NORTH TEXAS DIABETES & ENDOCRINOLOGY OF PLANO

LEO JENG, MD | JANE KO, MD

Demographic Information

Name	Date of Birth	Sex Male / Female

Social Security Number	Email	Marital Status Single / Married / Widowed / Divorced / Other

Mailing Address	City/State	Zip Code

Primary Phone	Secondary Phone	Work Phone

I authorize detailed messages containing pertinent medical information to be left in a voicemail at the following numbers:

☐Primary Phone ☐ Secondary Phone ☐ Work Phone ☐ Emergency Primary ☐ Emergency Secondary

Employer	Spouse/Parent's Name
Emergency Contact's Name	**Relationship to Patient**
Emergency's Primary Phone	**Emergency's Secondary Phone**

Primary Care Physician	Cardiologist	Referring Physician

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Language ☐ English ☐Other____________________

Race

☐ American Indian or Alaska Native ☐ Asian ☐ White ☐Other

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

Appointment Confirmation Preference

☐Email ☐Primary Phone ☐None

☐Other Contact______________________________

Protected Health Information Authorization

Name	Relationship	Type of Information Authorized
1.		☐All ☐Scheduling ☐Medical ☐Billing
2.		☐All ☐Scheduling ☐Medical ☐Billing
3.		☐All ☐Scheduling ☐Medical ☐Billing
4.		☐All ☐Scheduling ☐Medical ☐Billing

I have reviewed the above information and authorize my protected health information to be released to the individuals listed, as specified. I understand that this authorization applies to both written and verbal communications. I also understand that I may request to revoke this authorization, in writing, at any time.

____ ______________________

Signature of Patient/Legal Representative **Date**

Insurance Information

Primary	Secondary	Tertiary
Name of Insured	**Name of Insured**	**Name of Insured**
Insured Date of Birth	**Insured Date of Birth**	**Insured Date of Birth**
Relationship to Patient	**Relationship to Patient**	**Relationship to Patient**
Member ID/ Policy #	**Member ID/ Policy #**	**Member ID/ Policy #**
Group #	**Group #**	**Group #**

FINANCIAL POLICY

Thank you for choosing us as your Endocrinologist. Please read our financial policy carefully and sign below.

Payment for services is due at time services are rendered. We accept cash, checks, debit cards, MasterCard and Visa. Our office collects copays, unpaid deductibles, and coinsurance at the time of service. If you are unable to pay the full copay, you will be asked to reschedule your appointment. Returned checks will be subject to a $30 charge.

Please remember that our relationship is with you, not with your insurance company.
Your insurance policy is a contract between you and your insurance company.

If you have insurance, we ask that you provide us with the information at the time of the visit. **As a courtesy, we will file your claim to your insurance(s), Medicare, and/or Medicaid.**

Please inform the receptionist if you have any changes in your insurance or have received a new insurance card.
Please provide us with details of both primary and secondary insurance. **If you fail to provide us with the correct information at the time of service or at the latest within 30 days of service , we will not file a claim to your insurance and you will be billed the full fees.**

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You will receive a bill for any services not covered by your insurance company. After your claim is processed, you may still have a remaining deductible. You will be billed for the amount that your insurance company assigns towards your deductible.

Your insurance company may require additional information to process your claim. Your insurance company will request this information in writing. Our billing department will also notify you that your insurance is requesting more information. It is very important that you provide your insurance company with the information necessary to process your claims. You are allowed 10 days to get this information to your insurance company. If you fail to do this, the balance will become your responsibility and you will receive a statement from us for payment in full.

We ask that you pay all bills due within 30 days of receipt of your statement. If we do not receive full payment for any outstanding bills in a timely manner, your account may be forwarded to a collection agency.

It is required that Self Pay patients with no insurance pay the full amount due at the time of service. If you are unable to pay the full amount at the time of service, we will ask you to reschedule your appointment.

