



PATIENT DEMOGRAPHICS & INSURANCE

Patient Last Name	First Name	MI	Preferred Name
Mailing Address		City	State Zip
Home Phone ☐ Primary Number	Work Phone ☐ Primary Number	Mobile Phone ☐ Primary Number	
Email Address			
Emergency Contact Full Name & Relationship		Primary Phone	Secondary Phone
I authorize detailed messages containing medical information about me and my care in a voicemail at the following numbers:			
☐ Home Phone	☐ Work Phone	☐ Mobile Phone	☐ Emergency Primary ☐ Emergency Secondary
Marital Status		Sex	Date of Birth
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		☐ Male ☐ Female	
Race		Ethnicity	
☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Other ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander		☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	
Pharmacy Name	Pharmacy Address	Pharmacy Phone	

INSURANCE & SUBSCRIBER INFORMATION

Primary Insurance Company Name of Primary Subscriber Member ID/Policy No. Group No.	Secondary Insurance Company Name of Primary Subscriber Member ID/Policy No. Group No.
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IMPORTANT NOTICE - CANCELLATION, NO SHOW, & LATE ARRIVALS

If you cancel an appointment with less than 24 hours' notice or do not arrive for a scheduled appointment, you will be charged a **\$75.00** fee for the missed appointment.

If you arrive **10 minutes or later** to your scheduled appointment, you may be asked to reschedule your appointment.

PATIENT FINANCIAL RESPONSIBILITY

We have contracted with many health insurance plans to accept an assignment of benefits. This means that we bill those plans, and you may be required to pay a copayment, coinsurance, or deductible at the time of service. The benefits provided at time of service are an estimate, not a guarantee of your out-of-pocket cost.

If your health plan requires prior authorization in the form of a referral from your primary care provider (PCP), or precertification before procedures or treatment may be initiated, please inform our staff so that these arrangements are made in advance. We will bill your secondary coverage if we are contracted with the plan.

If you have a health insurance plan for which we are not contracted, we will prepare and send claims on your behalf. Please be aware that the patients' responsibility when using non-contracted providers will usually be more than when using contracted providers. Not all services are a covered benefit in all health insurance plans. Some health insurance plans select certain services that will not be covered. If your health insurance plan determines a service to be "not covered," you will be responsible for the complete cost of the service. Payment of your "patient responsibility" balance as determined by your health insurance plan is due upon receipt of a statement from our office.

The following services will be charged in addition to the office visit when applicable. It is possible that these services could be subject to additional copays, coinsurance, or deductible amounts. The coverage and amount due for each service is determined by each individual insurance plan.

Hemoglobin A1c tests
CGM data interpretation and analysis
Glucose
Thyroid ultrasound
Thyroid biopsy
Pathology
Blood draws
Laboratory tests
FMLA Paperwork

If you have not received a notice of payment from your health insurance plan within 30 to 45 days, please contact them to discuss any issues causing delays. **You will be responsible for services not paid by your health insurance plan.**

Minor Patients

For all services rendered to minor patients, the parent, guardian, or the adult accompanying the minor will be responsible for payment.

Acknowledgment

I have read and understand the Patient Financial policy, and I agree to its terms. I also understand and agree that the Company may amend such terms from time to time.

Patient Name (please print)

Date of Birth

Signature of Patient, Parent, or Legal Guardian

Date

CONTINUOUS GLUCOSE MONITORING SYSTEM (CGMS)

If your healthcare provider has requested that you have the "Professional CGMS" placed in-office, you will be expected to wear this device for 10-14 business days. You will be scheduled for an office visit to remove the CGM device and download the data. At this visit, the provider will analyze the CGM data obtained to determine your next step in treatment.

If your healthcare provider determines a "Personal CGMS" is the best option for you, they will review the options available and start the ordering process. Dependent on the model, you may require an office visit for additional training once the device has been received.

North Texas Diabetes & Endocrinology requires all Personal CGMS device users to provide their CGM data for interpretation & analysis at each visit. CGM data allows for the direct observation of glycemic excursions and daily profiles, which allows your healthcare provider to make informed decisions on immediate therapy and/or lifestyle modifications. CGM data also provides the ability to assess glucose variability and identify patterns of hypo-and-hyperglycemia.

