Patient Information and Questionnaire

Last Name _____ **First Name** _____ **MI** _____

Street _____ **City** _____ **State** _____ **Zip Code** _____

Preferred Contact Phone Number HOME # _____ **CELL #** _____

Email address: _____ **Birth Date** _____

Sex _____ **Social Security** _____ **Driver Lic. #** _____

Preferred Language: _____ **Ethnicity: (select one) □ HISPANIC or □ NON-HISPANIC**

Race: (select one): □ American Indian / Alaskan Native; □ Asian; □ African American ; □ Caucasian; □ Pacific Islander; □ Other; □ Declined

Patient Employer: _____

Referring Physician: _____ **Phone #:** _____

Primary Care Physician: _____ **Phone #:** _____

Reason for Visit: _____

Emergency Contact

Name: _____ **Relationship to Patient:** _____ **Phone Number:** _____

Guarantor/Responsible Party Information

Name: _____ **Relationship to Patient:** _____ **Phone Number:** _____

Pharmacy information:

Pharmacy Name: _____ **Phone Number:** _____

Street: _____ **City:** _____ **State:** _____ **Zip Code:**

Please list all allergies and type of reaction:

_____

_____

_____

_____

_____

_____

_____

_____

I hereby agree that the information provided above is accurate and current to the best of my knowledge.

Patient/Responsible Party Signature: _____ **Dat**

Medication List

Please list all prescriptions, vitamins, herbs, and over-the-counter medications that you are currently taking and/or bring your medications with you to your appointment.

Medication	Strength (how many milligrams)	Dose (number of pills)	How many times a day

HIPPA Compliance and Privacy Acknowledgment

The Health Insurance Portability and Accountability Act of 1996 requires us to notify you of our privacy practices in order to keep your private medical and personal information safe. Endocrinology and Osteoporosis Centers of Texas is committed to the continuation of confidential patient information. We are required by law to (i) maintain the privacy and protection of your 'health information; (ii) provide notice of our privacy practice; (iii) notify you if there is a breach of confidentiality of your health information; and (iv) how we may use and disclose your information.

We may use and share your information to:

- Provide care and treatment within our practice and/or other medical practices/hospitals.
- Bill or seek information from insurance companies for services we have provided.
- Maintain our medical practice.
- File reports with public health and safety entities.
- Conduct research studies.
- Respond to workers' compensation, law enforcement or any other government agency.
- Defend law suits or legal actions.

You may designate certain persons to receive your information. We will not disclose any information without your consent unless it is vital to the course of treatment.

I consent and designate this person may receive information regarding my medical condition.

Name:_____ Relationship:_____

Phone number: _____

As a patient you have the right to:

- Request a copy of your medical records.
- Make any correction to your records.
- Communication preferences of your records.
- Restriction of the information we share of your records.
- File a complaint if you believe your privacy has been violated.

I hereby acknowledge that I have read and understood the privacy policy

Patient/Responsible Party Signature: _____Date:

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name: _____ Patient's Date of Birth: _____

Address Patient's: _____ Telephone Number: _____

City, State Zip Code: _____ Any Other Names Used: _____

I hereby request that Endocrinology and Osteoporosis Centers of Texas use / disclose my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all):

_____

2. Be sent to the following person / entity at the address listed:

   Name: _____

   Address: _____

   City, State Zip Code: _____

3. I authorize disclosure of the following specific information (include dates of service):

_____

_____

_____

4. I understand that I have the right to receive a copy of my PHI. **Unless otherwise specified and agreed upon by Endocrinology and Osteoporosis Centers of Texas Staff, I understand that my PHI will be provided in paper format.** In addition, I understand that I will need to pick up the PHI in person so staff can confirm my identity and make sure that non-authorized person do not obtained access to my records.

5. This authorization expires on _____, 20_____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please specify) _____ .

6. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and would then no longer be protected by federal privacy regulations.

