Endocrinology Associates of Memphis, PLLC

Patient Registration

(Please Print-Make sure to answer ALL Questions)

Name_____SSN_____
(First) (Middle) (Last)

SEX____ Date of Birth _____ Martial Status_____ Language _____

RACE:

- Caucasian (White)
- African American (Black)
- Asian
- Native American
- Hispanic/Latino
- Other _____

Address: _____ City: _____

State _____ Zip _____ E-Mail_____

Phone Number: Home# _____Work# _____Cell# _____

Employment Status: _____ Employer: _____

Employer's Address: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Referring Physician: _____

Person Responsible for Payment: (If other than self): _____

Primary Insurance: _____ Secondary Insurance: _____

Insurance Subscriber: (If other than self): _____ D.O.B. _____

Preferred Pharmacy: _____ Phone: _____

If there is any other person such as a spouse, etc. that you would like to authorize us to talk to regarding your insurance or billing list them here:

Name: _____ *Phone#* _____

Signature: _____ Date: _____

Designation of Personal Representative

(For the Use and Disclosure of Protected Health Information)

In the event that for any reason you are unable to make decisions with respect to the use and/or sharing of your protected health information you have the right to have one or more persons act as your representative to make those decisions for you.

Date: _____

I, _____ (print name) hereby name the following person to act as my authorized representative with respect to decisions involving the use and /or sharing of my protected health information.

_____ _____

(Print name of Individual) (Relationship to you)

_____ _____

(Phone # where they can be reached) (Alternate # if available)

I understand that I may cancel this designation at any time by signing the revocation section below and returning it to Endocrinology Associates of Memphis. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

_____ _____

(Signature) (Date of Birth)

_____

(Date Signed)

Revocation Section

I no longer want this person to act as my personal representative.

_____ _____

(Signature) (Date)

ENDOCRINOLOGY ASSOCIATES OF MEMPHIS

6027 Walnut Grove Road, Suite 307
Memphis, TN 38120
(901) 681-0346

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth _____

The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- May individual rights with respect to protected health information and a brief description of how I may exercise these rights in ration to:
  - ❖ The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint
  - ❖ The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to aggress to a requested restriction.
  - ❖ The right to receive confidential communications of protected health information.
  - ❖ The right to inspect and copy protected health information.
  - ❖ The right to amend protected health information.
  - ❖ The rights to receive an accounting of disclosures of protected health information
  - ❖ The right to obtain a **paper copy** of the Notice of Privacy Practices from this practice upon request.

I have read and understand this practice's Notice of Privacy Practices written in plain language. This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature _____ Date_____

Relationship to patient (if signed by a personal representative of patient): _____

ENDOCRINOLOGY ASSOCIATES OF MEMPHIS, PLLC
Office Policies

Thank you for choosing Endocrinology Associates for your healthcare needs. We are dedicated to providing our patients the best possible care. To achieve this goal we need your assistance and understanding of our payment and office policies.

- If you have medical insurance we will need to scan your cards at each visit.
- If your insurance plan requires a referral, **it is your responsibility to obtain this from your primary care physician.** If you are unable to obtain a referral in a timely manner, you may either sign a waiver accepting responsibility for your visit, or reschedule your appointment for a later date. We send our tests to LabCorp and our biopsies to Trumbull Pathology. If your insurance requires that you use a particular laboratory, hospital, or out-patient facility, you **must advise us before services are provided.**
- We will file your insurance claim for you; however, we ask that you pay any co-payment and/or deductible at the time service is rendered. We accept cash, checks and major credit cards.
- If you **do not** have medical insurance, payment is expected at the time service is rendered.
- If you are 30 minutes or more late it will be necessary to reschedule your appointment.
- There is a $25 administrative charge for completions of forms that you request to have filled out or letters that you may request from your provider. (This does not apply to paperwork that we ask you to fill out). Also, if you call the office and leave a message for the nurse or a physician and their return call to you is greater than 15 minutes in length, it will be subject to a charge. (If you were seen in the office with the 7 days prior to your call, or if the call results in you being seen in the office within the next 24 hours, it will not be subject to this charge.
- There is a $35 charge for missed appointments. A 24 hour notice is required so another patient can utilize your time slot. As a courtesy reminder, we do attempt to reach patients prior to a scheduled appointment.
- **It is your responsibility to advise us of any changes of your address, phone or insurance information.** Failure to advise us of correct insurance information may cause delays and even denials of payment due to late filing. If denial occurs due to your failure to advise us of correct information, you will be responsible for payment for those services.
- You will be required to have your picture taken for your medical record. This is for the physician's benefit only.
- Please turn off cell phones.
- No Food or drink is allowed in the waiting room.

If you have any questions, please advise the receptionist.

