ENDOCRINOLOGY & DIABETES SPECIALIST
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BOARD-CERTIFIED IN ENDOCRINOLOGY, DIABETES AND METABOLISM

Endocrinology & Diabetes Specialists

Medical History Form

1. **Do you or Have you ever had any of the following medical conditions: (please circle)**

Diabetes	High blood Pressure	Polycystic Ovaries
Heart Attack	Stroke	High Cholesterol
Blood Clots	Prostate Cancer	Pancreatic Cancer
Infertility	Congestive Heart Failure	Breast Cancer
Thyroid Cancer	Stomach Cancer	Thyroid Problems
Osteoporosis	Back Problems	Colon Cancer
Skin Cancer	Pituitary Tumor	

2. **Have you ever had any of the following surgeries: (please circle & list approximate date)**

Hysterectomy
Weight Loss Surgery (Band, Sleeve or Bypass)
Hip Replacement
Eye Surgery-Pleas Specify:
Breast Surgery
Back/Spine Surgery
Gallbladder Surgery
Knee Replacement
Other Surgeries & Dates:

Appendectomy
Abdominoplasty (Tummy Tuck)
C-Section
Thyroid Surgery
Liposuction
Heart Surgery/Bypass
Rhinoplasty

3. **Do any of you family members have the following conditions: (please specify relationship)**

Diabetes
High Cholesterol
Thyroid Cancer
Blood Clots
Pituitary Tumor

Heart Disease
High Blood Pressure
Hypo or Hyperthyroidism
Adrenal Disease
Cancer (what type)

4. **If any Children, how many? (please specify if step children or adopted as well)**

5. **Do you smoke? (circle one)**

   □Yes How many packs a day? How many years?

   □No

   Former Smoker? Yes or No Quit Date?

6. **Do you drink alcohol?**

   □Yes How many drinks and what type per week?

   □No

7. **Please list all your <u>drug, food, and environmental allergies</u>. Please note severity (very mild, mild, moderate, or severe) & reaction.**

8. **Please list all your <u>current medication</u> with <u>dosages</u> at the bottom or back of this form & inform our staff of the list.**

ENDOCRINOLOGY & DIABETES SPECIALIST
REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status:

Email:	Driver's License#	Birth date:	Age:	Sex: ○ M ○ F

Address (city, state, zip code) :

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Chose clinic because/Referred to clinic by (please check one box): □ Dr. _____ □Insurance Plan □ Hospital
□ Family □Friend □ Close to home/work □ Newspaper/Magazine □Online □ Other

Preferred Pharmacy (address & phone number) :

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber: □ Self □Spouse □ Child □Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ENDOCRINOLOGY & DIABETES SPECIALIST or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

ENOCRINOLOGY & DIABETES SPECIALIST

Consent to Treat & Financial Responsibility

CONSENT TO TREAT

I hereby authorize employees and agents of Endocrinology & Diabetes Specialist, including physicians, physicians' assistants, nurse practitioners and other employees and staff members, to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Only if patient is a minor:

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Parent, or Legal Guardian **Date**

FINANCIAL RESPONSILBILITY

I hereby authorize payment of medical benefits directly to Endocrinology & Diabetes Specialist and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable disease, such as Acquired Immunodeficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Endocrinology & Diabetes Specialist. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of Endocrinology & Diabetes Specialist, if any. The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

ENDOCRINOLOGY & DIABETES SPECIALIST

Patient Secure Messaging

Endocrinology & Diabetes Specialist may implement in the near future a system to communicate electronically with you under the conditions and terms outlined below.

USE OF ELECTRONIC COMMUCATION FROM ENDOCRINOLOGY & DIABETES SPECIALIST TO PATIENT

□ **YES**, I want **Endocrinology & Diabetes Specialist** to communicate my information with me through a secure system that is designed to keep your information safe. You will be notified via email when there is secure information for you to review. The E-mail will provide a link that will take you to the secure site. After clicking on the link, you will required to log-in and provide a password to access your information. You will need to make note of the password to access any future information.

E-mail Address: _____

In choosing your e-mail address, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any person, such as your employer, that may have the right and /or ability to review all e-mail received at your work address.

□**NO**, I do not want **Endocrinology & Diabetes Specialist** to use electronic communication as a way to communicate to me.

ENDOCRINOLOGY & DIABETES SPECIALIST E-MAIL GUIDELINES

1. Upon implementation, **Endocrinology & Diabetes Specialist** can only send emails to patients. Endocrinology and Diabetes Specialist will not be able to accept patient emails through the secure portal.
2. The patient is responsible to notify **Endocrinology & Diabetes Specialist** promptly of any changes to his/her email address.
3. All of **Endocrinology & Diabetes Specialist** electronic communications to you are recorded in your medical record. Those who have access to your medical record also have access to the email messages sent to you.

