Endocrine & Diabetes Center

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.

PATIENT INFORMATION

Patient Name (Please Print) Date

Last First Middle Initial

Date of Birth Sex ❒ Male ❒ Female Age Social Security Number: - -

Parent if Patient is a Minor

Marital Status ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Other (Explain)

Home Address City State Zip

Home Telephone Number ( ) Work Telephone Number ( )

Cell Phone Number ( )

Occupation Employer's Name

Spouse's Name

Primary Physician's Name Telephone Number ( )

Referring Physician's Name, (if different than PCP) Telephone Number ( )

How did you learn about our practice?

NOTIFY IN CASE OF EMERGENCY

Name Relationship

Address City State Zip

Home phone ( ) Work phone ( ) Cell Phone ( )

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

Primary Insurance Name: Members Name: (Insurance in name of)

Address City State Zip

Subscriber's Name Subscriber's Date of Birth Subscriber's SSN#.

Relationship to patient ❒ Self ❒ Spouse ❒ Child ❒ Other

Group Number Insurance ID No.: Effective date

Secondary Insurance Members Name: (Insurance in name of)

Address City State Zip

Subscriber's Name Subscriber's Date of Birth Subscriber's SSN#

Relationship to patient ❒ Self ❒ Spouse ❒ Child ❒ Other

Group Number Insurance ID No. Effective date

Please Read Our Financial Policy Statement and Agreement on Reverse

Financial Policy Statement and Agreement

1. **AUTHORITY FOR TREATMENT:** I hereby authorize Endocrine and Diabetes Center, P.C. and/or doctors, providers and staff in charge of the patient to evaluate and perform procedures and treatment that may be deemed necessary or advisable. I hereby certify that all the information I have reported to your office including 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 understand that I am liable for the payment of all bills incurred. I agree to pay all attorneys' fees should it become necessary for the filing of a civil suit or fees associated with the use of a collection agency to collect said claims. A copy of this authorization may be used as the original. I also acknowledge that I have received and read a copy of the of the "Patient Information pamphlet"

Signature (parent if patient is a minor) _____ Date: _____

2. **INSURANCE AUTHORIZATION:** I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Endocrine and Diabetes Center, P.C. and /or the doctor indicated on the claim. I understand and agree that I am financially responsible for charges or any balance not paid by the insurance carrier.

Signature (parent if patient is a minor) _____ Date: _____

3. **RELEASE OF INFORMATION AND PRIVACY NOTICE:** I acknowledge that I have been presented with a copy of Privacy Notice (Health Insurance Portability and Accountability Act of 1996) explaining my rights regarding my individually identifiable health information (IIHI). I consent to the use and disclosure of my IIHI for purposes of treatment, payment or other health care operations. I hereby authorize Endocrine and Diabetes Center, P.C. to release any information pertaining to my health care, test results, billing and/ or accounting information to the following person(s) or agencies.

❒ Myself ❒ my spouse ❒ Leave information on my answering machine

❒ Others (specify) _____

Additional uses of my IIHI will require an authorization from me for the specific intention of disclosure.

Signature (parent if patient is a minor) _____ Date: _____

4. **MEDICARE:** I request that payment of authorized Medicare benefits for any services furnished to me, be made on my behalf to Endocrine and Diabetes Center, P.C. I authorize the release of my medical information to the Center for Medicare and Medicaid services and its agents to determine these benefits. Regulations pertaining to Medicare assignment of benefits apply.

Signature (parent if patient is a minor) _____ Date: _____

Endocrine & Diabetes Center

Privacy Policy

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, (The Health Insurance Portability and Accountability Act of 1996) (HIPAA), mandates that we issue this new revised Privacy Notice to our patients. This notice meets all current requirements as it relates to Standards for Privacy of Individually Identifiable Health Information (IIHI); affecting our patients. You are urged to read this notice.

As part of the Privacy Standard, implemented on April 14, 2001, you are required to provide this office with a new, signed and dated, Consent Agreement. Every patient must receive our new Privacy Notice and execute a new Consent Agreement before this office may use your information for treatment, payment, or other health care operations.

Our Privacy Notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: "any information, whether oral or recorded in any medium, that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past present or future payment for the provision of health care to an individual".

