Bay West Endocrinology Associates

REGISTRATION FORM

(Please Print) ☐ GBMC

APPT: ☐ Pao ☐ Tyzack ☐ Horowitz ☐ Lee ☐ Fraker ☐ Fratila ☐ Khan ☐ Levin ☐ Haber ☐ Peng ☐ Mindel ☐ Davidson

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Social Security No: - -	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Home Phone no.: ( )	Cell phone no.: ( )

City:	State:	Zip	Email:

Occupation:	Employer:	Employer phone no.: ( )

Referred to office by (please check one box):	☐ Dr.	PH #	Fax:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist at each appointment)

Name of Insurance:	Address	Ins phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

MODEL CLINICAL RESEARCH

Studies I would be interested in:	Diabetes:	Thyroid Disease:	Hypertension:	Osteporosis:

I have been told that Bay West Endocrinology Associates also has a research division: MODEL Clinical Research, LLC. I authorize the review of my record to determine if I am a viable candidate to participate in future studies. By signing this form I am agreeing only to the review of my medical history with this office and, not actually agreeing to participate in the study.

Patient/Guardian signature *Date*

OFFICE FEES NOT BILLED TO INSURANCE COMPANY

Cancellation fee (less than 24 business hours notice)	25.00 follow up visit	100.00 New patient or procedure visit
Medical Records copies	22.09 + .73 per page	40.00 flat fee for CD
Form Fees	10.00 up to 2 pages	20.00 3 or more pages
Billing fee for statement billing copays	10.00	
Late fee on accounts	25.00 every 45 days the account is not addressed	

Patient/Guardian signature *Date*

Bay West Endocrinology Associates Notice of Privacy Practices

Patients Name: **Date:**

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information: Please read it carefully.

This office is required by law to maintain the privacy of your health information to follow the terms of this notice, and to provide its legal duties and privacy practices with respect to your health information. We will not use or disclose the medical information about you without your written authorization, except as described in this notice.

How Bay West Endocrinology Associates May Use or Disclose Your Health Information:

- The law permits Bay West Endocrinology Associate to use or disclose your health information for the following purposes:
- Treatment, Payment, and Regular Health Care Operations-Information obtained by this office will be used to dispense medications and services to you. Information will also be provided to you upon request.
- As and When Required by law – We may use and disclose your health information to Public Officials, Law Enforcement, Health Oversight Activities (for audits, investigations etc…)
- Victims of Abuse, Neglect, or Domestic Violence – We may disclose your health information to a government authority such as social services, or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.
- Marketing Communications – We must obtain your written authorization prior to using your health information to send you any marketing materials. We may communicate with you about products or services relating to your treatment, care, or alternative treatments.

When Bay West Endocrinology Associates May NOT Use or Disclose Your Health Information:
Except as described in the Notice of Privacy Practices, Bay West Endocrinology will not use or disclose your health information without your written authorization. If you do authorize Bay West Endocrinology Associates to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If your state law provides additional restrictions upon any of the foregoing uses to disclosures, we must follow your state law.

You Have the Following Rights with Respect to Your Health Information:

- You have the right to request restrictions on certain uses and disclosures of your health information.
- You have the right to inspect a copy of your health information so long as Bay West Endocrinology Associates maintains your health information. You must submit your request in writing with the exact location you would like your records sent to. You may be charged a fee for the copying and mailing of your health information. Fees are never more than the state required rates.
- You have the right to request that we amend or correct any information that is incorrect or incomplete. Please send your request in writing to Bay West Endocrinology Associates.
- You have the right to receive an accounting of disclosures of your health information we have made after April 14, 2003.
- You may request communications of your health information by alternative means or at alternative locations. For example, you may request confidential communication of your health matters be sent to a PO Box , fax machine, or email address. You must complete a request for Alternative Communication to the location providing the services. We will accommodate all reasonable requests.
- We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Changes to this Notice of Privacy Practices
Bay West Endocrinology Associates reserves the right to amend our practices and this Notice of Privacy Practices at any time in the future and to make the new Notice effective for all medical information we maintain.

For More Information or to Report a Problem
If you have any questions or would like additional information about HIPAA, or believe your rights have been violated please contact the Secretary of Health and Human Services at HIPAA Privacy, 922 W. Walnut, Rogers, AR, 72756-3540.

I have read the above information and allow the following:

You have my permission to talk to ____________________________, who is my _______________on my behalf,
(friend or family member) (relationship)

The best number to reach him / her is ____
(phone)

You have my permission to leave information on my voicemail at home/cell, the number is______________________

You have my permission to obtain my medication history, this information is used for my safety only__________
(initials)

______________________________ ______________________________

Patient Signature Date

FINANCIAL AGREEMENT

If we participate with your insurance company, you will only be responsible for the copays and deductibles at the time of your visit. Any monies designated as patient liabilities, by your insurance company, will be billed in our next billing cycle and are due in 30 days or at the time of your next visit, whichever comes first. It is the patient's responsibility to provide all authorization and/or referral forms as required by your insurance carrier to this office. If you do not have the referral at the time of your visit, we will be unable to see you that day but will reschedule your appointment so that a referral may be obtained.

