□ Irving 972-253-4380 □ Plano 972-943-5914 □ Weatherford 817-458-4985

North Texas Diabetes & Endocrinology

Demographic Information

Patient Name		**Date of Birth**	**Sex** Male / Female
Social Security Number	**Email**	**Marital Status** ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Mailing Address		**City/State**	**Zip Code**
Primary Phone	**Secondary Phone**	**How did you hear about us?** ☐ Google ☐ Physician Referral ☐ Other: _____	
I authorize detailed messages containing pertinent medical information to be left in a voicemail at the following numbers: □Primary Phone □ Secondary Phone □ Emergency Primary □ Emergency Secondary			
Responsible Party □ Self □ Other – Information Below			
Name of Responsible Party		**Relationship to Patient**	
Date of Birth	**Primary Phone**	**Mailing Address** [☐ Check if Same as Above]	
Employer's Name			
Emergency Contact	**Emergency's Primary Phone**	**Emergency's Secondary Phone**	
Pharmacy Name and Address		**Pharmacy Phone Number**	
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 □ Text	

Protected Health Information Authorization

Name	Relationship	Type of Information Authorized
1.		□All □Scheduling □Medical □Billing
2.		□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
Insurance Company	**Insurance Company**	**Insurance Company**
Name of Insured	**Name of Insured**	**Name of Insured**
Member ID/ Policy #	**Member ID/ Policy #**	**Member ID/ Policy #**
Group #	**Group #**	**Group #**

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North Texas Diabetes & Endocrinology

Patient Financial Policy Sheet

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 within 30 days of service, at the latest, 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.**

I have read and understand the financial policy of the practice, and I agree to be bound by its' terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of Patient	Date of Birth
Signature of Patient/Legal Representative	Date

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North Texas Diabetes & Endocrinology

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 the 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**

Cancellation, No-Show Policy, and Late Arrival Acknowledgement

In an effort to minimize waiting periods and improve appointment availability we have found it necessary to enact a Patient Cancellation Policy. Any patient that cancels an appointment with less than 24-hour notice and/or does not show up for their appointment will be charged a fee of **$50 for the missed appointment**. Any messages left on voicemail *after* office hours for cancellations of appointments which are scheduled to take place the next business day are also considered missed appointments. Additionally, after 3 cancellations or no shows without adequate notice, we will no longer be able to accommodate schedule requests. Please be advised that anyone arriving 15 minutes or later to their scheduled appointment will be asked to reschedule their office visit. We hope this policy will ultimately benefit all patients by improving the quality of your treatment experience.

I understand North Texas Diabetes and Endocrinology's cancellation policy, no show policy, and late arrival agreement.

Printed Name of Patient | **Date of Birth**

Signature of Patient/Legal Representative | **Date**

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North Texas Diabetes & Endocrinology

Prescription Policy

Our practice is a medical office that treats many types of ailments and conditions. On occasion we may prescribe medications for you to help relieve pain. These medications, when used properly, can help patients feel better and lead productive lives. These medications can also be misused, causing harm to patients and to others. For this reason, the State of Texas and the Federal Drug Enforcement Administration regulates use of these medications. Our practice follows those laws:

Our Policy:

1. Written prescriptions will not be replaced if lost, stolen, destroyed, or misplaced.
2. Prescriptions are to be taken as directed. In other words, DO NOT change the frequency of the dose unless otherwise directed by your physician. If a change does occur, this will be documented in your chart.
3. By law, controlled substances cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in our office in the past three months, prescriptions for the following cannot be refilled. Exceptions to this must be discussed with the physician during an office visit. Exceptions will not be granted over the phone.
    a. Sleep Aids such as Ambien or Lunesta
    b. Anti-inflammatories such as Celebrex, Ibuprofen, or Naproxen
    c. Narcotics such as Lortab, Vicodin, Darvocet, or Hydrocodone
    d. Muscle Relaxers such as Soma, Flexeril, or Robaxin.
5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will NOT be authorized at night, on weekends, or holidays. Be sure to plan ahead to make sure you have enough medication.
7. Before you visit our practice, please check your supply of medication. If you need refills, please ask for them during your appointment.
8. Refill requests for hormone replacement and birth control pills can only be refilled if you have a routine gynecology appointment scheduled. Exceptions to this must be discussed with the physician during an office visit. Exceptions will not be granted over the phone.
9. Refill requests for prescriptions not prescribed by your physician will not be authorized.
10. At least 2 business days are needed for prescription request. Call before Friday.
11. Do not call more than once about a medication, refills, or any issue. When you call our office, a message is sent to your physician. Nothing can be done until your physician has a chance to review the message. The physician is the only one who can approve for your medication to be refilled.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescriptions refilled. I agree to abide by this policy and understand that this signed policy will be scanned into my chart.

Printed Name of Patient	**Date of Birth**
Signature of Patient/Legal Representative	**Date**

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North Texas Diabetes & Endocrinology

Authorized Release of Information

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

I, _____, hereby authorize The Facilities Listed below to release all medical information to North Texas Diabetes and Endocrinology.

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 would like your medical records request to be sent.*

Facility / Provider Name	Fax Number

I hereby authorize the above -mentioned provider/facility to release and/or disclose the medical information as indicated below to: North Texas Diabetes and Endocrinology. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health and alcohol and/or substance abuse.

DURATION- This information shall become effective immediately and shall remain in effect until ____/____/_____ or for ninety days from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED

( ) Entire medical record ( ) History and Physical ( ) Chart Summary ( ) Labs ( ) Radiology ( ) Pathology

( ) Other (Please specify)_____

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purpose only:

( ) Physician or Healthcare facility ( ) Legal ( ) Personal ( ) Other _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

Printed Name of Patient **Date of Birth**

Signature of Patient/Legal Representative **Date**

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North Texas Diabetes & Endocrinology

Health History Questionnaire

Name	Date of Birth
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other	
Occupation ☐ Retired ☐ Unemployed ☐ Employed Full Time ☐ Employed Part time ☐ Student	
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 an additional 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:**	

☐ **Irving** ☐ **Plano** ☐ **Weatherford**

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North Texas Diabetes & Endocrinology

Social History Continued…
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, etc.

Family Member	**Living or Deceased?**	**Significant medical history.**
Mother		
Father		
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Sibling		