Name_____ Date of Birth_____ Sex: □M □F

**Email Address**_____ Marital Status: Single / Married / Divorced / Widowed

Phone Number(s) – specify if home or cell _____

Primary Insurance_____ Secondary Insurance_____

Name of Primary Care Physician_____

Pharmacy Name_____ Pharmacy City/Street _____

Emergency Contact Name_____ Emergency Contact Phone_____

**List ALL medications (or attach complete list). If taking insulin, *please specify if using insulin pens or vials***

| Name of Medication | Dosage | # of Times per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you have any **drug allergies** to medications? □ NO □ YES (If YES, please list below)

| Drug | Reaction |
|---|---|
| | |
| | |
| | |

**Have you ever had:**

□Diabetes □Heart Disease □High Blood Pressure □High cholesterol □Stroke

□Hypothyroidism □Hyperthyroidism □Thyroid nodule □ Thyroid cancer □Radiation

□Osteoporosis □Kidney failure □COPD/emphysema □ Other cancer:

| Surgery | Month/Year |
|---|---|
| | |
| | |
| | |

Do you use tobacco? □YES □NO Did you use tobacco in the past? □YES □ NO

Have you had a drink containing alcohol in the past year? □YES □ NO

**Family History:**

| **Relationship** | **Diabetes** | High Blood Pressure | Heart Disease | Stroke | Cancer | Thyroid Cancer | HYPOthyroidism (UNDERactive) | HYPERthyroidism (OVERactive) | Osteoporosis |
|---|---|---|---|---|---|---|---|---|---|
| **Father** | | | | | | | | | |
| **Mother** | | | | | | | | | |
| **Siblings** | | | | | | | | | |
| **Daughter** | | | | | | | | | |
| **Son** | | | | | | | | | |
| **Paternal Grandfather** | | | | | | | | | |
| **Paternal Grandmother** | | | | | | | | | |
| **Maternal Grandfather** | | | | | | | | | |
| **Maternal Grandmother** | | | | | | | | | |

**Name**_____ **Currently Using Insulin Pump/Dexcom/Libre? Y N**

**Preferred Pharmacy/City/Street**_____

*Circle "Y" for Yes if you have recently experienced any of the following symptoms, otherwise leave blank*

**General/Constitutional**

Fever Y
Weight gain Y
Weight loss Y

**Ophthalmologic/Eyes**

Blurred vision Y
Eye pain Y

**ENT (Ear/Nose/Throat)**

Difficulty swallowing Y
Sore throat Y

**Endocrine**

History of radiation to the head or neck Y
Cold intolerance Y
Excessive thirst Y
Heat in tolerance Y

**Respiratory**

Shortness of breath Y
Cough Y
Wheezing Y

**Cardiovascular**

Chest pain Y
Dizziness on standing Y
Fluid accumulation in legs Y
Palpitations Y

**Gastrointestinal**

Abdominal pain Y
Constipation Y
Diarrhea Y
Heartburn Y
Nausea Y
Vomiting Y

**Hematology/Blood**

Easy bruising Y
Prolonged bleeding Y

**Women**

Decline in sexual desire Y
Heavy bleeding during menses Y
Hot flashes Y
Irregular menses Y
Missed periods Y

**Men**

Low sex drive Y
Erection problems Y

**Genitourinary**

Frequent urination Y
Painful urination Y

**Musculoskeletal**

Muscle aches Y
Painful joints Y

**Podiatric/Feet**

Foot numbness Y
Foot pain Y

**Skin**

Hives Y
Rash Y

**Neurologic**

Headache Y
Tremor Y

**Psychiatric**

Anxiety Y
Depressed mood Y

**Additional Comments:**

**ACKNOWLEDGEMENT**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES(HIPAA)**

**Ann Arbor Endocrinology and Diabetes Associates, P.C.**

Protected health information (PHI), about you, is maintained as an electronic record of your contacts or visits for healthcare services with our practice. PHI is information about you, including demographic information (i.e., name address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health services.

Our practice is required to follow specific rules on maintain the confidentiality of your PHI, using your information, and disclosing and sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

By signing below, I acknowledge that I have received the notice of Privacy Practices from Ann Arbor Endocrinology and Diabetes Associates, P.C.

_____ _____

Patient Signature Date

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**Documentation of Failure to Obtain Signed Acknowledgment**

On_____,_____presented this Acknowledgment of Receipt of Privacy Form to

(Date) (name of employee)

_____. The patient refused to provide a signature when requested.

(Patient name)

**ANN ARBOR ENDOCRINOLOGY AND DIABETES ASSOCIATES, P.C.**

**FINANCIAL POLICY (revised 07.19.2018)**

Thank you for choosing Ann Arbor Endocrinology as your health care provider. The following is a statement of our policy that outlines patient and practice financial responsibilities.

