New Patient Package

9328 E. Raintree Dr. Scottsdale, AZ 85260
924 W. Chandler Blvd. Chandler, AZ 85225
Phone: (602) 266 - 8463
Fax: (602) 266 - 0122
www.endoassocaz.net

Endocrinology Associates, P. A.

As a new patient, the following is **required** for your visit:

1. Insurance card, state issued ID with current address or proof of address. **2. You must bring all pertinent medical records to your visit which includes recent labs, Thyroid US reports, scans, and actual films(films can be picked up from imaging center). This information is critical for a prompt evaluation. 3.** If you have ***TriCare,*** your referring physician **MUST** send us your referral prior to your appointment. You ***cannot*** see the physician without the referral. **4.** If you are a non-english speaking patient, please bring a reliable interpreter to your appointment. (Si usted no habla ingles, traiga por favor un interprete confiable a su cita.) **5.** Bring a list of your medications including dosage and frequency.**6. Studies** of benefits will be processed and analyzed by Endocrinology Associates, P.A. CLIA Certified Lab Technicians.

Patient Information

Patient Name: _____ SSN: _____

Address: _____ Marital Status: Single: ☐ Married: ☐

City: _____ State: ____ Zip Code: _____ Phone #: _____ Work #: _____

Gender: Male: ☐ Female: ☐ Date of Birth: _____ Age: _____

Spouse Name: _____ Phone#: _____ Address: _____

Nearest Relative: _____ Phone#: _____ Address: _____

Responsible Party Information

Name: _____ SSN: _____

Relationship to Patient: Self ☐ Child ☐ Spouse ☐ Other ☐ Date of Birth: _____

Referring Physician Information

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ State: ___ Zip Code: _____ City: _____ State: ___ Zip Code: _____

Phone #: _____

Primary Insurance Information

Insurance Co: _____

Employer: _____

Policy #: _____ State: ___ Zip Code: _____

Group Claim #: _____

Secondary Insurance Information

Insurance Co: _____

Employer: _____

Policy #: _____ State: ___ Zip Code: _____

Group Claim #: _____

Policy Holder of Primary Insurance

Name: _____

Gender: _____

Birth Date: _____

Relationship to Pt.: _____

Policy Holder of Secondary Insurance

Name: _____

Gender: _____

Birth Date: _____

Relationship to Pt.: _____

Current Date 1/12/13

Name: _____ Date of Birth: _____ Age: _____ Occupation: _____

Race: Caucasian: ☐ Latino/Hispanic: ☐ African American: ☐ Asian: ☐ Other: _____

Primary Doctor: _____ Reffering Doctor: _____

Reason for Today's Visit: _____

Past Illnesses: (i.e. High Blood Pressure, Diabetes, Hypothyroid, Sleep Apnea)

_____

_____

Marital Status Married ☐ Single ☐ Divorced ☐ Widowed ☐

Tobacco Use: None ☐ Current ☐ Quit ☐ How much are/did you smoke per day: _____

Caffeine Use: Yes ☐ No ☐ Quit ☐ How much caffeine per day: _____

Alcohol Use: Yes ☐ No ☐ Quit ☐ How much alcohol per day: _____

Exercise: Cardio ☐ Weight Resistance ☐ Both ☐ Number of times weekly: _____

Past Surgeries (Please Add Year in selection): Thyroidectomy: _____ Hysterectomy: _____ Tonsillectomy: _____

Tubal Ligation/Ablation: _____ Appendectomy (Appendix Removed): _____ Hernia Repair: _____

Cholecystectomy (Gall Bladder): _____ CABG (Open Heart Surgery): _____ Breast Augmentation: _____

Cataract Surgery: _____ Pituitary Tumor Removal: _____ Adrenal Tumor Removal: _____

Knee Arthroscopy: _____ Gastric Bypass: _____ Other (Specify Surgery and Year): _____

Family Illnesses (i.e. Parents, Brothers, Sisters, Children) Check all that apply:

Diabetes ☐ Heart Failure ☐ Pituitary Disease ☐ High Blood Pressure ☐ Hyperthyroidism ☐ Osteoporosis ☐

Multiple Sclerosis ☐ Autoimmune disease ☐ Hypothyroidism ☐ Kidney Stones ☐ Vitiligo ☐ Enlarged thyroid/goiter ☐

High Calcium ☐ Heart Disease ☐ High Cholesterol ☐ Cancer (what type?) ☐ _____ Other Illness _____

Current Medications (include vitamins, herbs, and over-the-counter supplements)

