NORTHEAST
ENDOCRINOLOGY
ASSOCIATES P.A.

**Dr. Arthur Guerrero * Dr. Laura S. Akright**
**Dr. Omar Najera * Jeremy Schmidt FNP, CDE**
5000 Schertz Parkway #200 • Schertz, Texas 78154
210.650.3360 (office) • 210.650-3403 (fax)
www.neendocrinology.com

# New Patient Packet

*Please fill out the following information so we can update your chart.*

**Patient Name:** _____, _____ _____
Last First Middle Initial

**Social Security Number:** ____ / ____ / ____ **Date of Birth:** ____/____/____ **Sex:** ☐ Male ☐ Female

**Address:** _____
Street

_____
City State Zip

**Race:** ☐ Caucasian ☐ Asian ☐ African American ☐ Chinese ☐ Filipino ☐ Japanese
☐ Native American ☐ Native Hawaiian ☐ Pacific Islander ☐ Unknown ☐ Other _____

**Preferred Language:** ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown /Not Reported

**Marital Status:** _____ **Contact Preference:** ☐ Home Phone ☐ Cell Phone ☐ Work Phone

**Primary Care Provider (Family Doctor):** _____ **How did you hear about us?** _____

**Home Phone:** (___) ____-____ **Cell Phone:** (____) ____-____

**Work Phone:** (___) ____-____ **Employer Name:** _____

**E-mail Address:** _____

## PERSON TO CONTACT IN CASE OF AN EMERGENCY

**Name:** _____ **Phone:** (____) ____-____ **Relation:** _____

## INSURANCE INFORMATION

**PRIMARY INSURANCE INFORMATION:**
Name of Insurance: _____ Policy ID: _____
Group Number: _____ Group Employer: _____
Name of Policy Holder: _____ SSN#: ____-____-____ Date of Birth: ____-____-____
Policy Holder Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

**SECONDARY INSURANCE INFORMATION:**
Name of Insurance: _____ Policy ID: _____
Group Number: _____ Group Employer: _____
Name of Policy Holder: _____ SSN#: ____-____-____ Date of Birth: ____-____-____
Policy Holder Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

**THIRD INSURANCE INFORMATION:**
Name of Insurance: _____ Policy ID: _____
Group Number: _____ Group Employer: _____
Name of Policy Holder: _____ SSN#: ____-____-____ Date of Birth: ____-____-____
Policy Holder Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Signature (Patient/Guardian): _____ Date ____ / ____ / ____

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# General Health Information

*Welcome to our practice! Please take a moment to fill out the following health questions:*

Patient Name: _____ Today's Date: ____ /____ /____

Preferred Name: _____

---

**Prior medical problems** - *check all those that apply:*

☐ **Migraine** ☐ **Asthma** ☐ **Kidney stones** ☐ **Rheumatoid Arthritis**

☐ **Liver problems** ☐ **High blood pressure** ☐ **High cholesterol** ☐ **Diabetes**

☐ **Thyroid disease** ☐ **Osteoporosis** ☐ **Depression** ☐ **Other:** _____

---

**Prior surgeries** - *circle all those that apply, give dates if possible*:

☐ **Hysterectomy** ____ /____ /____ ☐ **Tonsillectomy** ____ /____ /____

☐ **Appendix removal** ____ /____ /____ ☐ **Gallbladder removal** ____ /____ /____

☐ **Prostate surgery** ____ /____ /____ ☐ **Breast surgery (cancer?** ☐ **benign?** ☐ **)** ____ /____ /____

☐ **Other:** _____ ____ /____ /____

---

Primary Care Physician (PCP): _____

Referring physician *if different from above*: _____

---

Do you drink milk or dairy products? ☐ Yes ☐ No If yes, how many servings per day? _____

Do you use caffeine (coffee, tea, soda)? ☐ Yes ☐ No If yes, how many servings per day? _____

Do you drink alcoholic beverages such as wine, beer, or mixed drinks? ☐ Yes ☐ No
If yes, how many servings per day? _____

