Endocrine & Diabetes Center

301 Maple Avenue West, Suite 120
Vienna, Virginia 22180
Phone: (703) 938-8885
Fax: (703)242-2437

Endocrine and Diabetes Center, P.C.

PATIENT REGISTRATION

Welcome to our office. We are committed to providing high quality, comprehensive specialty care. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Date
Patient Name Date of Birth Sex Age
Parent if Patient is a Minor
Patient's Social Security Number Marital Status
Home Address City State Zip Apartment #
Home Telephone Number ( ) Work Telephone Number ( ) Cell Phone ( ) Fax ( ) E-mail:
Occupation Employer's Name
Employer's Address City State Zip
Spouse's Name Employer Cell phone # ( )
Primary Physician's Name Address Telephone Number ( )
Referring Physician's Name, (if different than PCP) Address Telephone Number ( )
NOTIFY IN CASE OF EMERGENCY
Name Relationship
Address City State Zip
Home Telephone ( ) Work Telephone ( ) Cell Phone ( )
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES
Name Telephone
Address City State Zip
Insurance Company Claim Address
Subscriber's Name Subscriber's Date of Birth Subscriber's SSN#.
Insurance ID No.:
Secondary Insurance Claim Address
Subscriber's Name Subscriber's Date of Birth Subscriber's SSN#
Were You Injured on the Job? YES NO Have you Informed Your Employer? YES NO
Date of Original Injury:
Worker's Compensation Carrier Name Address

Please Read Our Financial Policy Statement and Agreement on Reverse

Medical Payments

I hereby certify that all the information I have reported to your office with regard to insurance coverage is correct, and authorize all payments of medical insurance benefits be paid to Endocrine and Diabetes Center, P.C. for services rendered. I hereby authorize the release of any necessary information including Individually Identifiable Health Information (IIHI) for any related claim to my insurance carrier, (or, in the case for Medicare or Medicaid to appropriate authorities). I understand and agree that I am financially responsible for charges not paid by insurance company. Any payments for services rendered will be made in a prompt manner. A copy of this authorization may be used as the original.

Authorization of Release to Others

I am hereby giving permission to staff and employees of the Endocrine and Diabetes Center, P.C. to leave medical information on my answering machine at my residence/ cell phone or use text massage, e-mail or fax to communicate with me or may contact my family members/ individual listed below when I am not available. This information could be regarding the results of laboratory tests, radiological reports, medication changes, recommendations or urgent matters. The following is the name of the Family member or Individual who may receive the information: _____ Relation: _____
Phone # ( ) -
I further understand that I may revoke this authorization at any time. This must be in writing to the healthcare provider with an effective date and no retroactive dates will be accepted. **Please initial.** _____

Consent Agreement and Privacy Notice

It is our policy to obtain a signed consent from all of our patients as it relates to the use and disclosure of their Individually Identifiable Health Information (IIHI). The law requires we inform you of our policy regarding the protection of your IIHI through our **Privacy Notice**, which we will provide you. In the notice you will find full explanation of how our office will accomplish this. The following statement allows us the necessary latitude to work within the requirements.

I have been presented with a **Privacy Notice** explaining my rights regarding my IIHI (individually identifiable health information). I consent to the use and disclosure of my IIHI for purposes of treatment, payment or other health care operations. Additional uses of my IIHI will require an authorization from me for the specific intention of disclosure. **Please initial.** _____

Pharmacy information and Medication Refills

Name of pharmacy_____ Phone number_____

Pharmacy Address: _____

We provide electronic prescriptions to all pharmacies online. With the exception of emergencies, prescription refills should be faxed into our offices by your pharmacy 72 hours in advance. If you participate with a mail away pharmacy, your new prescriptions will be sent either electronically or by fax, or provided to you directly. Please allow adequate time for the new prescription to reach you.

Please sign that you have read and understand the above.

Patient Name _____ Parent's Name If Patient is a Minor_____

Patient Signature: _____ Date: _____

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REVIEW OF SYSTEM FORM

Name_____ Date of Birth: _____ Date: _____

Please circle appropriate answer

- **CONSTITUTIONAL SYMPTOMS**
  - Good general health ……..…… No Yes
  - Fever ……..…….. No Yes
  - Fatigue ……..…….. No Yes
  - Headache ……..…….. No Yes
  - Insomnia ……..…….. No Yes

- **EYE**
  - Blurred vision ……..…….. No Yes
  - Glaucoma ……..……..…….. No Yes
  - Change in visual field ……..…..... No Yes
  - Cataract ……..……..……..... No Yes
  - Congestion

