PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print.** All information will be confidential.

Date _____ Patient Name _____ Patient SSN _____

□ Male □ Female Birthdate _____ Primary Phone _____

Address _____ City _____ State _____ Zip _____

Email address _____

Who referred you to our clinic? _____

Check appropriate box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

RACE: ***(Circle One)***
Caucasian
Black
Hispanic
Asian/Pacific Islander
Middle Eastern
Native American
Other

ETHNICITY: ***(Circle One)***
Not Hispanic or Latino
Hispanic or Latino

PREFERRED LANGUAGE: _____

Patient's or parent's employer _____ Work Phone _____

Person to contact in case of emergency _____ Phone _____

Primary Insurance Information and Responsible Party

Policy Holder's Name _____ Relationship to patient _____

Policy Holder's Birthdate _____ Policy Holder's SSN _____

Insurance company _____ Policy # _____ Group # _____

Do you have any additional insurance? □ Yes □ No If yes, complete the following:

Policy Holder's Name _____ Relationship to patient _____

Policy Holder's Birthdate _____ Policy Holder's SSN _____

Insurance company _____ Policy # _____ Group # _____

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____
Signature of patient or parent if minor Date

Endocrine and Psychiatry Center (EPC)

Nurse Practitioner/Physician Assistant
Consent For Treatment

This facility has on staff a nurse practitioner and physician assistant to assist in the delivery of medical care.

A nurse practitioner and a physician assistant is not a doctor. A nurse practitioner and a physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a nurse practitioner and a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

Supervision does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A nurse practitioner and a physician assistant may provide such medical services that are within hers/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above and hereby consent to the services of the nurse practitioner or physician assistant for my health care needs.

I understand that at any time I can refuse to see the nurse practitioner or physician assistant and request to see a physician but I will need to reschedule the appointment.

_____ _____

Name Date

_____

Signature

Endocrine – New Patient Form

Patient's name _____ Date _____

Reason for visit (Circle) Diabetes Thyroid Lipids Osteoporosis Other _____

Referring Doctor's Office (Name, Address, Phone #) _____

Pharmacy Name and Phone # _____

Do you have Diabetes? (Circle) No Yes: Type 1 Yes: Type 2 Unsure When diagnosed: _____

Do you have any of the following? (Circle all that apply):

Retinopathy	Neuropathy	History of heart attack	Hypertension
Nephropathy	History of Stoke	Peripheral Vascular Disease	High Cholesterol

Other medical problems: _____

_____

Please tell me about your usual diet:

Breakfast: _____ Lunch: _____

Dinner: _____ Snacks: _____

How often do you eat out? _____

Exercise (type and time per day and per week): _____

IF YOU DO HAVE DIABETES:

Do you take Aspirin daily: Yes No

Date of last eye exam: _____

Date of last diabetic education: _____ Date of last dietician visit: _____

What type of meter do you use? _____ How old is the meter? _____

Glucose readings:

Before breakfast: _____ Before lunch: _____ Before dinner: _____ Before bedtime: _____

Social history (circle):

Smoker: Y/N Alcohol: Y/N Other drug use: Y/N (explain Y _____)

Occupation: _____ Marriage status: _____ Children: _____

Family history (circle): Diabetes Thyroid Hypertension

Other problems (who and diagnosis): _____

Do you have any problems with any of the following (circle all that apply):

Increased Urination	Weight Gain/Loss	Depression	Headaches	Bone Pain
Increased Thirst	Irregular Menses	Anxiety	Constipation	Sexual Issues
Increased Hunger	Chest Pain	Mood Changes	Blurry Vision	Immune Problems
Diarrhea	Shortness of Breath	Skin Problems	Breast Discharge	
Nausea/Vomiting	Feeling Cold/Hot	Allergies	Muscle Aches	

MEDICATION	STRENGTH	FREQUENCY	HOW TAKEN

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1) The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI"). I understand that this information can and will be used to:

a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may by involved in the treatment.
b) Obtain payment for that treatment
c) Conduct normal healthcare operations.

The practice explained to me that the Privacy Notice will be available to me in the future at my request and my right to obtain a copy of the Privacy Notice prior to signing this consent. I have been encouraged to read the Privacy Notice carefully prior to my signing this consent.

2) The Practice reserves the right to change it privacy practices that are described in its Privacy Notice.

3) I understand, and consent to, the following appointment reminders that will be used by the practice:

a) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or
b) Postcard mailed to me at the address provided by me.
c) Confirmation calls are a courtesy. Patient is responsible for keeping appointments, calling to cancel or rescheduling appointments.

4) The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

5) I understand that I may request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the practice is not required to agree to any restrictions that I have requested. If the practice agrees to the requested restriction, then the restriction is binding on the practice.

6) I understand that this consent is valid for 7 years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the practice has the right to refuse to treat me.