Name: _____ Dose: _____ Times per day: _____

Name: _____ Dose: _____ Times per day: _____

Name: _____ Dose: _____ Times per day: _____

Name: _____ Dose: _____ Times per day: _____

Name: _____ Dose: _____ Times per day: _____

Name: _____ Dose: _____ Times per day: _____

Name: _____ Dose: _____ Times per day: _____

Name: _____ Dose: _____ Times per day: _____

Drug Allergies

Name: _____ Reaction: _____ Name: _____ Reaction: _____

Last Bone Density: _____ Results: Normal ☐ Osteopenia ☐ Osteoporosis ☐

Medication Treatment? Yes ☐ No ☐ What Medication? _____ How Long? _____

History of Fractures? Yes ☐ No ☐ What Area? _____

Females Only Age Menstrual Cycle Started: _____ # of Pregnancies: _____ # of Births: _____ # of Miscarriages: _____

Did you have diabetes while you were pregnant? Yes ☐ No ☐

Did you have thyroid problems while you were pregnant or 1 year after birth? Yes ☐ No ☐

If you are still menstruating, are your menstrual cycles regular? Yes ☐ No ☐ N/A ☐

Postmenopausal Women Only:

Age you stopped your menstrual cycle? _____ Was it due to a hysterectomy? Yes ☐ No ☐

Were your menstrual cycles regular prior to menopause? Yes ☐ No ☐

Have you ever been on hormone replacement therapy? Yes ☐ No ☐ If yes, how many years? _____

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Patient Name: _____ Date of Birth: _____ Gender: Male ☐ Female ☐

Please Check the box indicating that you have experienced the following symptoms in the past 6 months:

Constitutional: ☐ Fever ☐ Chills ☐ Headache

Eyes: ☐ Double Vision ☐ Blurred Vision ☐ Sensitivity to light

Ear Nose Mouth Throat: ☐ Nasal Congestion ☐ Earache ☐ Sore Throat ☐ Nasal Discharge
☐ Ringing in Ears ☐ Trouble Swallowing

Neck: ☐ Neck Pain ☐ Neck Stiffness ☐ Swollen Glands ☐ A Lump or Swelling

Breasts: ☐ Nipple Discharge ☐ Change in breast skin ☐ Breast Lump ☐ Breast Pain
☐ Breast Enlargement

Respiratory: ☐ Cough ☐ Wheezing ☐ Coughing up Sputum ☐ Shortness of Breath
☐ Difficulty Breathing

Cardiovascular: ☐ Chest Pain ☐ Palpitations ☐ Cold Hands or Feet ☐ Shortness of breath with Exertion
☐ Pain in legs with walking ☐ Trouble laying flat in bed

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Abdominal Pain
☐ Black Stools ☐ Blood in stool

Genitourinary: ☐ Pain with urination ☐ Burning on urination ☐ Decrease in urine flow ☐ Blood in urine
☐ Urination at night ☐ Going Frequently ☐ Sexual Dysfunction

Skin: ☐ Rash ☐ Itching ☐ Hives ☐ Bruising
☐ Eczema ☐ Lesions

Musculoskeletal: ☐ Back Pain ☐ Muscle pain ☐ Joint pain ☐ Leg pain
☐ Foot Swelling ☐ Joint Stiffness

Neurological: ☐ Difficulty Walking ☐ Confusion ☐ Fainting ☐ Dizziness
☐ Numbness ☐ Tingling ☐ Speech Difficulty ☐ Tremors

Psychiatric: ☐ Anxiety ☐ Fatigue ☐ Sleep Disturbances ☐ Decreased Energy
☐ Depression

Hematologic: ☐ Easy Bleeding Tendency ☐ Easy Bruising

Endocrine: ☐ Frequent urination ☐ Frequent thirst ☐ Temperature Intolerance

Other Symptoms _____

_____

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Financial Policy

Thank you for choosing **Endocrinology Associates P.A.** for your health care. We are committed to providing quality medical care for you. In order to reduce potential misunderstandings, our office has clarified our Financial Policy. We require that you read our Policies and agree to comply with them prior to beginning or continuing treatment.

Appointments
Our goal is to provide the best possible care and physician availability to each of our patients**. In order to achieve this,** our policy is to request that you call to cancel **at least** 24 hours prior to **your** scheduled appointment. If you missed your appointment, you will be charged a **$50 no show fee. Both** new and returning patients are subject to the $50 no show fee for missed appointments **that are not cancelled 24 hrs in advance**. A No Show fee will **not** be charged to you if you or a HIPAA compliant family member can provide documentation that you were in the hospital or you were attending a funeral at the time of the appointment.

Our system works as follows: You will receive an appointment reminder call two days prior to your appointment. The automotive TeleVox call will provide you with the option to confirm the appointment, cancel the appointment, or leave a message with a scheduler. If you do not reschedule the appointment, a scheduler will call you. If you missed an appointment, you will receive an automotive TeleVox no show call. It is our policy to send a Letter of Termination of Care to patients with **three cumulative** no show appointments.

Insurance
Your insurance policy is a contract between you and your insurance plan. We cannot efficiently bill your insurance company unless you provide us with current and valid insurance information. We will file claims to those plans with which we have a **contractual** agreement.

