Patient Registration Form

PATIENT INFORMATION **Please print clearly or type and review for accuracy.**

Name: (First) ______________________________ (MI) ______ (Last) ____________________________ Suffix _____

Birth Date ____/ ____/ ____ Age: ____ Social Security No. ______ - _____ - _______ Gender: ☐ M ☐ F

Referring Physician ____ Phone _____________________________
(If another physician encouraged you, or referred you to seek the care of an endocrinologist, then the name and phone number of that physician is needed, regardless of whether you require a referral form. The Clinic will communicate with this physician regarding the plan of care. HMO insurance policies frequently require a referral form.)

HOME ADDRESS Street Address ____ Apt# _______

City _______________________ State _____ Zip ________ Email __________________________ (Review for accuracy.)

Phone contact: home ___________________ cell _____________________ work ________________________

EMERGENCY CONTACT

Name ____ Relationship to you _______________________

Phone contact: home ___________________ cell _____________________ work ________________________

FINANCIAL RESPONSIBLE PERSON ☐Patient ☐Spouse ☐Parent ☐Other: ____________________
If your insurance coverage is in your name, please check the "patient box" and skip this area. If your insurance coverage is in someone else's name (*i.e.* spouse, parent), then please supply information about the policy holder.

Policy Holder Name: (First) ____________________________ (MI) ______ (Last) ____________________________

Street Address ____ Apt# _______

City ____ State ___________ Zip ____________

Phone contact: home ___________________ cell _____________________ work ________________________

Social Security No. _______ - ______ - ________ Date of Birth ________ - _______ - _______

INSURANCE INFORMATION

PRIMARY POLICY
Policy holder: ☐Patient ☐Spouse ☐Parent

Insurance Co. ___________________________________

Policy/member number: ___________________________

Group# ____

SECONDARY POLICY
Policy holder: ☐Patient ☐Spouse ☐Parent

Insurance Co. ____________________________________

Policy/member number: ____________________________

Group# ____

PHYSICIAN-PATIENT RELATIONSHIP AGREEMENT

My signature below serves as my confirmation of having read and understood the following policies for this office (please check each one – these boxes are **NOT optiona**l – you must check each box acknowledging Clinic policies):

☐ 1) **CONSENT TO TREAT**

I, or the person who represents me, consent to have the medical providers at the Washington Endocrine Clinic provide endocrinology care or treatment to me. If my care involves significant risk to me, my provider at the Clinic will discuss it with me unless it is an emergency.

☐ 2) **FINANCIAL CONTRACT and POLICY ACKNOWLEDGEMENTS**

I hereby authorize the release of any medical information necessary to process claims for my visit. I further authorize payment of medical benefits to The Washington Endocrine Clinic for professional services rendered. I understand I am financially responsible to The Washington Endocrine Clinic for charges not covered by this assignment and responsible for all reasonable costs of collection of any debt balance and any unpaid deficiency, including without limitation, court costs and reasonable attorney's fees incurred. I further understand that the Washington Clinic is NOT responsible for the misquoting of benefits provided by insurance companies should a claim adjudicate differently than how the Clinic was initially informed. Statements with outstanding balance charges shall be paid with a credit card, cash, or money order and I agree to pay such statements within 14 days of the e-mailed invoice.

☐ 3) The complete **CLINIC'S FINANCIAL POLICY** is found at www.washingtonendocrineclinic.com.
I understand that I must pay any applicable insurance co-pays, co-insurances, and deductibles ***at the time of the visit.***

☐ 4) The **NOTICE OF PRIVACY PRACTICES POLICY** is found at www.washingtonendocrineclinic.com.

☐ 5) **COMMUNICATIONS**

Patients may contact the Clinic by phone, regular mail, and during appointments. ***Email or fax is NOT to be used for discussing medical problems or making emergency prescription requests.***

☐ 6) **MEDICATION REFILLS.** Medication refills often require an office visit depending on the situation.