Please note: An additional charge for CGM Data Interpretation & Analysis will be charged in addition to each office visit charge. This may result in an additional copay, co-insurance, or deductible amount. The coverage and amount due for this service is determined by each individual insurance plan.

Patient Name (please print)

Date of Birth

Signature of Patient, Parent, or Legal Guardian

Date

TEXT AND EMAIL COMMUNICATION

By signing below, I authorize Premier Independent Physicians and its affiliated practices through its partners including but not limited to Summus Healthcare, LLC, SimpleTexting, and MailChimp to contact me by SMS text message to better serve me. Premier will send me text messages and/or emails to help me stay healthy including reminders about appointments, information about making healthy choices, and information about additional services.

I understand that message/data rates may apply to messages sent through Premier to my cell phone and that I may receive up to 2 texts or emails per month in addition to appointment reminders. I know I am not obligated to authorize Premier to send me text messages and/or emails.

I may opt out of receiving these communications from Premier at any time by calling my provider's office, emailing printandmedia@premiersummus.com, texting STOP in response to a text message, or using the unsubscribe function within any email I receive from Premier.

ACKNOWLEDGMENT OF POLICIES

Please initial your acknowledgment of each policy and sign at the bottom of the page.

Financial Policy Acknowledgment

I have read and understand the Patient Financial policy, and I agree to its terms. I also understand and agree that the Company may amend such terms from time to time.

Privacy Practices Notice

North Texas Diabetes & Endocrinology and its affiliated practices reserve the right to modify the Privacy Practices outlined in the notice. I have reviewed or have been given the opportunity to review Premier's 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 Practices, please request a copy from a staff member or visit our website at www.ntxd diabetes.com.

I have read and understand the Cancellation, No Show, and Late Arrival policy.

I have read and understand the Text and Email Communication policy.

RELEASE YOUR PROTECTED HEALTH INFORMATION - INDIVIDUALS

Name/Relationship	Phone Number	Information Authorized
		☐ All ☐ Scheduling ☐ Medical ☐ Billing
		☐ All ☐ Scheduling ☐ Medical ☐ Billing
		☐ 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 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.

CONSENT TO TREAT

I hereby authorize employees and agents of North Texas Diabetes & Endocrinology and its affiliated practices (including physicians, advanced practitioners, and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Patient Name (please print)

Signature of Patient, Parent, or Legal Guardian

Date

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical treatment, surgical procedures, and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Signature of Parent or Legal Guardian

Date

PRESCRIPTION POLICY

North Texas Diabetes & Endocrinology and its affiliated practices are medical offices that provide treatment for various types of conditions. In some cases, patients may be prescribed medication to treat their pain. Correct usage of these medications can greatly improve patients' quality of life; however, it is important to note that these medications can also be misused. As a result, both the State of Texas and the Federal Drug Enforcement Administration regulate their use. Our practices follow those laws and have adopted the following policy:

Our Policy

- Please allow 72 business hours for prescription request processing.
- Written prescriptions will not be replaced if lost, stolen, destroyed, or misplaced.
- Prescriptions are to be taken as directed. Do not change the frequency of the dose unless otherwise directed by your provider. If a change does occur, this will be documented in your chart.
- By law, controlled substances cannot be refilled over the phone.
- Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in our office in the last three months, prescriptions for the following medications cannot be refilled. Exceptions to this must be discussed with your provider 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.
- If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, contact our office and schedule an appointment.
- Refills will not be authorized at night, on weekends, or on holidays. Please plan ahead to be sure you have enough medication.
- Before you visit our practice, please check your supply of medication. If you need refills, please ask for them during your appointment.
- 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 your provider during an office visit. Exceptions will not be granted over the phone.
- Refill requests for prescriptions not prescribed by your provider will not be authorized.
- Please do not contact the office more than once about a medication or refill. Your provider is the only person who can approve 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 this policy and understand that this signed policy will be scanned into my chart. I understand that if I do not adhere to this policy or do not use my prescribed medications as directed or overuse my prescribed medications, North Texas Diabetes & Endocrinology and my health care provider may terminate the provider-patient relationship.

Patient Name (please print)

Date of Birth

Signature of Patient, Parent, or Legal Guardian

Date

RELEASE YOUR PROTECTED HEALTH INFORMATION - PROVIDERS

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

I, Date of Birth , hereby authorize the

Providers listed below to release all medical information to:

North Texas Diabetes & Endocrinology and its affiliated practices.

