WILMINGTON ENDOCRINOLOGY PA

Patient Registration Form

Name_____
Last First Middle

Address:_____
City State Zip

Home #:_____ Cell #:_____ Work #:_____

Primary Care Physician:_____ Referring Physician: _____

Date of Birth:_____

Please Check: Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security #:_____ Employer/School: _____

Employer Address:_____ Employer #:_____

Emergency Contact:_____ Relation: _____ Phone #:_____

Spouse Name or Parent/Guardian if Patient is under 18:_____

Relationship to Patient:_____ DOB: _____ SSN: _____

Primary #:_____ Address:_____

Insurance Information (Please present Insurance Card at time of Check-In)

Insurance Information	Primary	Secondary
Name of Insurance Company		
Insurance ID #		
Group ID #		
Name of Policyholder/Subscriber		
DOB of Policyholder/Subscriber		
SSN of Policyholder/Subscriber		

Email:_____ Would you like Patient Portal? ☐Yes ☐No

Ok to Leave a Message at: Home and/or Cell

☐Brief ☐ Brief

☐Extended ☐Extended

Pharmacy:_____ Address:_____ Phone #:_____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request the payment of authorized Medicare/other Insurance Company benefits be made to me or on my behalf to Wilmington Endocrinology, PA for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128D of the Social Security Act & 31 USC 3801-3812 provides penalties for withholding this information.

My signature below gives my acknowledgement and agreement to a $5.00 per month billing statement fee commencing after 60 days.

Signature:_____ Date:_____

History Questionnaire

Patient Name:_____ **Age**:_____ **Date of Birth**:_____

Please Circle and Fill in the Blanks

SOCIAL HISTORY:

Occupation: Retired Active: _____

Live With others: No Yes Who: _____

Children: No Yes # Sons: _____ # Daughters: _____

Exercise: No Yes Hours Per Week: _____

Illegal Drug Use: No Yes Type: _____

Alcohol Use: No Yes *If yes, please answer these additional questions (Circle One for Each):*

How often did you have a drink containing alcohol in the past year?

Never Monthly or Less 2-4x/Month 2-3x/Week ≥4x/Week

How many drinks did you have on a typical day when you were drinking in the past year?

1-2 3-4 5-6 7-9 ≥10

How often did you have ≥6 drinks on one occasion in the past year?

Never Less than Monthly Monthly Weekly Daily/ Almost Daily

Smoke Tobacco: Never Smoker Current Smoker Start: _____ PPD: _____ Former Smoker Start: _____ Quit: _____ PPD:_____

Claustrophobic: No Yes

If 65 Years or Older: Have you had a pneumonia vaccination in the past?

No Yes Approximate Date: _____

Please List all Medications and Supplements:

Name of Medication:	Strength:	Frequency:	Currently Taking:
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes
_____	_____	_____	No Yes

Please Answer and Fill in the Blank:

Any Allergies? No Yes _____

_____

_____

_____

PERSONAL MEDICAL HISTORY

Do you currently have or have you ever been diagnosed with the following problems?

Diabetes:	No	Yes
COPD:	No	Yes
High Blood Pressure:	No	Yes
Heart Problem:	No	Yes
Frequent Infections:	No	Yes
Anxiety:	No	Yes
Depression:	No	Yes
Kidney Stones:	No	Yes
Cancer:	No	Yes
Thyroid Disorder:	No	Yes

Other: _____

Metal in Your body:	No	Yes
Head/Neck Radiation:	No	Yes
Heart Valves/Stents:	No	Yes

Autoimmune Disease:

Osteoarthritis:	No	Yes
Rheumatoid Arthritis:	No	Yes
Lupus or SLE:	No	Yes
Psoriasis:	No	Yes
Sjogren's:	No	Yes

Other: _____

If yes, specify: _____

If yes, specify: _____

Location: _____

Date: _____ Hospital: _____

Reason: _____

Surgeries: Date:_____ Type of Surgery: _____

Surgeon/Hospital: _____

Date:_____ Type of Surgery: _____

Surgeon/Hospital: _____

Date:_____ Type of Surgery: _____

Surgeon/Hospital: _____

Date:_____ Type of Surgery: _____

Surgeon/Hospital: _____

Please Circle and Fill in the Blank for Blood Relatives:

Father: Living / Deceased Cause of Death:_____

Mother: Living / Deceased Cause of Death:_____

Brother(s): #___ Living #___ Deceased Cause of Death:_____

Sister(s): #___ Living #___ Deceased Cause of Death:_____

FAMILY MEDICAL HISTORY:

If any of your blood relatives have ever been diagnosed with the following, please circle Yes and specify who and what type. (Please specify maternal/paternal)

Diabetes:	No	Yes	Who:_____
Cancer:	No	Yes	Type:_____
Tumor/Lesion:	No	Yes	Type: _____
Stroke:	No	Yes	Who:_____
Heart Problem:	No	Yes	Who:_____
High Blood Pressure:	No	Yes	Who:_____
Autoimmune Disease:	No	Yes	Who/Type:_____
Thyroid Disease:	No	Yes	Who/Type:_____
Thyroid Cancer:	No	Yes	Who/Type:_____
Other Problems:	No	Yes	Specify: _____

Patient Name:_____ **Date of Birth**:_____

WILMINGTON ENDOCRINOLOGY PA

Patient Extra Demographics

Patient Name:_____
Last First Middle

Date of Birth: _____

To comply with government standards relating to our electronic health record software, we are required to capture certain demographic elements. Please help us so our records will be complete by answering the following questions. Thank you.