- **EAR/NOSE/MOUTH/THROAT**
  - Hearing loss or ringing …….. No Yes
  - Chronic sinus problem or rhinitis …… No Yes
  - Nose bleed ……..……..…….. No Yes
  - Hoarseness or difficulty speaking …….. . No Yes
  - Sore throat ……..……..…… No Yes
  - Swollen gland ……..……..…….. No Yes

- **CARDIOVASCULAR**
  - Chest pain ……..……..…….. No Yes
  - Palpitation ……..…….. No Yes
  - Shortness of breath with walking or lying flat. No Yes
  - Swelling of feet, ankles or hands.…… ….. No Yes
  - Heart trouble

- **RESPIRATORY**
  - Chronic or frequent cough ….……... . No Yes
  - Spitting up blood ……..…….. No Yes
  - Shortness of breath ……..…….. No Yes
  - Asthma or wheezing ……..…..…….. No Yes
  - Snoring ……..……..……..…….. No Yes

- **GASTROINTESTINAL**
  - Loss of appetite ……..…….. No Yes
  - Change in bowel movement ……..... No Yes
  - Nausea or vomiting ……..…….... No Yes
  - Frequent diarrhea ……..…..…….. No Yes
  - Abdominal pain ……..…… No Yes
  - Constipation ……..……..…… No Yes

- **GENITOURINARY**
  - Frequent urination ……..…….. No Yes
  - Burning or painful urination …… No Yes
  - Blood in urine ……..……..…….. No Yes
  - Change in force of urine …….. No Yes
  - Incontinence or dribbling ……..…….. No Yes
  - Kidney stone ……..…….. No Yes
  - **FEMALE** - Painful periods …… No Yes
  - **FEMALE -** Irregular period …… ….No Yes
  - **FEMALE** - Heavy bleeding …… No Yes
  - **FEMALE** - # of pregnancies ____ # of miscarriages____
  - **FEMALE** - Date of last period _____

- **MUSCULOSKELETAL**
  - Joint pain ……..…….. No Yes
  - Joint swelling ……..…….. No Yes
  - Muscle weakness …….. No Yes
  - Muscle cramp ……..……..…….. No Yes
  - Back pain ……..……..…….. No Yes

- **SKIN, BREAST**
  - Skin rash ……..……..…….. No Yes
  - Change in skin color ……..…….. No Yes
  - Change in hair or nail ……... No Yes
  - Varicose vein ……..……..…… No Yes
  - Breast pain ……..…….. No Yes
  - Breast lump ……..……..…….. No Yes
  - Breast discharge ……..…….. No Yes

- **NEUROLOGICAL**
  - Frequent or recurrent headache ……. No Yes
  - Light headed or dizzy ……..…….. No Yes
  - Convulsion or seizures …….. No Yes
  - Numbness or tingling sensation …. ….... No Yes
  - Tremor ……..…….. No Yes
  - Paralysis ….……..……..…….. No Yes
  - Stroke ….……..……..…….. No Yes

- **PSYCHIATRIC**
  - Memory loss or confusion …….. No Yes
  - Nervousness ……..…….. No Yes
  - Depression ……..……..…….. No Yes

- **ENDOCRINE**
  - Hormone problem (Explain) ……..…….. No Yes
  - Thyroid disease ……..…….. No Yes
  - Diabetes ……..……..…….. No Yes
  - Excessive thirst or urination.……..…….. No Yes
  - Heat or cold intolerance ……..…….. No Yes

- **HEMATOLOGIC/LYMPHATIC**
  - Bleeding or bruising tendency …….. . No Yes
  - Anemia ……..……..…….. . No Yes
  - Phlebitis ……..……..…….. . No Yes
  - Past transfusion ……..…..... No Yes

- **KNOWN DRUG ALLERGY**……
- **REVIWED BY**……

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MEDICATION RECORD

Please write the name, dosage and frequency of all medication you are currently taking

Name_____ Date of Birth: _____ Date: _____

MEDICATION NAME	DOSAGE	FREQUENCY	PRESCRIBER

PLEASE RECORD ALL ALLERGIC REACTIONS TO DRUGS:

1- ……...
2- ……
3- ……..
4- ……..
5- ……..

Endocrine & Diabetes Center

CONSENT FOR RELEASE OF MEDICAL INFORMATION
TO ENDOCRINE & DIABETES CENTER

I hereby authorize (Name of healthcare provider or organization): _____

_____
(Street) (City) (State) (ZIP Code)
to disclose health information from the medical record(s) of:

Patient Name: _____

Address: _____
(Street) (City) (State) (ZIP Code)
Date of Birth: _____ Approximate date(s) of treatment: _____

Please release Information to: <u>Endocrine and Diabetes Center, P.C.</u> at the following address:
❒ 301 Maple Avenue West, Suite 120, Vienna, VA 22180

Information requested:

_____ All medical record _____ Operative reports _____Pathology report _____Discharge summary

_____ Laboratory findings _____ Radiology reports _____ Nuclear Medicine

_____ Other: _____

I permit this confidential information be released for the following purpose:
_____ continuing medical care
_____ Confirmatory consultation
_____ Other: Specify Reason: _____

Print Patient's Name: _____

Signature of Patient: _____ Date: _____

Signature of Legally Authorized Person: _____ Date: _____

Signature of witness: _____ Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

ENDOCRINE & Diabetes Center, P.C.

