North Texas Diabetes & Endocrinology

NEW PATIENT FORM

PATIENT DEMOGRAPHICS & INSURANCE

Patient Last Name: Test | First Name: Test | MI: Test | Preferred Name: Test

Mailing Address: Test | City: Test | State: Tes | 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: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Sex: ☐ Male ☐ Female

Date of Birth

Race:

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

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

Ethnicity:

☐ 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.

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.ntxdiabetes.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**

Patient Name:

MEDICAL HISTORY

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

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:
Acid Reflux								
Alcoholism								
Allergy Problems								
Anemia								
Anxiety								
Artery/Vein Problems								
Arthritis								
Asthma								
Autoimmune Disease								
Bipolar Disorder								
Bladder Irritability								
Bleeding Problems								
Blood Clots								
Cancer								
Cataracts								
Chronic Pain								
Colitis/Crohn's								
Depression								
Diabetes								
Esophagitis, Ulcers								
Fractures								
Gallstones								
Glaucoma								
Gout								
Headaches								
Hearing Impairment								
Heart Attack								
Heart Disease								
Heart Valve Problems								
Hepatitis A								

Condition	Mother	Father	Grandmother	Grandfather	Brother	Sister	Other:	Other:
Hepatitis B								
Hepatitis C								
Hernia								
High Blood Pressure								
High Cholesterol								
Human Immunodeficiency Virus (HIV)								
Irregular Heart Rhythms								
Irritable Bowel								
Kidney Disease								
Liver Disease								
Lung Disease								
Mental Illness								
Migraines								
Methicillin-resistant Staphylococcus aureus (MRSA)								
Osteoporosis								
Post-Traumatic Stress Disorder								
Recurrent Skin Infections								
Recurrent Urinary Tract Infections								
Schizophrenia								
Seizures								
Sleep Apnea								
Sexually Transmitted Infections (STIs)								
Stroke								
Substance Abuse								
Suicide Attempts								
Suicidal Thoughts								
Tuberculosis								
Thyroid Disease								
Vision Impairment								
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?

_____

_____

_____

Patient Name:

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