7) I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the practice will not treat me.

I have read and understand the foregoing notice, and all my questions have been answered to my full satisfaction in a way that I can understand. I acknowledge and agree with the all of the above.

_____ _____

Patient Name (printed) Patient signature (or legal representative)

_____ _____

Name of Legal Representative (printed) Relationship to patient

Date signed _____

Employee Witness: _____ _____

Printed Signature

Date witnessed: _____

OFFICE POLICY OF
ENDOCRINE AND PSYCHIATRY CENTER (EPC)

ENDOCRINE AND PSYCHIATRY CENTER (EPC) welcomes you to the practice. We hope that each visit will meet your expectations on service, timeliness and courtesy. Please let us know if we fall short of these expectations at any time.

We ask that all patients arrive on time for their appointment. We will strive to see that your appointment begins at the scheduled time. If you arrive 10 minutes or more late, it is possible that you may be asked to reschedule your visit so as not to inconvenience other scheduled patients. If you do not show for your appointments or reschedule, there may be a possibility that you will not receive refills for your medications.

Our practice has adopted the following possibly additional fees:

1) A cancellation fee of $40.00 if an appointment is not cancelled more than 24 hours in advance or you no show. This fee will be collected prior to you next appointment. Our Office Manager does understand true emergencies and will work with you individually on an emergency issue.
2) A charge of $25.00 for returned checks, which must be paid prior to you next appointment.
3) Due to the frequency and length of patient phone calls, please be aware that a charge of $25.00 for the doctor’s time may be incurred, which may not be reimbursed by the insurance carrier.
4) Our practice charges $25.00 for medical records/paperwork requested by the patient/insurance company.

We are always glad to receive comments on how we might better serve you, OUR PATIENT. Please ask to speak with the Office Manager about any thoughts, problems or issues you might have.

I have read and understand the above information. I acknowledge and agree with all of the above.

____________________________ __________________________________ _____________

Patient Name (printed) Patient signature Date

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient: ______________________________________ DOB: __________________ SSN: ________________________

I request and authorize the office of ENDOCRINE AND PSYCHIATRY CENTER (EPC) to release to the following FAMILY OR FRIENDS, healthcare information for the patient named above:

Name: ____ Relationship: ____________________________

Name: ____ Relationship: ____________________________

Name: ____ Relationship: ____________________________

This release and authorizations applies to:

____ All healthcare information
____ Only dates of service from ______________ to ______________
____ Only information pertaining to the treatment of ____
____ Mental Health information, Mental Retardation information
____ Alcohol/Drug (Substance) information
____ HIV/AIDS information
____ Other: ____

I request that information NOT be release to the individuals listed below (Name and relationship):
____

If I revoke this authorization, I do understand that information may have already been released by the doctors named above in reliance on my original authorization.

___________________________________ ______________________________ ___________________

Patient Signature Relationship to patient Date
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Endocrine and Psychiatry Center (EPC)

HMO

PATIENT WAIVER AGREEMENT

When my Primary Care Physician referred me to this office, I understand he/she was given an authorization number and a copy of the referral form was mailed to this office and to me. IF I DO **NOT** HAVE A COPY OF THE REFFERAL FORM WITH ME AT THIS TIME OR IF THIS OFFICE HAS NOT RECEIVED THEIR COPY YET, I REALIZE I HAVE THE FOLLOWING OPTIONS:

1. I can call my Primary Care Physician and get the authorization number for this visit: (_____) _____

2. I can reschedule this appointment and bring my copy of the referral form or the authorization number with me to that appointment, or

3. I can keep this appointment today, without either of the above and I understand that my insurance plan will NOT PAY for the charges related to my visit today.* Further, I understand that I will be responsible for payment of ALL CHARGES related to my visit today.

_____ _____
Printed Name of Patient Date of Service

_____
Signature of Patient or Authorized Representative

_____
Insurance Identification Number/Group Number

* No retroactive referrals/authorizations will be accepted

PPO

I understand that I will be responsible for payment for ALL CHARGES related to my visit today that are not covered or paid for by insurance.

_____ _____
Printed Name of Patient Date of Service

_____
Signature of Patient or Authorized Representative

Endocrine and Psychiatry Center (EPC)

Patient Consent for Use of Email Communications

To better serve our patients, this office has established an email address for some forms of communication via your account on MDBug.com. For routine matters that do not require immediate response, please fell free to contact us at MDBug.com using your user id and password. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is usually less than 8 hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

When sending email, please put the subject of your message in the subject line so that we can process it more efficiently. Also, be sure to put a return telephone number in the body of the message.

All communications via email will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and /or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email through MDBug.com and that we may respond to your emails to us via email.

_____ _____

Patient Name (please print) Date

_____ _____

Patient Signature Witness