NORTHEAST
ENDOCRINOLOGY
ASSOCIATES P.A.

7323 N. 1604 E, Suite 601 * San Antonio, Texas 78233
210.650.3360 (office) • 210.650-3403 (fax)
www.neendocrinology.com

Patient Information Form

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

Patient Name: _____, _____ _____
Last First Preferred Name

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

Address: _____
Street City State Zip

Cell phone: _____**Email:** _____

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

EMERGENCY/HIPPA CONTACT

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

Please check if: _____Authorized to release HIPPA _____ Authorized to release financial information

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_____

Preferred Pharmacy and phone number:

_____

ASSIGNMENT OF BENEFIT: I hereby authorize payment directly to physician of benefits due to me for his/her services. I understand I am financially obligated for charges not covered by this authorization. I authorize the release of any medical or other information necessary to process this claim

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

NORTHEAST
ENDOCRINOLOGY
ASSOCIATES P.A.

7323 N. 1604 E, Suite 601 * San Antonio, Texas 78233
210.650.3360 (office) • 210.650-3403 (fax)
www.neendocrinology.com

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:*

☐ **Diabetes** ☐ **Kidney stones** ☐ **Autoimmune Disease Type** _____

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

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

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

☐ **Cancer** ____ / ____ / ____ ☐ **Thyroid Surgery** ____ / ____ / ____

☐ _____ ____ / ____ / ____ ☐ _____ ____ / ____ / ____

☐ _____ ____ / ____ / ____ ☐ _____ ____ / ____ / ____

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** ☐ **E-cigarettes**

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

Physician List

Please include Primary Care Physician and Referring Physician

Please identify those MD's that records are to be requested from:

_____ _____

_____ _____

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:**

Office Policies

We would like to welcome you to Northeast Endocrinology. We want your visit with us to be a pleasant one. Below are our policies concerning several operational issues that will help us better manage your healthcare and expectations.

General

To avoid cancellation of appointment:

- All New Patient packets **must be received 21 business days prior to visit**.
- All Patients must complete on-line registration documents prior to arrival.

Please bring your list of medications, insurance card, and driver's license to every appointment. Updated signatures are required.

Copayments, Co-insurance, and Deductibles are due at the time services are rendered. It is your contractual obligation with your insurance carrier. Should you have any questions regarding responsibility, please reach out to your insurance carrier prior to your appointment.

Scheduling

Please consider the needs of our other patients. If you are unable to keep an appointment, please call within 48 hours of your scheduled appointment time to cancel your appointment. If you do not cancel your appointment within 48 hours and/or miss a confirmed appointment, you will be billed a fee of $75.00. This fee must be paid prior to rescheduling of visit.

If you miss appointments, we reserve the right to terminate the patient / physician relationship.

If you are running more than 15 minutes late for your appointment, please call to let us know of your delay. It may, in some instances, become necessary to reschedule your appointment to allow us adequate time to process your paperwork and to allow the doctor adequate time to discuss your healthcare needs without infringing upon the other appointments for the day.

Prescription Refills

Please remember that your pharmacy should always be your first call. If your pharmacy finds that you have no refills available, they will contact Northeast Endocrinology.

We require 72 hours to accommodate appropriate prescription refills.

We will NOT refill any medications for new patients until they are seen. Also, we will NOT refill any medications for our existing patients that have not been seen by our Dr.'s within the past year.

No prescriptions refills will be provided after hours or on weekends.

Financial Responsibility

For patients not covered by any insurance plans (ie. self-pay patients), we offer a private pay discount. This discount is ONLY extended at the time services are rendered and your account must be paid in full at that time. If we must bill you for services, you will be billed the full amount for your treatment and no discount will be extended.
Co-payments are a contractual fee between you, the patient, and your insurance company. You are required to pay your physician at the time services are rendered. The physician's contract with your insurance carrier requires that we collect your co-payment at the time services are rendered without exception. Your insurance policy is a contract between you, your employer, and / or your insurance company. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, and secondary insurance.

Compliance of Treatment

Follow-up appointments are mandatory for continued care. Failure to adhere to treatment plans or follow-up recommendations may result in dismissal from the clinic.

Respect and Consideration

Patients and visitors must always treat Dr.'s, staff, and fellow patients with respect and courtesy. Disruptive, disrespectful, or inappropriate behavior will not be tolerated.

Patients are encouraged to provide constructive feedback. However, repeated complaints, misuse of communication channels or repeated non-compliance with clinic policies may result in dismissal.

Phone and Portal Messages

The expected timeframe for calls and portal messages to be responded to is 48 business hours. Sending multiple messages or calls only causes additional delays. We appreciate your patience.

Parking

We must enforce stricter measures to maintain the integrity of our parking area. Patients found parking in a handicap or reserved physician parking spots without authorization will be subject to dismissal from our practice. Your acknowledgement provides Northeast Endocrinology Associates consent to complete a license plate identification.

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that Northeast Endocrinology Associates reserves the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

_____ _____

Patient Name- Printed Patient Signature Date

NORTHEAST ENDOCRINOLOGY

HIPAA Notice of Privacy Practices

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 7323 North Loop 1604 East, suite 601 San Antonio, Texas 78233.

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, 7323 North Loop 1604 east, suite 601 San Antonio Texas 78233. All complaints must be made in writing. You will not be penalized for filing a complaint.

Received by:

Patient Name Date