WASHINGTON ENDOCRINOLOGY

806 West Diamond Ave, Ste 310
Gaithersburg, MD 20878
p 301-977-0056
f 301-977-5151
info@washendo.com

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

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Patient Registration Form

Patient Name *First* *Middle* *Last*	
Date of Birth	Social Security Number
Marital Status Single ❒ Married ❒ Divorced ❒ Widow(er) ❒	Sex Male ❒ Female ❒
Email (to be used for the patient portal)	

Home Address		
City	State	Zip Code
Cell Phone	Home/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

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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

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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)		

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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

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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 that 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 enclose 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 IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliant with the law.

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

Thank you,