Confidentiality and Privacy

1. If the electronic communication process described above is not used, we **CANNOT** guarantee the confidentiality of the information.
2. **Endocrinology & Diabetes Specialist** will not share your email address with anyone unauthorized to view your medical records.

Consent and Agreement

I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for electronic communication from **Endocrinology & Diabetes Specialist**. I understand that the service will be offered at no charge and that I will be notified if and when fee is administered for the service.

_____	_____	____/____/____
Print Name Patient	Signature Patient/Guardian	Date

ENDOCRINOLOGY & DIABETES SPECIALIST

Patient Preferences Regarding Communications of Patient Health Information

Approved HIPAA Contacts

□ **DO NOT** disclose or discuss any information related to my **billing account information** and **medical condition(s)** with anyone other than myself.

□ I hereby give permission to disclose discuss any information related to my **billing account information** and **medical condition(s)** with the following family members, relatives, and other persons:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Preferred Method of Contact

□ I request that communications regarding my **medical condition(s)** to occur **ONLY** when I am in the clinic. Please only print and hand me information when I am in the clinic. **I DO NOT** wish to be notified by any other communications method regarding my medical condition(s).

□ Please communicate with me regarding my medical condition(s) using the method I've indicated below:

□ Home Phone □ Work Phone □ Cell Phone □ Email

□Mailed Letter □ Guardian □ Other: _____

If the above method of contact is by phone, please check the appropriate box below:

□ Okay to leave a message with detailed information.

□ Please leave a message with a call back number only.

Please note that you are responsible for any changes occurred in receiving out communications. For example, if you provide a cell phone number ass a method of contact, then you are responsible for any charges imposed by your mobile carried for receiving calls or text messages from the clinic.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed on this form will require my specific authorization prior to the disclosure of any medical information.

Signature of Patient, Parent, or Legal Guardian	Date
Name of Legal Guardian	Relationship to Patient

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H)_____ **Phone: W)**_____

Address:_____ **City/State/Zip:**_____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:_____ **Facility Phone:**_____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip:_____

Dates and Type of information to disclose:

- ☐ 2 years prior from last date seen
- ☐ Dates Other:_____
- ☐ Specific Information Requested:

_____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To:_____

Address:_____

City, State, Zip:_____

- ☐ **Please mail records.**
- ☐ **Please fax records.**

Fax:_____ **Phone:**_____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status.) **Date**

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

ENDOCRINOLOGY AND DIABETES SPECIALIST

Cancellation Policy/No Show Policy

1. Cancellation/ No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

If you've cancel your appointment on same day of visit you will still be charged a fifty dollar ($50) fee, as it's consider last minute cancellation.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

_____	_____	___/___/___
Print Name Patient	Signature Patient/Guardian	Date

ENDOCRINOLOGY & DIABETES SPECIALIST

PRESCRIPTIONS REFILL REQUEST

Please be advised that taking your best interest into consideration, we will **NOT refill** medications for patients who **miss or cancel 2 consecutive appointments until they show up to their next scheduled appointment. Effective immediately, this policy is enforced to ensure first and foremost patient safety that could potentially be compromised by medication usage that goes without regular monitoring for effectiveness and/or side effects.**

I have read and understand the policy above and by my signature I attest that I fully understand and agree to the terms above.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

ENDOCRINOLOGY & DIABETES SPECIALIST

ADDITIONAL PRACTICE POLICIES

(Please read the policies below & initial beside each)

Prescriptions Refills:

You should be responsible in knowing when your medication must be refilled at least 1 week before you run out. Please request all your refills through your pharmacy as they will contact us. We cannot refill prescriptions over the weekend, as walk-in or after hours.

Emergencies:

We will try to respond to your calls promptly in an emergency. However if you do not receive an immediate response, you should call 911 to seek care in the nearest emergency facility.

Telephones Encounters with Physician:

We do not treat new patients or new illnesses over the phone. For any questions or health problems, the physician will determine if it is necessary for the patient to be seen face-to-face should the questions or problem be beyond the scope of a telephone call, and patient will be informed to make an appointment.

Medical Records:

Your medical records are the property of the practice but will be available to you at a fee determined by Texas Medical Board. Your records may be forwarded to another physician in charge of your healthcare free of charge.

Patient Discharge:

The practice deserves the right to discharge a patient any reason. Usually discharges are made on the basis of patient failure to comply with practice policies or treatment plans as determined appropriate by the physician. Inappropriate conduct towards our physician(s) or staff may also result in discharge from the practice.

I have read and understand each policies above and by my signature I attest that fully understand and agree to the terms above.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**