1. It is your responsibility to provide us with correct insurance information at the time of your appointment. If you are a new patient to us, and do not have your **insurance card and photo ID**, we cannot verify your identity, we will have to reschedule your appointment. As a service to you, we will file a claim to your **primary** and **secondary** insurance **ONLY**. We do not file tertiary claims. Your insurance is a contract between you and your insurance company, we are not part of that contract, and we cannot guarantee payment of your claims. If your insurance pays only portion of your claim, or rejects entirely, you must follow up with them as any explanation should be made to you, their policy holder.

2. **Co-payments** and all outstanding balances are due at the time of check-in. We accept cash, check, money order, credit cards, HSA debit cards.

3. Additional balances due, if applicable, will be billed to you after insurance carrier has processed the claim. You will have **30 days** to pay balance **in full** unless other arrangement has been made with our office. We do offer payments on line through secure patient portal www.annarborendo.com. After 60 days, delinquent accounts will be forwarded to collection agency and $10.00 fee will be added to your balance to recover our cost for collection. A $30.00 fee will be charged for any NSF checks. **Unpaid balances may result in inability to schedule a follow up appointment.**

4. Some HMO health plans may require a referral to be seen by our doctors. You, **not our office**, are responsible for obtaining an **i**nsurance authorization from your Primary Care Physician prior to your visit. We need to have your referral 3 days before your appointment, or your appointment will be canceled. Patients without proper referral who elect to receive service from the office will be required to make payment in full at the time of service.

5. In the event you are unable to keep your appointment we request, at minimum, a **24-hour notice**. We reserve the right to dismiss any patient that has accumulated two or more missed or late cancelled appointments. You will be notified in writing of such termination. Our physician will continue to serve you for 30 days (unless otherwise specified) allowing you and your referring doctor to make alternative arrangements for your care. If you are more than 15 minutes late to your scheduled visit we will have to reschedule your appointment.

6. Ann Arbor Endocrinology is a part of Patient Centered Medical Home (PPP). We are committed to providing you with the best care possible to reach your goals and improve your overall health through timely, appropriate, and coordinated care. If you are not satisfied with your current provider we will not switch within this office. We will be happy to forward your records to any endocrinologist you choose outside this practice.

By signing below, I acknowledge that I have read and understand the information presented above and agree to be fully responsible for any and all charges rendered and not covered by my insurance plan.

I acknowledge receiving a copy of PPP brochure.

Print Name_____ Signature_____ Date _____

# Limited Patient Authorization for Disclosure of Protected Health Information

**Ann Arbor Endocrinology and Diabetes Associates, P.C.**

Patient Name:_____Date of Birth: _____

I authorize Ann Arbor Endocrinology and Diabetes Associates, P.C to disclose or provide my protected health information (PHI) about me to the individual(s) listed below.

Individual Name: _____

Relationship to patient: _____

Phone number: _____

Individual Name: _____

Relationship to patient: _____

Phone number: _____

Please select all categories of PHI to be released to the entity above.

[] complete health record

[] clinical information only

[] financial information only

[] other specify _____

This authorization will expire after one year of the date of your signature below. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your PHI disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, andwill no longer be the responsibility of Ann Arbor Endocrinology. You have the right to terminate this authorization at any time by submitting a written request to us.

Patient or representative signature:_____Date: _____

**Ann Arbor Endocrinology & Diabetes Associates Patient Portal Access**

_____

Patient's printed name

_____

Patient's email address

The Following agreements and procedures relate to online communications:

1. Ann Arbor Endocrinology will not forward online communications with you to third parties except as authorized or required by law for treatment or billing purposes.
2. Online communications should be used for limited purposes only, and should never be used for emergency or time-sensitive matters. Urgent matters should only be handled via other means of communication such as telephone or existing emergency communication tools.
3. Ann Arbor Endocrinology will strive to respond to online requests in a timely manner, but it is your responsibility for determining if an unanswered online communication was not received. Therefore, if you do not receive a response from the practice in a timely fashion either by phone, mail or patient portal please be sure to contact the practice to follow up.
4. You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication between AAEDA and me via the patient portal and consent to the conditions herein. In addition, I agree to the instructions outlined above, as well as any other instructions that AAEDA may impose to communicate with patients via the patient portal. Any questions I may have had were answered.

_____

Patient signature Date

**External Prescription History**

In order to ensure that your medication list is current and accurate, your doctor may need to access your prescription history through your pharmacy. By signing below, you give permission to allow AAEDA to access your External Rx history.

_____

Patient signature Date

# Telemedicine Service Consent Form

Patient: _____ Date of Birth _____

Informed Consent for Telemedicine Services

- I understand that telemedicine is the use of electronic information and communication technologies by Ann Arbor Endocrinology, used to deliver services to an individual when he/she is located at a different site other than the office of Ann Arbor Endocrinology.

- I understand that the telemedicine visit will be done through a two-way HIPPA-compliant video link-up. The doctors at Ann Arbor Endocrinology will be able to see my image on the screen and hear my voice. I will be able to hear and see the doctors at Ann Arbor Endocrinology.

- I understand the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.

- I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care and treatment.

- I understand that by signing this form that I am consenting to receive health care services via telemedicine.

Patient or Guardian: _____ Date: _____
(Print Name)
Patient or Guardian: _____ Date: _____
(Signature)