7. I understand I may revoke this authorization by notifying Endocrinology and Osteoporosis Centers of Texas in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

8. My purpose/use of the information is for ☐ personal use; ☐ or other (please specify) _____ .

FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, and labor for creating a summary/explanation of the PHI if a summary or explanation was requested. If the charges will exceed $10, we will inform you of the approximate charges prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

Signature of Patient	Date of Patient's Signature	Patient's Date of Birth
_____	_____	_____
If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate	Date of Legal Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual
_____	_____	_____

For Office Use Only

Date Received	Date Processed	Fee	Pt Notified of Fee	Medical Record #
_____	_____	_____	_____	_____

Endocrinology and Osteoporosis Centers of Texas

FINANCIAL POLICY

Welcome to Endocrinology and Osteoporosis Centers of Texas and its affiliates! We are excited that you have chosen us for your specialty care and cannot wait to meet you. At Endocrinology and Osteoporosis Centers of Texas and its affiliates, we are committed to providing high quality, evidence-based care via interdisciplinary and patient collaboration. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. Some insurance plans tell us exactly what you will owe at the time of your visit; in that case, we may request full payment for your share when you check in or out. Other insurance plans do not provide immediate information regarding patient responsibility; in that case, you will be asked to pay at the next visit.

TYPES OF PAYMENTS

1. *Co-payments*. Insurance carriers require that we collect your co-payment at the time of your visit. If you are not prepared to make your co-payment, you may reschedule your appointment.

2. *Deductibles.* Most insurance plans require you to pay a predetermined amount (the "deductible") before insurance will cover certain charges. If your visit will require a procedure, we will do our best to contact your insurance company to determine your portion of the payment before the visit.

3. *Co-insurance.* Some insurance plans require that you pay a certain percentage (for example, 20%) of the allowable charge amount. If we can determine the amount, we will ask that you pay your co-insurance at the time of your visit.

4. *Uninsured Patients / Self-Pay.* If you do not have insurance or if the services provided are not covered by your insurance, payment for all services is due at the time of your visit. Two options are available: 1) Pay in full at the time of service with a discount being applied; or 2) we can bill you if you do not pay at the time of service.

5. *Out-of-Network.* We participate with most major insurance plans. You should contact your insurance company to confirm if your provider is in network prior to making your appointment. If we do not participate with your insurance plan, you will be required to pay for your visit at the time of service. We may send a courtesy bill to your insurance company.

6. *Non-Covered Services.* It is your responsibility to contact your insurance plan to determine whether a certain service is covered. If we provide you non-covered services, you are expected to pay for the services at the time of your visit.

7. *Non-Covered Services for Medicare.* If you are a Medicare patient, we will inform you of any non-covered services prior to your treatment. Your provider will review options with you and document your decision. Acceptance of financial responsibility by the patient will use the Centers for Medicare and Medicaid Services (CMS) form CMS-R-131 – Advance Beneficiary Notice (ABN).

DISCOUNTS

Anyone without insurance (medical indigence) or who is unable to pay due to financial indigence will get a discount. The minimum amount a patient must pay is the amount Medicare/Medicaid would reimburse for that service. Payment plans are available.

INSURANCE

We ask all patients to provide their insurance card and proof of identification (Photo ID or Driver's License) at every visit. If you do not have current proof of insurance and we can verify your active insurance in our system, you may be billed in full for services for that visit at the uninsured rate. However, if you provide your insurance card(s) later, we may be able to retroactively bill the services to your insurer depending on the insurance plan's requirements and may be able to make further adjustments to your account. We have agreements with a large variety of third-party carriers and are always working to add new partnerships, however sometimes we are not able to reach an agreement with some carriers. You are expected to pay the entire amount determined by your insurance to be the patient's responsibility. Keep in mind that our fees are for physician services only; additional services from laboratory, radiology, or other diagnostic related providers may result in additional fees and bills from these services.

You are responsible to:

- Arrive for your appointment with all required documentation.
- Fully cooperate and provide necessary assistance for us to file any appeals with your insurance plan.
- Contact your insurance company in advance to make sure all ordered lab studies and procedures are approved. (We also recommend contacting the insurance company to see if they can provide estimate costs to you as well)
    - If you have a non-covered test ordered and wish to proceed, please contact our office to see if we can provide any assistance prior to getting that study.
- Know if a referral or authorization is necessary for office visits (For instance, all HMO patients need to have a referral from a PCP sent to Endocrinology and Osteoporosis Centers of Texas and its affiliates for services to be covered). This is required and if you don't have the appropriate referral or authorization, you may be billed as an uninsured patient for that visit.
- Coordinate benefits if you have more than one insurance plan. This is done by contacting the insurance company and determining which plan is primary versus secondary and resolved any other issues as well.

Insurance Verification. We will attempt to verify your insurance eligibility prior to your visit. If we are unable to confirm active insurance coverage, we will contact you about your insurance eligibility. If you are unable to provide information about other active insurance coverage prior to the visit, you will be required to either pay at the time of your visit or reschedule your appointment. For same day appointments, we will check eligibility when the appointment is made.