I agree to the above listed policies and also have received and read a copy of the "Notice of Privacy Practices" of Endocrinology Associates. I authorize payments of medical insurance benefits to Endocrinology Associates, PLLC and understand that I am responsible for any balance not covered by my insurance. If this account is placed for collections, I will be responsible for all collection fees, reasonable attorney fees, and any court costs incurred. By signing below I give my consent for Endocrinology Associates to use and disclose my personal health information for treatment, payment and healthcare operations pursuant to the Health Insurance Portability and Accountability Act of 1996.

Name (please print):_____

Signature: _____ Date: _____

Endocrinology Medical History Form

Name: _____ Date of birth: _____ Today's date: _____

Current medications:

Drug Name	Dosage (mg, mcg, etc,)	Frequency	Start Date

Allergies: *(List all known allergies (drug, food, etc.) and reaction)*

- **No known allergies**

_____ _____

_____ _____

_____ _____

Prior surgeries:

Type of surgery/year: _____

_____ _____

_____ _____

Name: _____ Date of birth: _____Today's date: _____

Review of systems: In the last 6 months, have you consistently experienced any of the following symptoms?

Constitutional:			Genitourinary:		
Weight Loss	Y	N	Blood in your urine	Y	N
Weight Gain	Y	N	Menstrual changes	Y	N
Fever	Y	N	Erection problems	Y	N
Fatigue	Y	N	Vaginal discharge or bleeding	Y	N
Eyes:			Musculoskeletal:		
Eye pain or drainage	Y	N	Broken bones	Y	N
Dry, irritated eyes	Y	N	Muscle aches	Y	N
Visual changes	Y	N	Muscle weakness	Y	N
			Neck pain	Y	N
			Joint pain	Y	N
ENT/month:			Skin/breasts:		
Ear pain or drainage	Y	N	Masses or lumps	Y	N
Hearing changes or loss	Y	N	Nipple discharge	Y	N
Nosebleeds	Y	N	Rashes and non-healing ulcers	Y	N
Dizziness	Y	N			
Respiratory:			Neurologic:		
Cough lasting > 1 month	Y	N	Seizures	Y	N
Shortness of breath	Y	N	Coughing/choking with swallowing	Y	N
Wheezing	Y	N	Excessive daytime sleepiness	Y	N
	Y	N	Leg pain or burning sensation	Y	N
			Numbness or tingling	Y	N
			Headache	Y	N
Cardiovascular:			Endocrinologic:		
Chest pain and heaviness	Y	N	Hair loss	Y	N
Palpitations	Y	N	Frequent urination	Y	N
Fainting or near fainting spells	Y	N	Increased thirst	Y	N
Swelling of feet or legs	Y	N	Cold intolerance	Y	N
Shortness of breath lying flat in bed	Y	N	Heat intolerance	Y	N
Gastrointestinal:			Heme/Lymph:		
Abdominal pain	Y	N	Unexplained bruising	Y	N
Nausea/vomiting	Y	N	Night sweats	Y	N
Constipation	Y	N	Swollen, painful lymph nodes	Y	N
Diarrhea or food intolerance	Y	N			

Name: _____ Date of birth: _____ Today's date: _____

Medical history:

Problem	Year of Diagnosis	Problem	Year of Diagnosis	Problem	Year of Diagnosis
Diabetes		Hypothyroidism		Low testosterone	
High blood pressure		Hyperthyroidism		Pituitary tumor	
High cholesterol		Thyroid nodule (s)		*Specify type:*	
Heart attack(s)		Thyroid cancer		Other _____	
Stroke		Osteoporosis		Other _____	
Kidney disease		Vitamin D deficiency		Other _____	
Years of dialysis:		High calcium levels		Other _____	
Diabetic eye disease		Adrenal insufficiency		Other _____	
Diabetic neuropathy		Polycystic ovarian		Other _____	

Family member	**Good Health**	**Heart Disease (age of onset)**	**Hypertension (age of onset)**	**Stroke (age of onset)**	**Cancer type (age of onset)**	**Diabetes (age of onset)**
Father						
Mother						
Grandfather (paternal)						
Grandmother (paternal)						
Grandfather (maternal)						
Grandmother (maternal)						
Brother						
Sister						
Other_____						

Gynecologic history:

Your age during your first menstrual period: ____ Average time between cycles: _____ Average length of each cycle: _____How many pregnancies?_____

Social history:

1. Please briefly describe your occupation: _____

2. Please briefly describe your living situation, i.e. who lives in your house/apartment and relationship to you?
_____

3. Tobacco use: Current / Former/Never Cigarettes/Day: ___Years used: ___Year Quit? ___
   If you are currently smoking, are you ready to quit? Yes or No

4. Recreational drug use: Yes or No/ Former/ Type: _____ How often? _____

5. Alcohol use: Yes or No/Former/ Amount: _____ How often? _____

6. Exercise/activity: Yes or No Type: _____ Frequency/how often?_____ Hours per week: _____