.
3. I am responsible for the payment of services that are not covered by my insurance.(I am encouraged to contact the insurance company if I am unclear as to whether or not a proposed service is considered "covered by my policy").
4. I authorize the release of any medical information necessary to process any claim, as subject to Federal, State, and local legislation.

Subscriber's Signature Date

ASSIGNMENT OF BENEFIT PAYMENT

I authorize payment of insurance benefits to the medical practice of Drs. Jellinger, Lerman, Gonzalez-Alvarez and Jacobson, P.A. for all laboratory, medical services and procedures that are provided to me by the doctors and their staff.

Subscriber's Signature Date