Outstanding Balances. After your visit, we will send you a statement for any outstanding balances. We usually send out statements every 30 (30) days, beginning when the balance becomes the patient's responsibility.

For outstanding balances, we will usually provide the patient with options to pay it at their convenience. Your outstanding balances can be paid conveniently by contacting our office to review the different options available. However, if you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee as permitted by applicable state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

LATE ARRIVALS, CANCELLATIONS, AND NO-SHOWS

Late arrivals. If you arrive late for a scheduled appointment, please contact the office prior to arriving to the clinic. You may be asked to reschedule your appointment or wait for an open appointment time on that day's schedule. We will try to accommodate all of our patients; however we wish to be respectful of other patient's scheduled times as well.

Cancellations. If you are unable to keep a scheduled appointment, you must call at least one (1) business day in advance or we may consider you a "no-show."

No-shows. If you miss your appointment, you will be given a notice of our policy regarding Late Arrivals, Cancellations, and No-shows. We understand that unexpected events occur and that patients have no control over their schedules when this happens. If this does occur, please let the clinic know as well so we can document the reason.

However, if you miss your appointment and do not notify the office prior to 24 hour before your appointment, you may be charged a $30.00 fee. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

If permitted by state law, you may be discharged as a patient following three (3) no-shows in a one-year period (365 days).

Thank you for choosing Endocrinology and Osteoporosis Centers of Texas and its affiliates!

_____ _____

Patient Signature **Dated**

Past Medical History

Diabetes: Type		Yes		No
High Cholesterol		Yes		No
Hypertension (high blood pressure)		Yes		No
Diabetic Foot Exam Date		Yes		No
Retinal Exam Date		Yes		No
Hypothyroid (underactive thyroid)		Yes		No
Hyperthyroid (overactive thyroid)		Yes		No
Thyroid Nodule		Yes		No
Thyroid Cancer		Yes		No
Coronary Artery Disease / Heart Blockage		Yes		No
Congestive Heart Failure		Yes		No
Osteoporosis / Osteopenia		Yes		No
Prostate Cancer		Yes		No
Breast Cancer		Yes		No
Blood Clots / DVT		Yes		No
Other Cancer Type	[redacted]			
Pituitary Problem / Disease		Yes		N
Kidney Stones		Yes		o
Kidney Disease		Yes		N
Chronic Renal Insufficiency		Yes		o
CVA / Stroke		Yes		N
Peptic Ulcer / GERD		Yes		o
Colonoscopy Date		Yes		N
Asthma / COPD		Yes		o
Depression		Yes		N
Anxiety		Yes		o
Other Medical History:				N
				o

Social History

Never smoker		Yes		N
Current every day smoker		Yes		o
Current some day smoker		Yes		N
Former smoker		Yes		o
Alcohol use Quantity		Yes		N
Past drug use		Yes		o
Current drug user		Yes		N
Exercise:	[redacted]			
Occupation:				
With whom do you live:				

Family History

Diabetes If Yes, Relation:		Yes		No
Hyperthyroidism		Yes		No
Thyroid Cancer Type		Yes		No
Heart Disease (CAD)		Yes		No
Hypertension (high blood pressure)		Yes		No
High Cholesterol		Yes		No
Osteoporosis / Osteopenia		Yes		No
Stroke		Yes		No
Breast Cancer		Yes		No
Prostate Cancer If Yes, Relation:		Yes		No

Other Family History:

Surgical History

Cataract (eye) surgery		Yes		No
Tonsillectomy (tonsils removed)		Yes		No
Thyroidectomy (thyroid surgery)		Yes		No
Thyroid Biopsy		Yes		No
Breast Biopsy		Yes		No
Mastectomy / Lumpectomy		Yes		No
Coronary Artery Bypass (heart surgery)		Yes		No
PTCA Angioplasty / Stent		Yes		No
Aortic or Mitral Heart Valve Repair		Yes		No
Pacemaker		Yes		No
Appendectomy (appendix removed)		Yes		No
Cholecystectomy (gallbladder removed)		Yes		No
Hysterectomy (total/partial)		Yes		No
Caesarian Section		Yes		No
Tubal Ligation (“tubes tied”)		Yes		No
Urinary or bladder surgery		Yes		No
Prostate Surgery		Yes		No
Hernia Repair		Yes		No
Colectomy (colon removal)		Yes		No
Back surgery		Yes		No
Hip surgery		Yes		No
Knee surgery		Yes		No
Other Surgical History:				