Payment for all office visits, including lab work and/or injections, are due at the time of service, unless prior arrangements have been made with this office. We will submit all medical insurance claims for you. Your insurance form then will reflect the payment and all reimbursements will come to you directly from your insurance carrier.

Complete and accurate insurance information is an absolute necessity so we can properly submit your claim.

AUTHORIZATION TO RELEASE INFORMATION

I, hereby, authorize Bay Endocrinology Associates to release any information regarding my medical care for claim processing. I understand that this authorization will remain in effect as long as I am a patient of this practice, or revoke my authorization in writing. I understand that my records will not be distributed in anyway that violates HIPPA (The patient privacy act of 1996).

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I, hereby, authorize payment to be made directly to Bay Endocrinology Associates for surgical and/or medical benefits. In the event that I directly receive any proceeds from my insurance, and my account balance is unpaid, I agree to immediately make payment to Bay Endocrinology Associates, upon receipt of such monies. ANY PAYMENT MADE DIRECTLY TO THE OFFICE AT THE TIME OF SERVICE WILL BE REFLECTED ON MY INSURANCE FORM FOR THE REIMBURSEMENT. I further understand that failure to provide proper insurance information, authorization and/or referrals is a breach of the contract signed between my medical insurer and myself. If I still wish to be seen, I understand that I am agreeing to opt out of my insurance plan and I would be responsible for services rendered at each visit and payable at time seen.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY IN FULL ANY NON-COVERED SERVICES AND/OR REMAINING BALANCE ON MY ACCOUNT WITHIN 30 DAY. IF IT BECOMES NECESSARY TO REFER MY ACCOUNT FOR COLLECTION OR LEGAL ACTIVITY, I WILL THEN BE RESPONSIBLE FOR ANY ADDITIONAL COSTS INCURRED. THESE FEES CAN INCLUDE INTEREST ON THE UNPAID BALANCE, COURT COSTS AND FILING FEES, AS WELL AS COLLECTION AND ATTORNEY FEES.

Signed____(Seal)
Date____

Witness____(Seal)
Date____

Original Date:
Dates Revised:

Appointment Date:______________________________ Time:_____________________

BAY WEST ENDOCRINOLOGY ASSOCIATES
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*: ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.				
Exercise	☐ Yes ☐ No			
	Details:			
Diet	Are you dieting?		☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?		☐ Yes	☐ No
	# of meals you eat in an average day?			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	If yes, what kind?			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?		☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?		☐ Yes	☐ No
Sex	Are you sexually active?		☐ Yes	☐ No
	If yes, are you trying for a pregnancy?		☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:			
Personal Safety	Do you live alone?		☐ Yes	☐ No
	Do you have frequent falls?		☐ Yes	☐ No

Employer Name:	Occupation:

Review of Systems

Patient Name:___________________________________ Date:_____________________

Had a flu shot this year?	No	Yes

Had a pneumonia shot?	No	Yes

Name of Primary Care Physician___________________________ Phone Number________________________________

Please indicate below systems you are currently experiencing:

General, constitutional:

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Eyes and Vision

Eye disease or injury	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

Ears, Nose, Throat

Hearing Loss or ringing in ears	No	Yes
Sinus problems	No	Yes
Nose bleeds	No	Yes
Mouth sores or bleeding gums	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

Heart and Cardiovascular

Palpitations	No	Yes
Chest Pain	No	Yes
Swelling in legs, or feet	No	Yes
High Blood pressure	No	Yes
High Cholesterol	No	Yes

Respiratory

Frequent coughing	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

Gastrointestinal

Loss of Appetite	No	Yes
Heartburn	No	Yes
Nausea or vomiting	No	Yes
Constipation or diarrhea	No	Yes
Blood in stool	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes

Skin

Rash or itching	No	Yes
Change in skin, hair, or nails	No	Yes

Musculoskeletal:

Joint pain, stiffness or swelling	No	Yes
Muscle pain, cramps or weakness	No	Yes
Back or Neck pain	No	Yes
Osteoporosis	No	Yes
History of Fractures	No	Yes
Last DXA scan date		

Neurological

Frequent or recurrent headaches	No	Yes
Light headedness or dizziness	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Stroke	No	Yes
Head Injury	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Anxiety or Depression	No	Yes
Sleep problems	No	Yes

Endocrine

Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Change in shoe or glove size	No	Yes

Hematologic/Lymphatic

Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes
Anemia	No	Yes
Transfusion	No	Yes

Male Patients:

Prostate Problems	No	Yes
Erectile dysfunction	No	Yes
Breast enlargement or discharge	No	Yes

Female Patients

Irregular periods	No	Yes
Breast pain/lumps/discharge	No	Yes
Last Menstrual Period		
Menopause Date		

Signed by patient:	