All health plans are not the same and they do not always cover the same services or facilities. In the event that your health plan determines that a service is “not covered” you will be responsible for the entire charge. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. Payment for services rendered is due by the **1st day of the month** after the charge has printed on your statement.

We expect you to familiarize yourself with the benefits and limitations of your insurance policy including, but not limited to: deductible and co-payment amount as well as approved labs, radiology facilities, and hospitals contracted with your plan. It is your responsibility to notify our office when either your insurance plan or benefits change. Any cost incurred by this office because of incorrect information you provided to us will be passed on to you. Balances must be paid in full at the time of the appointment. **Endocrinology Associates P.A.** does not extend credit, offer discounts to patients with contracted insurances, or waive balances.

If you have insurance coverage with a plan with which **Endocrinology Associates P.A.** does not participate, charges for your care and treatment are due at the time of service. **Endocrinology Associates P.A.** does not extend Self Pay status to new patients with out of network insurances.

No Insurance
If you have no insurance coverage **Endocrinology Associates P.A.** has implemented a Self Pay Fee Schedule for those services that are `Medically Necessary'.

_____ _____
Patient name (Please Print) Date

_____ _____
Patient Signature Date

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Delinquent Payments

The following types of accounts will be referred to a collection agency:

- Mail returned with no forwarding address.
- Guarantors who refuse to cooperate.
- Guarantors who not do respond to telephone and mail contacts.
- Guarantors who do not make promised payments.
- Balances that are not paid within 30 days will incur further collection activity

Deductibles/Copays/Payments

Our insurance contracts require us to collect deductible amounts and copays at the time of service. These amounts will be collected prior to service being rendered. For your convenience we accept VISA, MasterCard, Discover, and American Express in addition to personal checks and cash. If your check is returned to us for insufficient funds, we will assess a service charge equal to the bank fees assessed to **Endocrinology Associates P.A**.

Notice of Privacy (HIPAA)

Endocrinology Associates P.A. originates and maintains health records, describing your health history, symptoms, examinations, test results, diagnosis, treatments, and any plans for further care. This information serves a basis for your care and treatment, as a means of communication among healthcare professionals who contribute to my care, a source of information for applying your diagnosis and surgical information to your bill, a means by which a third-party can verify that services billed were actually provided, and a tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals. Your health records may be disclosed by fax, mail, verbal conveyance, type written, and or electronically transmitted to other healthcare professionals to assist in your care. Examples of information that may be in your chart, but that are not considered private according to the Health Insurance and Portability Act (HIPAA) are: date of birth, address, admission/discharge dates, telephone numbers, and social security number. You have the right to ask your physician, directly, for your health information contained in your medical chart. Family and friends may only have access to your health information if you designate them on the Notice of Privacy Practices portion of this form, at the bottom of the last page.

Information

I hereby agree that the enrollment information is correct and I also agree that any changes to the enrollment information will be communicated to **Endocrinology Associates P.A.** as required to fulfill the medical and financial obligation for services rendered.

Authorization

I hereby request and consent that my medical records and non written records be sent to my referring physicians, those physicians or ancillary facilities that I am referred to by the **Endocrinology Associates P.A.** and to my insurance company or its agents that may be authorizing treatment. I further understand that my medical records may contain sensitive information and hereby authorize the release of all confidential HIV related information, communicable diseases related information, drug and alcohol abuse/treatment information and mental health diagnosis/treatment information to the undersigned.

_____ _____

Patient name (Please Print) Date

_____ _____

Patient Signature Date

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I hereby authorize payment directly to the attending physician for medical and/or surgical benefits, if any from the insurance carrier to **Endocrinology Associates P.A.**; if paying cash, I am responsible to pay at the time of service.

Daniel S. Duick
MD, F.A.C.E.

Chandana Mishra
MD, F.A.C.E.

Sreedevi Reddy
MD, E.C.N.U.

Abdul-Razzak Alamir
MD

Amir Harari
MD, F.A.C.E., F.A.C.P.

Andrea Ferenczi
MD, E.C.N.U.

Marie Perkins
ANP-C, GNP

Ashlyn Smith
PA-C

Erin Berry
ANP-C

Morgan Montez
FNP-C

Susan Bast
FNP-C

Patient name (Please Print) _____ Date of Birth _____

Signature of Patient and/or Legal Guardian _____ Date _____

Endocrinology Associates' Witness _____ Date _____

I authorize the following person(s) to have access to my medical information.

_____ _____
Relationship

_____ _____
Relationship

I authorize **Endocrinology Associates P.A.** to leave detailed **medical information**, appointment reminder calls and no show calls on the phone number(s) listed below:

Appointment Reminder Call: _____ No Show Call: _____

DIPLOMATES OF AMERICAN BOARDS OF DIABETES, ENDOCRINOLOGY AND METABOLISM

LOCATIONS:
9328 E. Raintree Dr.
Scottsdale, AZ 85260

924 W Chandler Blvd.
Chandler, AZ 85224