

New Patient Registration Guide

Please use this form to fax or email back to our office
at least 7 days prior to your appointment.

TO: **New Patient Registration** FROM: _____
FAX: **301-977-5151** DATE: _____
EMAIL: **info@washendo.com** PAGES: _____

The following are attached:

- _____ Patient Registration Form
- _____ Privacy Notice (HIPAA)
- _____ Consent for Release of Information/Cancellation Policy
- _____ Medical History Form
- _____ Medication History Form
- _____ Most recent test pertaining to your visit (last 12 months)

**Also bring
with you:**

- Photo ID
- Insurance Card
- Referral from your primary care physician (PCP) if required

Patient Registration Form

Patient Name			<i>First</i>	<i>Middle</i>	<i>Last</i>
Date of Birth			Social Security Number		
Marital Status			Sex		
Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <input type="checkbox"/>			Male <input type="checkbox"/> Female <input type="checkbox"/>		
Email (to be used for the patient portal)					

Home Address		
City	State	Zip Code
Home/Cell Phone		Work Phone

Employer (or previous employer, if retired)		Occupation
Address		
City	State	Zip Code

Spouse/Parent/Family Member Name		Relationship
Address		
City	State	Zip Code
Home Phone		Work Phone

Referring Physician	Phone Number
Preferred Pharmacy Name	Preferred Pharmacy Phone Number

Primary Insurance

Secondary Insurance

Name of Insurance Company		
Policy Number		
Group Number		
Policy Holder's Name		
Policy holder's Date of Birth		
Employer		

Policy Concerning Payment of Medical Bills

Our policy is that co-payments are to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. You are responsible for payments on your account for any past due balances. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above. Payments are accepted in the form of cash, check, or money order.

Patient Name

Date

Current Medication History

Patient Name: _____

Date of Birth: _____

Medications: List your prescribed drugs, over-the-counter drugs, vitamins and herbal supplements

Name of Drug	Strength/Dose	How often

Allergies: List any allergies or adverse reactions to medications or other substances – please list drug name and allergic reaction

Name of Drug	Allergic Reaction

Medical History (last 3 months only)

Patient Name: _____

Date of Birth: _____

Eyes	Y	N
Discharge	___	___
Dry eyes	___	___
Itchy eyes	___	___
Pain	___	___
Droopy eyelids	___	___
Redness	___	___
Scratching sensation	___	___
Swelling	___	___
Tearing	___	___
Vision difficulties	___	___
Vision loss	___	___

Ear/Nose/Throat	Y	N
Hearing loss.	___	___
Altered sense of smell.	___	___
Tooth condition.	___	___
Gum condition.	___	___
Trouble swallowing.	___	___
Hoarseness.	___	___
Throat pain.	___	___
Cough.	___	___

Respiratory	Y	N
Cough	___	___
Cough with blood	___	___
Shortness of breath	___	___
Wheezing	___	___

Cardiac	Y	N
Chest discomfort	___	___
Chest pain	___	___
Chest pressure	___	___
Cold hands and feet	___	___
Blue discoloration of skin	___	___
Shortness of breath with exercise	___	___
Swelling of legs	___	___
Shortness of breath when lying down	___	___
Heart racing	___	___

Stomach/Intestine	Y	N
Abdominal pain	___	___
Abdominal distention	___	___
Feeling bloated	___	___
Change in bowel movements.	___	___
Change in bowel habits	___	___
Food intolerance	___	___
Heartburn	___	___
Indigestion	___	___
Yellowing of the skin	___	___
Loss of appetite	___	___
Loss of weight	___	___
Nausea	___	___
Reflux	___	___
Abnormal stools	___	___
Blood in stool	___	___
Trouble swallowing	___	___
Vomiting	___	___

Urinary	Y	N
Abnormal menstruation history.	___	___
Sexual dysfunction.	___	___
Urinary problems	___	___

Muscular/Skeletal	Y	N
Recent joint pain	___	___
Muscle cramps	___	___
Muscle pain	___	___

Neurological	Y	N
Balance problems	___	___
Concentration difficulties	___	___
Dizziness	___	___
Headache	___	___
Loss of consciousness	___	___
Numbness (finger/toes)	___	___
Memory lapse	___	___
Muscle weakness	___	___
History of seizures	___	___
Speech difficulties	___	___
Tremors (fingers/hand)	___	___

Mood Disorders	Y	N
Change in personality	___	___
Depression.	___	___
Irritability.	___	___
Hyperactivity.	___	___
Nervousness.	___	___
Forgetfulness.	___	___
Mood swings	___	___
Restlessness.	___	___
Insomnia	___	___
Unusual behavior	___	___

