Name_____ Date _____

Date of Birth:_____ Sex: □M □F Marital Status: S/M/D/W

Email Address:_____ Phone:_____

Ethnicity:_____ Race:_____

Primary Insurance_____ Secondary Insurance:_____

Name of Primary Care Physician:_____

Pharmacy:_____ City/Street: _____

Emergency contact: Name:_____ Phone:_____

Please list all Medications you take: (if you brought your med list, please attach)

*If you are on insulin, please be sure to specify whether you use insulin pens or vials

Name of Medication	Dosage	# of Times per Day

Do you have any **drug allergies** to medications?□ NO □ YES Please list:

Drug	Reaction

Do you have a personal history of?

□Diabetes □High Cholesterol □Osteoporosis □ Hypertension

□Thyroid Disease □Cancer □Heart Disease □Stroke

□Hormone or gland condition □Asthma □Kidney failure □ Radiation

Do you use tobacco? □YES □NO Did you use tobacco in the past? □YES □ NO

Have you had a drink containing alcohol in the past year? □YES □ NO

Have you had any surgical procedures? If Yes, please list them.

Surgery	Month/Year

Family History:

Relationship	**Alive or Deceased**	Diabetes	High Blood Pressure	Heart Disease	Stroke	Cancer	Thyroid Cancer	Thyroid Goiter	Osteoporosis
Father									
Mother									
Siblings									
Daughter									
Son									
Spouse									
Paternal G.Father									
Paternal G.Mother									
Maternal G.Father									
Maternal G. Mother									

CIRCLE "Y" FOR YES IF YOU HAVE RECENTLY EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS, OTHERWISE LEAVE BLANK

General/Constitutional

Fever Y
Weight gain Y
Weight loss Y

Ophthalmologic/Eyes

Blurred vision Y
Eye pain Y

ENT (Ear/Nose/Throat)

Difficulty swallowing Y
Sore throat Y

Endocrine

History of radiation to the head or neck Y
Cold intolerance Y
Excessive thirst Y
Heat in tolerance Y

Respiratory

Shortness of breath Y
Cough Y
Wheezing Y

Cardiovascular

Chest pain Y
Dizziness on standing Y
Fluid accumulation in legs Y
Palpitations Y

Gastrointestinal

Abdominal pain Y
Constipation Y
Diarrhea Y
Heartburn Y
Nausea Y
Vomiting Y

Hematology/Blood

Easy bruising Y
Prolonged bleeding Y

Women

Decline in sexual desire Y
Heavy bleeding during menses Y
Hot flashes Y
Irregular menses Y
Missed periods Y

Men

Low sex drive Y
Erection problems Y

Genitourinary

Frequent urination Y
Painful urination Y

Musculoskeletal

Muscle aches Y
Painful joints Y

Podiatric/Feet

Foot numbness Y
Foot pain Y

Skin

Hives Y
Rash Y

Neurologic

Headache Y
Tremor Y

Psychiatric

Anxiety Y
Depressed mood Y

Additional Comments:

Patient Name:

ACKNOWLEDGEMENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES(HIPAA)

Ann Arbor Endocrinology and Diabetes Associates, P.C.

Protected health information (PHI), about you, is maintained as an electronic record of your contacts or visits for healthcare services with our practice. PHI is information about you, including demographic information (i.e., name address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health services.

Our practice is required to follow specific rules on maintain the confidentiality of your PHI, using your information, and disclosing and sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

By signing below, I acknowledge that I have received the notice of Privacy Practices from Ann Arbor Endocrinology and Diabetes Associates, P.C.

_____ _____

Patient Signature Date

Documentation of Failure to Obtain Signed Acknowledgment

On _____, _____ presented this Acknowledgment of Receipt of Privacy Form to

(Date) (name of employee)

_____. The patient refused to provide a signature when requested.

(Patient name)

ANN ARBOR ENDOCRINOLOGY AND DIABETES ASSOCIATES, P.C.

FINANCIAL POLICY (revised 07.19.2018)

Thank you for choosing Ann Arbor Endocrinology as your health care provider. The following is a statement of our policy that outlines patient and practice financial responsibilities.

