ROCKLAND ENDOCRINE & DIABETES SERVICES, P.C.

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Katerina Listopad, N.P. INTERNAL MEDICINE
Kristine Bihun, R.D.N. NUTRITIONIST

PLEASE PRINT **DATE: _____**

PATIENTS NAME:_____

DOB:_____ SEX: ○ MALE ○ FEMALE AGE:_____

HOME ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE: _____

REFERRED BY:_____ PHONE: _____

PRIMARY PHYSICIAN:_____ PHONE:_____

BY YOUR SIGNATURE BELOW YOU ARE ACKNOWLEDGING THAT IF YOUR INSURANCE DOES NOT COVER YOUR OFFICE VISIT, OF IF YOUR REFERRAL IS NOT UP TO DATE FOR THIS VISIT OR ANY VISIT IN THE FUTURE, YOU ARE RESPONSIBLE FOR FULL PAYMENT.

PATIENT SIGNATURE:_____

HIPAA

I hereby give my consent to Rockland Endocrine & Diabetes Services, P.C. (the practice) to communicate with me by the communication methods listed below.

○ TEXT ○ E-MAIL ○ CELL ○ HOME

HIPAA- Health Insurance Portability and accountability Act prompted new federal regulations, which require physicians to ensure they are protecting the privacy and security of patients medical information.
Your signature will allow us to transmit your information to your insurance comapanies as well as share your medical records with other physicians, medical groups, including radiologists on a need to know basis.
In addition, you have the right to request disclosure of your information to family members, other relatives, or any other person identified by you. Please list below:

NAME:_____ RELATIONSHIP: _____

NAME:_____ RELATIONSHIP: _____

NAME:_____ RELATIONSHIP: _____