REFERRALS

If your insurance company requires a referral from your primary care physician, it is your responsibility to get us this referral. Our office does not give appointments if we do not have the referral in our office at the time of scheduling. If you do not obtain a referral and one is needed, or if your referral has expired at the time of visit, you will be considered a self-pay patient and will be responsible for the entire bill. **Please remember it is the patient's responsibility to have their PCP's office renew referrals that are expired. Failure to do so may result in non-payment by your insurance company and you will be responsible for all outstanding charges.**

BROKEN APPOINTMENT POLICY

Our office requires 24 hours (1 business day) notice for all appointment cancellations and reschedules. **There is a $75 fine for all broken appointments.** All same day cancellations are considered broken (missed) appointments. Messages left on voice mail after office hours for cancellations of next business day appointments are also considered missed appointments. Any patient who has missed a total of 3 appointments may not be given any future appointments.

I ____do hereby affirm that I have read and understand the above policies.
(Please print name)

Patient Signature ____ Date_____________________________________
Signature of Patient/Legal Representative

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed, or have been given the opportunity to review this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

** If you would like to receive a copy of our Notice of Privacy Practice, please ask an associate.*

____ ____________________

Printed Name of Patient **Date of Birth**

____ ____________________

Signature of Patient/Legal Representative **Date**

NORTH TEXAS DIABETES & ENDOCRINOLOGY OF PLANO

LEO JENG, MD | JANE KO, MD

Main Office Location
4100 W 15th Street, Suite 202
Plano, Texas 75093

Authorization to Release Healthcare Information

This is a release form for authorization of your medical information to be transferred between **health care providers, health insurance companies and any other party involved in your medical care.**

I, ____, hereby authorize the following facilities/hospitals and doctor(s) to release all medical information to North Texas Diabetes and Endocrinology of Plano to better manage my health.

This request includes: hospital summaries, laboratory reports, physician progress notes, and any other healthcare information relating to my condition.

**List facility name(s), hospital name(s) and/or physician(s) below where you have been seen so that we may obtain your medical information:*

*1*____

*2*____

*3*____

*4*____

*5*____

____ ____________________________

Printed Name of Patient **Date of Birth**

____ ____________________________

Signature of Patient/Legal Representative **Date**

NORTH TEXAS DIABETES & ENDOCRINOLOGY OF PLANO

LEO JENG, MD | JANE KO, MD

Health History Questionnaire

Name	**Date of Birth**
Pharmacy:	
Insulin Pump: ☐ **N/A** ☐**Medtronic** ☐ **OmniPod** ☐ **Animas** ☐ **Tandem** ☐ **Other**	**Advanced Directive** ☐**Yes** ☐**no**
Continuous Glucose Monitor: ☐ **N/A** ☐**Dexcom** ☐**Libre** ☐ **Other**	**Last Lab Draw:** Approximately_____________ **Days / Weeks/ Months** ago
Glucose Meter: ☐ **N/A** ☐**One Touch** ☐ **Bayer** ☐ **Accu-Chek** ☐ **Freestyle** ☐ **Other**	

List any Medical problems that you have been previously diagnosed with

☐ Atrial fibrillation	☐ Heart Attack	☐ Kidney Disease	Other
☐ Gastrointestinal Disease	☐ Congestive Heart Failure	☐ Lung Disease	Other
☐ Diabetes	☐ Stroke	☐ Cancer	Other
☐ Hypertension	☐ Coronary Artery Disease/ Heart Disease	☐ High Cholesterol	Other

List any past surgeries

Year	Surgery	Hospital

List any hospitalizations from the past 24 months

Date	Reason	Hospital

Medication List (Please attach a list if you need more space)

Medication	Dosage	Medication	Dosage

Please List Any Allergies:

Social History

Tobacco Usage	☐ Never	☐ Used for_________ years	☐ Quit years/months _________ ago	
	____Cigarettes per day/week	____Chew per day/week	____Pipes per day/week	____Cigars per day/week
Exercise	☐ Rarely or Never Exercise	☐ Frequently Exercise	☐ Occasionally Exercise	☐ Exercise Daily
Caffeine	☐ Coffee ☐ Tea ☐ Cola	☐ Energy Drink ☐ None	**Cups per Day:**	
Alcohol	☐ Never	☐ _________ Drinks **Per Day**	☐ _________ Drinks **Per Week**	☐ _________ Drinks **Per Month**
Recreational Drugs	☐ Never	☐ Previously	☐ Currently	

List any Significant family medical history such as heart disease, diabetes, hypertension, stroke, heart rhythm problems

Mother	**Father**
Grandmother	**Grandfather**
Siblings	**Other**