Effective April 14, 2003; Revised May 18, 2019

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services.

- **Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of the physicians and other providers healthcare in our practice. These activities include, but are not limited to, quality assessment activities, employee review or arranging for other business activities.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Endocrine and Diabetes Center is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization, including, but not limited to:

- Disclosures required by law

- Disclosures to avert serious threats to health or safety

- Disclosures with reference to Workers' Compensation or Food and Drug Administration

Endocrine and Diabetes Center may contact the individual to provide appointment reminders or information about treatment or other health-related benefits and services that may be of interest to the individual or patient. Endocrine and Diabetes Center will routinely contact patients via telephone at home and/or mobile, may leave messages on the appropriate voice mail or answering service regarding appointments, test results, etc.

Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization. {Please see our registration form for identifying persons to whom you would allow disclosures of otherwise protected information.

YOUR RIGHTS:

Following is a statement of your rights with respect to your protected health information:

1. The right to request restrictions on certain uses and disclosures of PHI. However, we may not agree to all requested restrictions.
2. The right to restrict disclosures to your insurance company for health care items or services for which you have paid for in full at the time of service.
3. The right to receive confidential communications of protected health information, as applicable.
4. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
5. The right to amend protected health information, as provided in the Privacy Regulation.
6. The right to receive an accounting of disclosures of protected health information.
7. The right to obtain a paper copy of the Notice from the covered entity upon request.
8. The right to file a complaint if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.
9. The right to receive timely notification of any breach of your unsecured protected health information.

Endocrine and diabetes Center is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. Endocrine and diabetes Center is required to abide by the terms of the Notice currently in effect.

Endocrine and diabetes Center reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains. Virginia Heart will provide individuals or patients with a revised Notice by posting new regulations in the office. If you have any questions about this information discussed above please contact the privacy officer.

In the event of a breach of security involving the patient’s protected health information, Endocrine and Diabetes Center will follow the recommendations outlined by the American Medical Association.

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Financial Agreement:

1. Endocrine & Diabetes Center, P.C. (EDC) will file for insurance benefits and accept payments according to contractual agreements with participating insurance companies. Any dispute or questions concerning insurance coverage or payment of benefits is a matter between the policyholder and the insurance company.

2. Referrals and Authorizations: I understand that it is my responsibility to contact and obtain from my insurance plan any referrals, pre-certifications or authorizations prior to receiving any non-emergency medical services from EDC. If a referral is required and I do not bring it with me, my appointment may need to be rescheduled. I accept full responsibility of all charges and fees billed by EDC if a referral is required and I do not provide one.

3. I understand that I will be responsible for payment of "non-covered" or "incidental" services related to patient care, including but not limited to telephone and/or email consultations, prescription refills not done at the time of service, dietary instruction or diabetes education not covered by my insurance policy or other medical care requested.

4. I understand there will be a charge for copying medical records, letters or any medical forms which need to be completed by the physician.

5. I agree to pay a $50.00 fee for any missed appointments not cancelled twenty-four (24) hours prior to the scheduled appointment.

6. I understand that I will be billed for any balances which arise due to insurance co-payments, co-insurance, deductibles, insurance denials, termination of coverage, non-addition of a dependent to insurance plan, non-payment at time of service and/or any other reason and agree to pay all charges within thirty (30) days of the billing date. Interest of one and one-half percent (1.5%) per month, eighteen percent (18%) per annum, may be charged on all delinquent accounts over sixty (60) days.

7. If the balance is not paid within sixty (60) days of the billing date, or if agreed upon payment arrangements on my account are not made, EDC may retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. I understand that I will be responsible for all additional fees incurred from that attorney and/or collection agency.

8. I agree that if for any reason a check is returned on my account, I will be responsible for a $25.00 returned check fee in addition to the original fees for services.

9. I certify that the information I have provided to EDC with regard to my insurance coverage is correct and agree to immediately inform EDC of any changes in my personal demographic information, address, e-mail and, telephone number (s), or insurance coverage.

10. I understand that prescription refills that are not obtained at the time of my visit would require evaluation of my medical records and decision making regarding the advisability and safety of refilling the medication. I agree to pay the fee for prescription refills not obtained at the time of service as follows: For up to 2 prescriptions $15, three (3) or more prescription $25.

_____	_____	_____
Patient's name	Signature	Date