---

***If you have ever used tobacco:***

Tobacco Use: ☐ **Current** ☐ **Former** ☐ **Never** Type: ☐ **cigarettes/cigars** ☐ **chewing tobacco** ☐ **snuff**

How much a day? _____ Age quit: _____

Years used: ____

Ever tried to quit? ☐ **Yes** ☐ **No**

---

*Do you have a **family history** of - check all that apply and list family member next to disease.*

☐ **Diabetes** _____ ☐ **Thyroid Disorders** _____ ☐ **Colon Cancer** _____

☐ **High Cholesterol** _____ ☐ **High Blood Pressure** _____ ☐ **Obesity (overweight)** _____

☐ **Skin Disease** _____ ☐ **Migraines** _____ ☐ **Depression** _____

☐ **Breast Cancer** _____ ☐ **Infertility** _____ ☐ **Arthritis** _____

☐ **Coronary Heart Disease (Heart Attack or Surgery)** _____ ☐ **Osteoporosis/Hip Fractures** _____

☐ **Other:** _____

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# Systems Review

Patient Name: _____ Today's Date: ____ / ____ / ____

Current Primary Care Physician (First & Last Name): _____

Reason for office visit: _____

## General

| | | |
|---|---|---|
| Do you feel well in general? | ☐ Yes | ☐ No |
| Is your weight stable? | ☐ Yes | ☐ No |
| Are you sleeping well? | ☐ Yes | ☐ No |
| Are you experiencing any: | | |
| Fatigue | ☐ Yes | ☐ No |
| Fever/Chills | ☐ Yes | ☐ No |
| Night Sweats | ☐ Yes | ☐ No |
| Cold/heat intolerance | ☐ Yes | ☐ No |

## Ear/Eye

| | | |
|---|---|---|
| Visual changes | ☐ Yes | ☐ No |
| Sinus problem | ☐ Yes | ☐ No |

## Heart/Lung

Describe any exercise: _____

_____

| | | |
|---|---|---|
| Shortness of breath with exercise | ☐ Yes | ☐ No |
| Coughing/Wheezing | ☐ Yes | ☐ No |
| Chest pain or discomfort with exercise? | ☐ Yes | ☐ No |
| Lower Extremity Swelling | ☐ Yes | ☐ No |
| Palpitations | ☐ Yes | ☐ No |

## Gastrointestinal

| | | |
|---|---|---|
| Abdominal pain | ☐ Yes | ☐ No |
| Constipation | ☐ Yes | ☐ No |
| Diarrhea | ☐ Yes | ☐ No |
| Loss of appetite | ☐ Yes | ☐ No |
| Nausea/vomiting | ☐ Yes | ☐ No |

## Urinary Symptoms

| | | |
|---|---|---|
| Dysuria (painful urination) | ☐ Yes | ☐ No |
| Hematuria (blood in urine) | ☐ Yes | ☐ No |
| Yeast infection | ☐ Yes | ☐ No |

## Nervous System

| | | |
|---|---|---|
| Dizziness | ☐ Yes | ☐ No |
| Extremity numbness/weakness | ☐ Yes | ☐ No |
| Headaches | ☐ Yes | ☐ No |
| Memory loss | ☐ Yes | ☐ No |
| Seizures/Tremors | ☐ Yes | ☐ No |
| Anxiety | ☐ Yes | ☐ No |
| Depression | ☐ Yes | ☐ No |

## Skin

| | | |
|---|---|---|
| Rash | ☐ Yes | ☐ No |

## Musculoskeletal

| | | |
|---|---|---|
| Back/Neck pain | ☐ Yes | ☐ No |
| Joint pain | ☐ Yes | ☐ No |
| Muscle weakness | ☐ Yes | ☐ No |

## Have you ever used Tobacco?

☐ Current ☐ Former ☐ Never

Ever tried to quit ☐ Yes ☐ No Age quit: _____

## IF YOU ARE DIABETIC:

Are you experiencing low blood sugars? ☐ Yes ☐ No

If yes, how many times per week? _____

How often do you check your blood sugar? _____

**Have you had a recent eye exam?** ☐ Yes ☐ No

Date of eye exam: ____ / ____ / ____

Eyes dilated ☐ Yes ☐ No

Name of eye doctor: _____

Have you been told you have diabetic eye changes?