Endocrine	Y	N
Change in hair (head/body)	___	___
Hoarseness.	___	___
Change in energy level	___	___
Excessive sweating.	___	___
Increase thirst	___	___
Increase hunger	___	___
Increase urination	___	___
Hot flashes.	___	___
Breast lactation.	___	___
Decrease sex drive.	___	___
Menstrual irregularities	___	___
Muscle weakness.	___	___
Brittle bones.	___	___
Increase acne.	___	___
Increase skin pigmentation.	___	___
Dry skin.	___	___
Oily skin.	___	___
Temperature intolerance	___	___
Recent weight increase	___	___
Recent weight decrease	___	___

Blood Disorders	Y	N
Easy bleeding	___	___
Easy bruising	___	___
Persistent swelling of lymph nodes	___	___

Allergies	Y	N
Seasonal	___	___
Environmental (animal/dust)	___	___

Consent for Release of Information for Treatment, Payment and Health Care Operations

I hereby authorize Washington Endocrinology, to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Washington Endocrinology can refuse to treat me.

I have received a copy of the Notice of Privacy Standards ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations.

I understand that I may revoke this consent at any time by notifying Washington Endocrinology, in writing, but if I revoke my consent, such revocation will not affect any actions that Washington Endocrinology, took before receiving my revocation. I understand that Washington Endocrinology has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Washington Endocrinology restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Washington Endocrinology, does not have to agree to such restrictions, but that once such restrictions are agreed to Washington Endocrinology, must adhere to such restrictions.

Cancellation/Reschedule Policy

Our medical practice will be charging patients for failure to cancel or reschedule office appointments on a timely manner. This is due to the increase of patients not showing up for their appointments, and not giving us the courtesy of canceling or rescheduling them in advance.

We require **1 business day notice** should you find it necessary to cancel or reschedule your office appointment. If you fail to notify, within the time frame, you will be charged **\$50 for existing patients or \$100 for new patients**. These fees are not covered by health insurance companies or Medicare, and will be the responsibility of the patient.

Thank you for your cooperation.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to the patient

Privacy Notice (HIPAA)

The Department of Health and Human Services, Office of civil rights, under the Public Law 104-191, (The Health insurance Portability and Accountability Act of 1996) (HIPAA), mandates that we issue this new revised Privacy Notice to our patients. This notice to our patients meets all current requirement as it relates to Standard for Privacy of individually Identifiable Health information (IIHI); affecting our patients. You are urged to read this notice.

Our Privacy Notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: "any information, whether oral or recorded in any form or medium, that is created or received by a covered entity, that relates to the past, present or future physical or mental health or condition of an individual, the provision of healthcare to an individual, or the past, present, or future, payment for the provision of healthcare to an individual that identifies the individual or, with respect to which there is reasonable basis to believe that the information can be used to identify the individual."

Our office will use and/or disclose your PHI for purpose of treatment, payment and other healthcare operations. It is our policy to control access to your PHI to only those who have a need to know; and even in cases where access is permitted, we exercise a "minimum necessary information" restriction to that access.

An Authorization differs from a Privacy Notice in that it is very specific with respect to the information allowed to be disclosed or used, the entity to which the information may be disclosed, the intent for which it may be disclosed, and the time frame of the authorization and used only for one specific request for information. In the event of a non-healthcare related request for personal health information this office will insist that the requestor have you complete an Authorization Form.

You, as our patient, may restrict the use or disclosure of an authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke an Authorization you must provide this office with a written request with your signature and date and provide instructions regarding the exiting Authorization or consent. Any revocation will not apply to information already used or disclosed. If you had a "personal representative" initiate as Authorization you may revoke that authorization at any time.

(continued on other side)

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to the patient

You may request to examine your healthcare information, may request copies of your information, and may request amendments to your information. The physician or principal will exercise professional judgment with regards to request for amendments and by law may reject the request. If we agree with the request to amend the information, we will abide by the changes.

In limited circumstance, the Privacy Standard permits, but does not require, covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities. These permitted disclosures include: identification of the body of a deceased person, or to assist in determining the cause of each; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the healthcare system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

There are specific state laws that require the disclosure of healthcare information related to communicable diseases like Hepatitis C, and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail.

All of these disclosures could occur previously under former laws and regulations however; The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgments to decide whether to disclose any information, reflecting our own policies and ethical principles.

On occasion we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another healthcare provider for further treatment or additional services. Although we will institute a "chain of trust" contract with our business associates, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way that is not permitted by the HIPAA Privacy Standard. It is our practice to retain information about non-healthcare related requests for your healthcare information for a period of six years.

The law requires us to obtain your signature on this Privacy Notice to indicate only that you have received it. It is the law that your rights are communicated in this manner.

In complying with the Privacy Standard, we have appointed a Privacy Office, trained our Privacy Office and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security process to guard and protect your PHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

Please sign below and date the form indicating, only, that you have received this Privacy Notice.

Thank you,