1. It is your responsibility to provide us with correct insurance information at the time of your appointment. If you are a new patient to us, and do not have your **insurance card and photo ID**, we cannot verify your identity, we will have to reschedule your appointment. As a service to you, we will file a claim to your **primary** and **secondary** insurance **ONLY**. We do not file tertiary claims. Your insurance is a contract between you and your insurance company, we are not part of that contract, and we cannot guarantee payment of your claims. If your insurance pays only portion of your claim, or rejects entirely, you must follow up with them as any explanation should be made to you, their policy holder.

2. **Co-payments** and all outstanding balances are due at the time of check-in. We accept cash, check, money order, credit cards, HSA debit cards.

3. Additional balances due, if applicable, will be billed to you after insurance carrier has processed the claim. You will have **30 days** to pay balance **in full** unless other arrangement has been made with our office. We do offer payments on line through secure patient portal www.annarborendo.com. After 60 days, delinquent accounts will be forwarded to collection agency and $10.00 fee will be added to your balance to recover our cost for collection. A $30.00 fee will be charged for any NSF checks. **Unpaid balances may result in inability to schedule a follow up appointment.**

4. Some health plans may require a referral to be seen by our doctors. You, **not our office**, are responsible for obtaining an **i**nsurance referral from your Primary Care Physician prior to your visit. Patients without proper referral who elect to receive service from the office will be required to make payment in full at the time of service.

5. In the event you are unable to keep your appointment we request, at minimum, a **24-hour notice**. We reserve the right to dismiss any patient that has accumulated two or more missed or late cancelled appointments. You will be notified in writing of such termination. Our physician will continue to serve you for 30 days (unless otherwise specified) allowing you and your referring doctor to make alternative arrangements for your care. If you are more than 15 minutes late to your scheduled visit we will have to reschedule your appointment.

6. Ann Arbor Endocrinology is a part of Patient Centered Medical Home (PPP). We are committed to providing you with the best care possible to reach your goals and improve your overall health through timely, appropriate, and coordinated care. If you are not satisfied with your current provider we will not switch within this office. We will be happy to forward your records to any endocrinologist you choose outside this practice.

By signing below, I acknowledge that I have read and understand the information presented above and agree to be fully responsible for any and all charges rendered and not covered by my insurance plan.

I acknowledge receiving a copy of PPP brochure.

Print Name_____ Signature_____ Date _____

Limited Patient Authorization for Disclosure of Protected Health Information

Ann Arbor Endocrinology and Diabetes Associates, P.C.

Patient Name: _____ Date of Birth: _____

I authorize Ann Arbor Endocrinology and Diabetes Associates, P.C to disclose or provide my protected health information (PHI) about me to the individual(s) listed below.

Individual Name: _____

Relationship to patient: _____

Phone number: _____

Individual Name: _____

Relationship to patient: _____

Phone number: _____

Please select all categories of PHI to be released to the entity above.

[] complete health record

[] clinical information only

[] financial information only

[] other specify _____

This authorization will expire after one year of the date of your signature below. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your PHI disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of Ann Arbor Endocrinology. You have the right to terminate this authorization at any time by submitting a written request to us.

Patient or representative signature: _____ Date: _____

Ann Arbor Endocrinology & Diabetes Associates Patient Portal Access

_____

Patient's printed name

_____

Patient's email address

The Following agreements and procedures relate to online communications:

1. Ann Arbor Endocrinology will not forward online communications with you to third parties except as authorized or required by law for treatment or billing purposes.
2. Online communications should be used for limited purposes only, and should never be used for emergency or time-sensitive matters. Urgent matters should only be handled via other means of communication such as telephone or existing emergency communication tools.
3. Ann Arbor Endocrinology will strive to respond to online requests in a timely manner, but it is your responsibility for determining if an unanswered online communication was not received. Therefore, if you do not receive a response from the practice in a timely fashion either by phone, mail or patient portal please be sure to contact the practice to follow up.
4. You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication between AAEDA and me via the patient portal and consent to the conditions herein. In addition, I agree to the instructions outlined above, as well as any other instructions that AAEDA may impose to communicate with patients via the patient portal. Any questions I may have had were answered.

_____

Patient signature Date

External Prescription History

In order to ensure that your medication list is current and accurate, your doctor may need to access your prescription history through your pharmacy. By signing below, you give permission to allow AAEDA to access your External Rx history.

_____

Patient signature Date