LAWRENCE D. SCHUSTER, M.D., Ph.D., F.A.C.P., F.A.C.E.
THE SCHUSTER CLINIC FOR ENDOCRINE AND METABOLIC DISORDERS
CENTRAL OFFICE
255 PINEHURST BUILDING, 4999 FRANCE AVENUE S, MINNEAPOLIS/EDINA, MN 55410

REGISTRATION INFORMATION

Patient Last Name | First Name | Middle

Address Street | City | State | Zip Code + 4 (9 digit)

Social Security Number | Birthdate | Age | Marital Status | Home Phone

Ethnicity | Language | Email address

Referring Physician | Location of Physician | Physician's Phone Number

Employer | Occupation | Business Address | Business Phone

Name of Spouse | Spouse's Employer | Occupation | Business Phone

Name of Children and Ages (name of parents if patient is a minor)

Person to Contact in Case of Emergency | Relationship to Patient | Phone Number

Is there anyone involved in your care or payment of your care with whom we may share your medical information?

May we leave voice messages for you ☐ at home ☐ at work ☐ other _____

PRIMARY INSURANCE INFORMATION

Person Responsible for Account Last Name | First Name | Middle

Relationship to Patient | Address (if different from patient's) | SSN | Birthdate

Name of Insurance Company

Identification Number | Group Number | Name of Subscriber

SECONDARY INSURANCE INFORMATION

Name of Insurance Company | Identification Number | Group Number | Subscriber

ASSIGNMENT AND RELEASE

I hereby authorize and assign directly to the above named physician, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including deductibles, coinsurance, and copays as assigned by insurance. I hereby authorize the clinic to release all information necessary to secure the payment for benefits. I authorize the use of this signature on all insurance submissions. We will verify benefits and if your insurance company advises us that you have greater than $500 left to pay on your deductible, we will require either 1)$300 deposit at time of service, on a credit/debit if desired; 2)credit/debit put on file to be run for patient balance owed immediately when insurance responds, or 3)arrange with business office a payment plan prior to your visit for the estimated amount due. I understand that any patient balance over 60 days will be charged 1.5% interest per month, and if my account is referred to a collection agency, their fee will be added to my bill. I also understand I will be charged $20 for any failed follow-up appointments.

Patient Signature (or parent if patient is a minor) | Date