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

Please list the names and fax numbers of the providers/doctors you see so they may share your records with us.

Provider/Doctor Name	Fax Number

I hereby authorize the above-mentioned provider/facility to release and/or disclose the medication information as indicated below to: Premier Independent Physicians and its affiliated practices. I also understand this information may contain information related to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health conditions/diagnosis, and alcohol and/or substance abuse.

Effective Time Period: This authorization is valid until the death of the individual, the individual reaching the age of majority, permission is withdrawn, or the following specific date:

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Premier Independent Physicians and its affiliated practices. I understand that prior actions taken in reliance on this authorization will not be affected.

Please specify records to be released and/or disclosed.

☐ Entire Medical Record	☐ History and Physical	☐ Chart Summary	☐ Labs	☐ Radiology	☐ Pathology
☐ Other (please specify)					

Your initials are required to release the following information.

Mental Health Records (excluding psychotherapy notes)	Genetic Information (including testing results)
Drug, Alcohol, or Substance Abuse Records	HIV/AIDS Test Results and/or Treatment

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

Patient Name (please print)

Signature of Patient, Parent, or Legal Guardian

Date

MEDICAL HISTORY

What is the reason for your visit today and when did your problem symptoms begin?

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Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Yes	No	Condition
		Acid Reflux			Hepatitis B
		Alcoholism			Hepatitis C
		Allergy Problems			Hernia
		Anemia			High Blood Pressure
		Anxiety			High Cholesterol
		Artery/Vein Problems			Human Immunodeficiency Virus (HIV)
		Arthritis			Irregular Heart Rhythms
		Asthma			Irritable Bowel
		Autoimmune Disease			Kidney Disease
		Bipolar Disorder			Liver Disease
		Bladder Irritability			Lung Disease
		Bleeding Problems			Mental Illness
		Blood Clots			Migraines
		Cancer			(MRSA)
		Cataracts			Osteoporosis
		Chronic Pain			Post-Traumatic Stress Disorder
		Colitis/Crohn's			Recurrent Skin Infections
		Depression			Recurrent Urinary Tract Infections
		Diabetes			Schizophrenia
		Esophagitis, Ulcers			Seizures
		Fractures			Sleep Apnea
		Gallstones			Sexually Transmitted Infections (STIs)
		Glaucoma			Stroke
		Gout			Substance Abuse
		Headaches			Suicide Attempts
		Hearing Impairment			Suicidal Thoughts
		Heart Attack			Tuberculosis
		Heart Disease			Thyroid Disease
		Heart Valve Problems			Vision Impairment
		Hepatitis A			Other

SURGICAL HISTORY

(LIST THE MOST RECENT DATE FOR ANY SURGERIES/EXAMS OF THE FOLLOWING)

Appendectomy		Coronary Artery Bypass Graft	
Back Surgery		Hysterectomy	
Cardiac Catheterization		Implantable Defibrillator	
Cardiac Stent		Inguinal Hernia Repair	
Carotid Endarterectomy		Mastectomy	
Cataract Surgery		Permanent Pacemaker	
Cesarean Section		Tonsillectomy	
Cholecystectomy		Other: _____	

Patient Name: _____

FAMILY HISTORY

Please list the blood relatives who have been diagnosed with the following conditions:

Condition	Mother	Father	Grandmother	Grandfather	Brother	Sister	Other	Other	Condition	Mother	Father	Grandmother	Grandfather	Brother	Sister	Other	Other
Acid Reflux									Hepatitis B								
Alcoholism									Hepatitis C								
Allergy Problems									Hernia								
Anemia									High Blood Pressure								
Anxiety									High Cholesterol								
Artery/Vein Problems									Human Immunodeficiency Virus (HIV)								
Arthritis									Irregular Heart Rhythms								
Asthma									Irritable Bowel								
Autoimmune Disease									Kidney Disease								
Bipolar Disorder									Liver Disease								
Bladder Irritability									Lung Disease								
Bleeding Problems									Mental Illness								
Blood Clots									Migraines								
Cancer									Methicillin-resistant Staphylococcus aureus (MRSA)								
Cataracts									Osteoporosis								
Chronic Pain									Post-Traumatic Stress Disorder								
Colitis/Crohn's									Recurrent Skin Infections								
Depression									Recurrent Urinary Tract Infections								
Diabetes									Schizophrenia								
Esophagitis, Ulcers									Seizures								
Fractures									Sleep Apnea								
Gallstones									Sexually Transmitted Infections (STIs)								
Glaucoma									Stroke								
Gout									Substance Abuse								
Headaches									Suicide Attempts								
Hearing Impairment									Suicidal Thoughts								
Heart Attack									Tuberculosis								
Heart Disease									Thyroid Disease								
Heart Valve Problems									Vision Impairment								
Hepatitis A									Other								