☐ 7) **OLD MEDICAL RECORDS.** It is the patient's responsibility to have all needed records sent prior to their visit.

☐ 8) **LABORATORY AND TEST RESULTS**

The Clinic partners with Sunrise Laboratories for most blood/urine tests. (A full explanation of laboratory billing can be found on the financial page.) For specific health insurance plans, specimen are also sent to LabCorp. Patients are not required to use the Clinic's laboratory. A follow-up appointment is required to discuss test results.
Results are NOT discussed outside of an office visit.

☐ 9) **MISSED VISITS**

Patients who fail to complete a scheduled appointment without canceling within 24 hours incur a $75 fee for established patients, $125 for new patients, and $50 for dietitian visits. Showing up to an appointment without an acceptable form of payment (cash, credit, or debit) results in a late cancellation. Personal checks are NOT accepted. These fees are routinely collected from patients who make appointments, but do not keep them for a variety of reasons. The patient is responsible for all appointments. Failure to complete medical tests requested by the medical provider at any visit is NOT an acceptable reason to cancel an appointment on the same day it is scheduled. Courtesy e-mail and automated phone reminders of appointments are sent, BUT failure to receive these is NOT an acceptable reason to cancel an appointment on the same day it is scheduled.

☐ 10) **RECORDS TRANSFER.** A HIPAA compliant form on our web site is required with payment for record transfers.

☐ 11) **ELECTRONIC BILLING NOTICES.** I understand that the Clinic sends electronic notices for bills by email.

☐ 12) **DISMISSAL.** I understand that I can be dismissed from the Clinic for not following the provider's medical orders, not paying bills on time, or disrespecting the Clinic staff.

I understand that I can access all policy forms on the Clinic's web site, preview a copy of these forms in the office at the time of registration, and/or ask for a printed copy from the receptionist.

______________________	____________	______________________	
Patient Name (please print)	Date	Patient Signature	(Form version 02/15)

Please make sure ALL boxes are checked above – Appointments will not be honored without acknowledging Clinic policies

HEALTH BACKGROUND INFORMATION

CURRENT MEDICAL CONDITIONS (list previously diagnosed conditions, i.e. diabetes, hypertension)

____

____

PREVIOUS MAJOR SURGERIES:

____

____

CURRENT REVIEW OF SYSTEMS (please check persistent problems over the past month)

☐ anxiety	☐ depressed mood	☐ join pain	☐ rash
☐ blood in stool	☐ erectile dysfunction	☐ low libido	☐ shortness of breath
☐ blood in urine	☐ eye pain	☐ muscle pain	☐ stomach pain
☐ bone pain	☐ fatigue	☐ nausea	☐ trouble swallowing
☐ cold intolerance	☐ fever	☐ neck pain	☐ visual disturbance
☐ chest pain	☐ headache	☐ night sweats	☐ vomiting
☐ constipation	☐ heat intolerance	☐ numbness	☐ weakness
☐ cough	☐ hoarseness	☐ pain	☐ weight gain
☐ diarrhea	☐ irregular periods	☐ pain with urination	☐ weight loss

FAMILY HISTORY:

Mother: If deceased, age at death _____.

Medical conditions: ____

____

Father: If deceased, age at death _____.

Medical conditions: ____

____

Siblings: Medical conditions: ____

____

SOCIAL HISTORY:

Occupation: ____

Marital status: ☐ single ☐ married ☐ partnered ☐ divorced ☐ widowed

Tobacco use: ☐ none

☐ currently smoke ___ packs per day OR ___ cigarettes per day, for ___ years.

☐ previously smoked ____ packs per day for ___ years and quit in ______ (year).

Alcohol use: ____ drink(s) per week.

ALLERGIES TO MEDICATIONS: ____

____

CURRENT MEDICATIONS:

Medication	*Dosage*	*How often do you take it?*