Race?

	American Indian or Alaska
	Asian
	Native Hawaiian
	Black or African American
	White/Caucasian
	Hispanic or Latino
	Other Pacific Islander
	Other Race
	Prefer not to report

Ethnicity?

	Hispanic
	Non-Hispanic
	Prefer not to report

Preferred language?

	English
	Spanish
	Indian (includes Hindi & Tamil)
	Russian
	Other:

Signature:_____ Date:_____

WILMINGTON ENDOCRINOLOGY PA

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by Wilmington Endocrinology for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Wilmington Endocrinology. I understand that diagnosis or treatment of me by Ghobad Azizi, MD may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Wilmington Endocrinology is not required to agree to the restrictions that I may request, the restriction is binding on Wilmington Endocrinology and Ghobad Azizi, MD.

I have the right to revoke this consent, in writing, at any time, except to the extent that Ghobad Azizi, MD or Wilmington Endocrinology has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Wilmington Endocrinology's Notice of Privacy Practices prior to signing this document. Wilmington Endocrinology's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Wilmington Endocrinology. The Notice of Privacy Practices for them is also provided in the waiting area. This Notice of Privacy Practices also describes my rights and Wilmington Endocrinology's duties with respect to my protected health information.

Wilmington Endocrinology reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

WILMINGTON ENDOCRINOLOGY PA

Wilmington Endocrinology Insurance Policy

Welcome to our practice. We are committed to providing you with the best possible care and we are open to discussing our professional fees with you at any time.

Currently, we are participating with most major insurance companies. However, all deductibles, co-payments, and/or co-insurance payments are due at time of service. If your insurance has a percentage co-insurance, please be prepared to make this payment at the time of service.

Insurance is a contract between you and your insurance company. We cannot become involved in disagreements between you and the insurance company regarding deductibles, co-payments, covered charges, etc.

In order for insurance claims to be filed promptly it is your responsibility to inform our office of any changes to your insurance. If you do not provide correct insurance information to the office, this may result in claims being denied for timely filing. If a claim is denied for timely filing for this reason, you will be responsible for all charges.

Wilmington Endocrinology Financial Policy

Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions.

As per above payment is due at time of service. We accept cash, checks, Visa, MasterCard, and Discover.

Returned checks will be subject to additional collection fees. A $50 charge may also be assessed for no show appointments and same day cancellations.

Self Pay Patients must pay entire discounted amount on the date of service.
Patients with past due balances must pay entire balance plus today's charges.

We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Payment arrangements must be made prior to treatment.

Thank you for understanding our financial and insurance policies. If you have any questions about the above information, do not hesitate to ask us. We are here to assist you.

Signature:_____ Date:_____

Upon request a copy of this agreement will be given to the patient.

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E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- **Formulary and benefit transactions**
  Gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions**
  Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification**
  Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Wilmington Endocrinology, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Wilmington Endocrinology, PA to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient or Representative Date

WILMINGTON ENDOCRINOLOGY PA

Appointment Cancellation Policy

At Wilmington Endocrinology we strive to render excellent medical care to you and the rest of our patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

We request that you please give our office 24 hours notice in the event that you need to reschedule your appointment. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office, this is considered a missed appointment (NO SHOW). A $50 fee may be charged to you for the 2nd missed appointment. This fee must be paid before another appointment will be scheduled. If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments and will be asked to leave the practice.

Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment may be cancelled. New patient appointments cannot be rescheduled, as they often involve authorizations that are valid only for a specific amount of time.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient Signature Date

_____

Printed Name of Patient

WILMINGTON ENDOCRINOLOGY PA

Authorization for Release of Information

Name of Patient:_____ **Date of Birth:**_____

Wilmington Endocrinology, PA is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Please Check the Following:

Entity to Receive Information: Check each person/entity that you approve to receive information	Description of Information to be Released: Check each that can be given to person/entity on the left in the same section.
☐ **Voice Mail** ☐ Home ☐ Cell	☐ Results of lab tests/x-rays ☐ Other: _____
☐ **Spouse** Name: _____ Phone Number:_____	☐ Financial ☐ Medical
☐ **Other person(s)** Name: _____ Phone Number:_____	☐ Financial ☐ Medical
☐ **Email communication-Provide email address*** _____ *For email communication to occur, please accept the disclosure below:	☐ Medical Communication such as: Thyroid Research Medical Articles, Publication Notifications, Holiday Greetings, Newsletters ☐ Results of lab tests/x-rays, upon request

For **email and/or text communication** I understand that if information is **NOT** sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

X_____

Signature Authorizing Email Communication

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

X_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority
(attach necessary documentation)

Revised August 2017