☐ Yes ☐ No

**(Continue on reverse)**

**Are there any updates in your family history** (close relatives)?

_____

_____

**If this is a follow up visit,** have you had any hospitalization, accident or illness since your last visit? ☐ **Yes** ☐ **No**

If yes _____

_____

## Prescription refills needed (list):

_____

_____

_____

_____

## Preferred Pharmacy and phone number:

_____

_____

**Are there any problems you would like to discuss?**

_____

_____

_____

_____

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# Medication List

Please take the time to fill out **all** the information

| Name: | Dose/Mg: | Directions: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# Supplements or Vitamins:

| Name: | Dose/Mg: | Directions: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please list all medications to which you are allergic:

_____

_____

_____ _____

**Patient Name:** **Date:**

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# List of Physicians:

*Please take the time to list your current Physician(s) and your Primary Care Provider.*

| Name (First & Last): | Type of Physician: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

# Referring Physician:

| Name (First & Last): | Type of Physician: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Patient Name:** _____ **Date:** _____

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# Authorization for release of Health Information

***I hereby authorize the use or disclosure of information from the medical record of:***

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

**SSN (optional):** _____ - _____ - _____

. . . . . .

I authorize the following individual(s) or organization(s) to disclose the above named individual's health information:

_____

_____

. . . . . .

For the purpose of **MEDICAL TREATMENT**, please release the following records:

☐ **All Records** ☐ **Lab Results (indicate)** _____

☐ **Bone Mineral Density Report** ☐ **Other (indicate)** _____

. . . . . .

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I hereby consent to the release of any and all records listed above. This authorization is valid for six months from the date of my signature. I understand that I have the right to revoke this authorization at any time.

*If the patient is a minor and/or unable to give consent, the authorization must be signed by the legal representative or guardian. I understand the contents of this form as represented by my signature.*

**Signature of Patient or Legal Representative:** _____

**Relationship to the Patient (if Legal Representative):** _____

**Today's Date:** ____ / ____ / ____

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# HIPAA Notice of Privacy Practices
# Acknowledgment and Questionnaire

May we leave messages, including appointment reminders, on your voicemail or answering machine? Yes / No

May we mail you an appointment reminder postcard? Yes / No

Please indicate if we may send a text message as an appointment reminder? Yes / No

Northeast Endocrinology uses an electronic medical record system, which includes the ability to obtain a 2 year medication history from SureScripts (a pharmacy clearinghouse) for our active patients. This will allow your physician to check drug to drug interactions for any new prescriptions prescribed. This authorization is effective for 3 years.

I authorize, Northeast Endocrinology to obtain and download my medication history from SureScripts (pharmacy clearing house). Yes / No

**Acknowledgement of Practice's *Notice of Privacy Practices*:**

By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms. By signing this form, I also freely consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

_____ _____
Patient Signature Date

If you are signing this on behalf of patient, please complete below:

Patient Relationship: _____

Reason Patient Cannot Sign: _____

Please list below those who we may inform about your general medical condition, diagnosis, treatment, and billing:

(1) Name: _____ Phone Number: _____

(2) Name: _____ Phone Number: _____

To view and/or obtain the HIPAA Privacy Policy visit *www.neenndocrinology.com.*

NORTHEAST ENDOCRINOLOGY ASSOCIATES

# HIPAA Notice of Privacy Practices

**Effective Date: 7/13**

## PLEASE REVIEW CAREFULLY:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS DOES NOT CHANGE THE OPERATIONS OF OUR OFFICE; NORTHEAST ENDOCRINOLOGY ASSOCIATES HAS ALWAYS STRIVED FOR HIGH STANDARDS REGARDING PRIVACY ISSUES. THIS NOTICE IS A FEDERAL REQUIREMENT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).

If you have any questions about this notice, please contact our privacy officer.

## OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected PHI
- Give you this notice of our legal duties and privacy practices regarding PHI about you
- Follow the terms of our notice that is currently in effect

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies Personal Health Information or PHI. Except for the following purposes, we will use and disclose PHI only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

***Treatment.*** We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside the office, who are involved in your medical care and need the information to provide you with medical care.

***Payment.*** We may use and disclose PHI so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

***Out of Pocket.*** If you are paying out of pocket for an episode (one or more visits) and you **DO NOT** want a claim filed with your insurance company, you have the right to request that we don't give the treatment or diagnosis for that specific episode to your insurance company.

***Health Care Operations.*** We may use and disclose PHI for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office.

***Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services.*** We may use and disclose PHI to contact you and to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

***Individuals Involved in Your Care or Payment for Your Care.*** When appropriate, we may share PHI with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

***Research.*** Under certain circumstances, we may use and disclose PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose PHI for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any PHI.

## SPECIAL SITUATIONS

***As Required by Law.*** We will disclose PHI when required to do so by international, federal, state, or local law.

***To Avert a Serious Threat to Health or Safety.*** We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

***Business Associates.*** We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billings services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

***Organ and Tissue Donation.*** If you are an organ donor, we may use or release PHI to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donations; and transplantation.

continued on page 2

continued from page 1

*Military and Veterans.* If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

*Workers' Compensation.* We may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

*Public Health Risks.* We may disclose PHI for public health activities. These activities generally include disclosures to prevent or control disease (including vaccination records), injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

*Health Oversight Activities.* We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

*Lawsuits and Disputes.* If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

*Law Enforcement.* We may release PHI if asked by a law enforcement official if the information is: 1.) in response to a court order, subpoena, warrant, summons, or similar process; 2.) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3.) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4.) about a death we believe may be the result of criminal conduct; 5.) about criminal conduct on our premises; and 6.) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

*Coroners, Medical Examiners, and Funeral Directors.* We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release PHI to funeral directors as necessary for their duties.

*National Security and Intelligence Activities.* We may release PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

*Protective Services for the President and Others.* We may disclose PHI to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

*Inmates or Individuals in Custody.* If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI to the correctional institution or law enforcement official. This release would be made if necessary: 1.) for the institution to provide you with health care, 2.) to protect your health and safety or the health and safety of others, or 3.) for the safety and security of the correctional institution.

# YOUR RIGHTS

You have the following rights regarding PHI we have about you:

*Right to Inspect and Copy.* You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. You have the right to an electronic or hard copy of your record; the most efficient method via our Patient Portal. We may charge a reasonable fee for copying your records up to current state limits.

*Right to Amend.* If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office.

*Right to an Accounting of Disclosures.* You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment, and health care operations or for which you provided written authorization.

*Right to Request Restrictions.* You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

*Right to Request Confidential Communication.* You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

*Right to a Paper Copy of This Notice.* You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.neendocrinology.com

Make all requests in writing to the Privacy Officer, Northeast Endocrinology Associates, 5000 Schertz Parkway, Suite #200, Schertz, TX 78154

## CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All requests must be made in writing to: Privacy Officer, Northeast Endocrinology Association, 5000 Schertz Parkway, Suite #200, Schertz, TX 78154. All complaints must be made in writing. You will not be penalized for filing a complaint.

Received by:

Patient Name Date

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# FINANCIAL POLICY

Thank you for choosing **Northeast Endocrinology Associates** as your health care provider. We are committed to providing you the best available medical care. We ask that all patients read and sign our office policies as well as our patient information form prior to seeing the physician.

Payment for service is due at the time services are rendered. We accept Cash, Check, Visa, MasterCard, and Discover.