Is your mother living? ☐ Yes ☐ No If not, what was the cause of death? _____

Is your father living? ☐ Yes ☐ No If not, what was the cause of death? _____

Is there anything else about your or your family's medical history we should know?

SMOKING STATUS

Check One	
☐	Current every day smoker (an individual who has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes every day)
☐	Current every day smoker (an individual who has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes periodically, yet consistently)
☐	Former smoker (an individual who has smoked at least 100 cigarettes during his/her lifetime but does not currently smoke)
☐	Never smoker (an individual who has not smoked at least 100 cigarettes during his/her lifetime)
☐	Smoker, current status unknown (an individual who has smoked at least 100 cigarettes during his/her lifetime, but whether they currently still smoke is unknown)
☐	Unknown if ever smoked (unknown if an individual has ever smoked)
☐	Heavy tobacco smoker (an individual who smokes more than 10 cigarettes per day, or an equivalent quantity of cigar or pipe smoke)
☐	Light tobacco smoker (an individual who smokes less than 10 cigarettes per day, or an equivalent quantity of cigar or pipe smoke)

SOCIAL HISTORY

Alcohol

☐ Social alcohol use
 ☐ Denies alcohol use
 ☐ Drinks alcohol regularly
 ☐ Occasional alcohol use

Diet

☐ ADA
 ☐ Low Calorie
 ☐ Low Salt
 ☐ High Protein
☐ Low Fat
 ☐ Regular

Illicit Drugs

☐ Caffeine
 ☐ Marijuana
 ☐ Oxycodone
 ☐ Cocaine
☐ No history of illicit drug use

Marital Status

☐ Has children
 ☐ Widowed
 ☐ Lives with partner
 ☐ Single
☐ Divorced
 ☐ Lives w/roommate
 ☐ Married

Working Status

☐ Currently working
 ☐ Homemaker
 ☐ Retired
 ☐ Works part time
☐ Full time student
 ☐ Part time student
 ☐ Unemployed

ALLERGIES

☒ No known allergies

Please include medication, food, latex, and environmental allergies):

Allergy to:			
Severity:	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe
Reaction:			

Patient Name:

CURRENT MEDICATIONS

LIST ANY MEDICATIONS INCLUDING NON-PRESCRIPTION, VITAMINS, AND SUPPLEMENTS. PLEASE INCLUDE THE DRUG NAME, DOSE, HOW MANY TIMES PER DAY, & HOW LONG YOU HAVE BEEN TAKING THE MEDICATION

1		5		9	
2		6		10	
3		7		11	
4		8		12	

HEALTH MAINTENANCE

(LIST THE MOST RECENT DATE FOR EACH OF THE FOLLOWING)

WOMEN ONLY	BOTH MEN AND WOMEN	MEN ONLY
Menstrual period	Cholesterol testing	Digital rectal exam
Mammogram	Colonoscopy/ Cologuard	PSA (prostate blood test)
Pap Smear	Bone Density (DEXA)	

IMMUNIZATIONS

(LIST THE MOST RECENT DATE FOR EACH OF THE FOLLOWING)

(PLEASE PROVIDE CURRENT IMMUNIZATION RECORDS FOR MINORS)

Tetanus vaccination		Hepatitis B vaccination	
Flu vaccination		COVID vaccination	
Pneumonia vaccination		Shingles vaccination	

PAST PHYSICIANS AND HOSPITALIZATIONS

Doctor/Clinic Name	Length of Treatment	Location (City/State)	Reason for Treatment

Have you ever been hospitalized?

☐ No ☐ Yes (If yes, please provide information below.)

Doctor/Clinic Name	Dates of Stay	Location (City/State)	Reason for Treatment