Our office will use or disclose your PHI for purposes of treatment, payment and other healthcare purposes as required to provide you the best quality healthcare services that we offer to the extent permitted by your Consent Agreement or in such specific situations, by your signed and dated Authorization. It is our policy to control access to your PHI; and even in cases where access is permitted; we exercise a “minimum necessary information” restriction to that access. Which we define as the minimum necessary information needed to accomplish the intent of the request.

An Authorization is very specific with regard to the information authorized that will be disclosed or used. The individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration of the authorization. In the event of a non-healthcare related request for personal health information this office will request you to complete an Authorization Form.

You, as our patient, may revoke any Consent Agreement or Authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke either the Consent Agreement or the Authorization you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization or Consent Agreement. Any revocation will not apply to information already used or disclosed. If you had a “personal representative” initiate as Authorization you may revoke that authorization at any time.

You, the patient have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician or principal will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes.

❒ **Vienna Office:**
301 Maple Avenue West, #120
Vienna, Virginia 22180
PHONE (703) 938-8885 FAX: (703) 242-2437

❒ **Woodbridge office:**
2200 Opitz Blvd., #250
Woodbridge, Virginia 22191
PHONE (703) 494-5858 FAX: (703) 491-1416

In limited circumstances, The Privacy Standard permits, but does not require, covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities. These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. There are specific state laws that required the disclosure of health care information related to Hepatitis C, and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail.

All of these disclosures could occur previously under former laws and regulations however; The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgments to decide whether to disclose any information, reflecting our own policies and ethical principals.

On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a "chain of trust" contract and monitor our business associates' contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard. Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

Effective October 19, 2005, Board of Medicine regulations (18VAC85-20-26) now require physicians practices to maintain an adult patient's record for a minimum of six years following the last patient encounter. The regulations provided an exception to this retention requirement for records that have previously been transferred to another physician or provided to patient. Records of a minor child, including immunizations, must be maintained until the child reaches the age 18, with a minimum time for records retention of six years from the last patient encounter regardless of the age of the child

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

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.

If you have any questions about this information discussed above please contact the privacy officer directly in

the office where you are seen.

❒ **Vienna Office:**
301 Maple Avenue West, #120
Vienna, Virginia 22180
PHONE (703) 938-8885 FAX: (703) 242-2437

❒ **Woodbridge office:**
2200 Opitz Blvd., #250
Woodbridge, Virginia 22191
PHONE (703) 494-5858 FAX: (703) 491-1416

Endocrine & Diabetes Center

REVIEW OF SYSTEMS

Date _____

Name _____ Age _____ Date of Birth _____

Please Circle Appropriate Answer

- CONSTITUTIONAL SYMPTOMS

Good general health	No	Yes
Recent weight change (explain)	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes
Insomnia	No	Yes

- EYES

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes
Changes in visual field	No	Yes

- EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Hoarseness or difficulty speaking	No	Yes
Bleeding gums	No	Yes
Sore throat	No	Yes
Swollen glands in neck	No	Yes

- CARDIOVASCULAR

Heart trouble	No	Yes
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
Cold extremities	No	Yes

- RESPIRATORY

Chronic or frequent coughs	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 movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

- GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Female - painful periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes

Female - # pregnancies _____ # miscarriages _____

Female - date of last pap smear _____

- MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Difficulty in walking	No	Yes

- INTEGUMENTARY (skin, breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

- NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	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
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

- HEMATOLOGIC/LYMPHATIC

Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

- ALLERGIC/IMMUNOLOGIC

Known drug allergies _____

_____

_____

_____

_____

Known food allergies _____

_____

_____

_____

_____

Reviewed By: _____

Endocrine & Diabetes Center

PATIENT NAME:
DATE:

MEDICATION RECORD

Medication Name	Dosage	Frequency	Prescribing Doctor

Endocrine & Diabetes Center

CONSENT FOR RELEASE OF MEDICAL INFORMATION

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: Endocrine and Diabetes Center, P.C. at the following address:

❒ 301 Maple Avenue West, Suite 120 Vienna, VA 22180

❒ 2200 Opitz Boulevard, Suite 250, Woodbridge, VA 22191

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: _____

❒ **Vienna Office:**
301 Maple Avenue West, #120
Vienna, Virginia 22180
PHONE (703) 938-8885 FAX: (703) 242-2437

❒ **Woodbridge office:**
2200 Opitz Blvd., #250
Woodbridge, Virginia 22191
PHONE (703) 494-5858 FAX: (703) 491-1416