***Please read the following and sign below (return to receptionist at front desk):***

- If you need to cancel or reschedule an appointment, all cancelations must be made at least 24 hours in advance. If you fail to cancel your appointment in that time frame, you will be subject to a $50 fee for each missed appointment. FNA appointments will be subject to $100 fee (Please see Cancellation/No-Show Policy)
- New patient appointments that are not cancelled with 24 hour notice, will be subject to a $100 fee (Please see Cancellation/No-Show Policy)
- Walk-ins requiring medical attention by either the physician or medical assistant will be subject to an office visit charge (co-pay may apply).
- Co-pays, co-insurance and/or deductibles and any other previous balance due must be paid before services are rendered, unless prior arrangements have been made.
- Returned checks will be subject to a $25 fee.
- Some insurance plans require a referral from a PCP. It is the patient's responsibility to obtain this referral in order to be seen by one of our doctors. If a valid referral is not obtained at the time of appointment, your appointment will be rescheduled.
- Your insurance policy is a contract between you and your insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges.
- All charges not covered by your insurance benefit plan are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- For billing / medication policy / lab results (see page 2).
- After hours non-urgent phone calls or pages through the exchange service will be subject to a $25 fee.
- Our office is happy to complete any FMLA, Disability, or Attending Physician Statements or copy Medical Records. Payment for these services is due BEFORE these forms are released (fees may vary).

We encourage you to communicate with our business office about any payment issues, so that we may assist you in the management of your account. Again, thank you for choosing Northeast Endocrinology Associates as your health care provider. We appreciate your trust in us and we look forward to the opportunity to serve you.

Print Name: _____ Patient's Signature (Legal Guardian): _____ Date: _____

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## BILLING

We mail statements every 30-45 days and accounts are due upon receipt. We work hard to make it as easy as possible for you to take care of your account with us. If, however, reasonable time has passed and you have made no effort to pay on your account, you may be reported to a credit bureau and/or a collection agency where a collection fee will be assessed.

## MEDICATION REFILL POLICY

You should contact your pharmacy before contacting our office about medication refills. You may already have a current authorized refill, and most local pharmacies will contact our office if you do not have a refill. If you take a medication every day, you should ask your pharmacy for a refill at least five days before the medication runs out as it is impossible to handle each request immediately.

Our office handles medication refills during normal working hours Monday through Friday from 8:30am to 5pm. We will handle your request within 48 hours. We have a policy of not calling in medications for conditions or complaints that they have not treated. The after-hours exchange service is reserved for emergency calls only. No refills on medications will be made over the weekend. Also, if we have not treated you within a one-year period, you must have an office visit before your refill can be granted.

## LAB RESULTS

Please do not call for lab results. You will receive all results within 2-3 weeks. You will be called if any medication change needs to be made. Please contact the office if you do NOT receive your results in 3 weeks.

You or your insurance company may be billed for lab reviews or phone calls by the physician without an appointment.

## NEXTMD

In an effort to save time and eliminate phone calls we have implemented a secured internet patient portal with NextMD as a way to communicate with our patients for any medical issues, billing, and/or any results. With NextMD you will be able to communicate directly with your physician or Nurse Practitioner on any matter you may have. In order for you to obtain your results you must be signed up with NextMD. If you are not registered with NextMD you will be required to schedule an appointment in order to receive your results.

Print Name: _____ Patient's Signature (Legal Guardian): _____ Date: _____

NORTHEAST
ENDOCRINOLOGY
ASSOCIATES P.A.

**Dr. Arthur Guerrero * Dr. Laura S. Akright**
**Dr. Omar Najera * Jeremy Schmidt FNP, CDE**
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# CANCELLATION / NO-SHOW POLICY

## Please read carefully.

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement a no-show/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

**Cancellation of an Appointment:**

In order to be respectful of the medical needs of other patients, please be courteous and call Northeast Endocrinology @ 210-650-3360 promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

**Late Cancellations:**

Late cancellation will be considered as a "no-show".

**No-Show Policy:**

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The following are Northeast Endocrinology's "no-show" fees:

1. Office Visit No-Show: $50
2. New Patient No-Show: $100
3. Procedure (FNA/Ultrasound) No-Show: $100

**The "no-show" fees will not be covered by your insurance, but will have to be paid by you personally before you will be able to schedule another appointment.**

In the event you have three "no-shows"/cancellations, all remaining appointments may be cancelled and may be referred back to your primary care/referring physician for future medical care.

Patient signature_____Date_____