



Albemarle Endocrinology, PLC  
Sandhya Chhabra, M.D.  
215 Wayles Lane, Suite 150  
Charlottesville, VA 22911  
Telephone (434) 244-0934 Fax 244-0935

## PATIENT REGISTRATION

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Marital Status: S M W D Separated

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Birthdate: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Next of Kin (not living with you): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Names of other physicians you want us to send records to:

\_\_\_\_\_  
\_\_\_\_\_

How did you hear about our practice? Primary care physician, web search, Yellow Pages, family friend, or Other: \_\_\_\_\_

## INSURANCE INFORMATION

Please present your card(s) for copying.

Primary Insurance: \_\_\_\_\_

Subscriber: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Subscriber: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

**See reverse side please**

Does your insurance company require Precertification or Preadmission review? \_\_\_\_\_

If yes, Preadmission Review Phone Number (from your card): \_\_\_\_\_

## **RELEASE & ASSIGNMENT**

I hereby consent to any necessary medical diagnosis and treatment for myself, child, or above-named individual for whom I am legally responsible. The release of medical information to any insurance carrier and direct payment to the practice for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **OUR FINANCIAL POLICY**

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you. Your clear understanding of our financial policy is important to our professional relationship. If you have any billing questions that we cannot answer directly, please call (434) 982-7794.

Albemarle Endocrinology, PLC participates and accepts assignment of insurance benefits of most insurance organizations. Of course, you are still responsible for the timely payment of deductibles, co-insurance, and/or co-payments. Co-payments are due at the time of your visit.

If you have insurance with an organization that we do not participate with, provide us with adequate information, and we will bill your insurance company for you. In these cases, payment of your bill remains your responsibility, including any balance after your insurance company settles your claim.

## **NOTICE OF PRIVACY PRACTICES**

Albemarle Endocrinology, PLC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning our acknowledgment and consent.

## **ACKNOWLEDGEMENT & CONSENT**

I have received the Notice of Privacy Practices for Albemarle Endocrinology. Albemarle Endocrinology is authorized to use and disclose health information about

\_\_\_\_\_  
(Print patient name)

\_\_\_\_\_  
Date of Birth

for treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices, including discussions with family members (unless otherwise requested).

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date