ENDOCRINE & ONCOLOGIC SURGICAL ASSOCIATES

SPECIALIZING IN DISORDERS OF THE THYROID AND SURGERY FOR CANCER

NEW PATIENT INFORMATION

Name: ____

Last **First** **Middle**

Date of Birth: ____

Social Security Number: ___________________________________

Address: ____

____

Cell: _____________________ **Home:** _____________________ **Work:** __________________

Email: ____

Emergency Contact: ____

Name **Relationship** **Phone**

Primary Care Provider: ____

Referring Physician: ____

Endocrinologist: ____

Who above would you like your records sent? ____

Reason for today's Visit: ____

When would you estimate the problem began/was discovered: _________________________

Ethnicity: __________________________

In general the **HIPAA** privacy rule gives individuals the right to request a restriction on uses and disclosures of Protective Health Information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office.

I wish to be contacted in the following manner (check all that apply)

TELEPHONE CORRESPONDENCE

____O.K. to leave message with detailed information

____Leave message with call back number only

WORK PHONE

____O.K. to leave message with detailed information

___ Leave message with call back number only

CELL PHONE

___ O.K. to leave message with detailed information

___ Leave message with call back number only

WRITTEN CORRESPONDENCE

___O.K. to mail to home address

___ O.K. to mail to work address

___ O.K. to email

___ O.K. to fax this number ___________________________

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I hereby grant permission to Dr. Carolyn Garner, staff and contract agencies to openly discuss my healthcare information with the following persons. I understand that this authorization may only be revoked in writing. ***(This section MUST BE COMPLETED in order to discuss care with anyone other than you, including your spouse, children, parents, etc.)***

____

Name ***Relationship*** ***Phone Number***

____

Name ***Relationship*** ***Phone Number***

____

Signature of Patient or Guardian

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AUTHORIZATION TO RELEASE INFORMATION

Endocrine and Oncologic Surgical Associates is authorized to release or request from any hospital or insurance company having coverage on me, any other physician involved in my care, or to the employer if coverage is under a group insurance plan, any medical records or insurance information pertaining to my treatment. Any copy of this authorization shall be considered as effective and valid as the original.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to Endocrine and Oncologic Surgical Associates all rights, title and interest in benefits payable for services rendered by Endocrine and Oncologic Surgical Associates in any policies presented. Said irrevocable assignment and transfer shall be the recovery on said policy (ies) of insurance but shall not be construed to be an obligation of Endocrine and Oncologic Surgical Associates to pursue any such rights of recovery. Provided, however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I hereby authorize the insurance company(ies) presented to pay directly to Endocrine and Oncologic Surgical Associates for all charges incurred or alternatively, for all charges in excess of sums actually paid pursuant to said policy(ies). Any copy of this authorization shall be considered as effective and valid as the original.

I HAVE BEEN PROVIDFED WITH THE OFFICE POLICY INFORMATION PACKET AND HAVE AGREED WITH THESE POLICIES BY SIGNING BELOW.

_______________________________________ ___________________________

SIGNATURE OF PATIENT OR GUARDIAN DATE

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MEDICATIONS LIST	DOSAGE
MEDICATION ALLERGIES:	

PHARMACY OF CHOICE: ____

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REVIEW OF SYMPTOMS

Check All That Apply

CONSTITUTIONAL
- ❑ Nausea
- ❑ Low Energy
- ❑ Vomiting
- ❑ Difficulty Sleeping
- ❑ Weakness
- ❑ Weight Gain
- ❑ Weight Loss

EARS/NOSE/THROAT
- ❑ Inability to shout/sing
- ❑ Sensation that something is stuck in your throat
- ❑ Pain with speaking
- ❑ Voice changes (hoarseness/raspy)
- ❑ Chocking sensation
- ❑ Clearing throat often
- ❑ Ear pressure and pain

CARDIOVASCULAR
- ❑ Chest pressure/pain
- ❑ Light headedness
- ❑ Tachycardia
- ❑ Palpitations

RESPIRATORY
- ❑ Cough
- ❑ Snoring

GASTROINTESTINAL
- ❑ Heartburn
- ❑ Abdominal Pain

MUSCULOSKELETAL
- ❑ Muscle stiffness
- ❑ Muscle cramping
- ❑ Numbness
- ❑ Joint pain
- ❑ Joint swelling

DERMATOLOGIC
- ❑ Dry Skin
- ❑ Hair Loss
- ❑ Brittle Nails

BREAST
- ❑ Breast mass
- ❑ Breast Pain
- ❑ Breast swelling
- ❑ Nipple pain/inversion
- ❑ Nipple Discharge

NEUROLOGIC
- ❑ Attention deficits
- ❑ Numbness
- ❑ Confusion

PSYCHIATRIC
- ❑ Anxiety
- ❑ Panic attacks
- ❑ Suicidal ideation
- ❑ Depression
- ❑ Insomnia

ENDOCRINE
- ❑ Cold intolerance
- ❑ Heat intolerance
- ❑ Goiter
- ❑ Hypothyroid

HEMATOLOGIC
- ❑ Easy Bruising/Bleeding
- ❑ Swollen glands
- ❑ Nights sweats

PHARMACY OF CHOICE: ____.

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Financial Policy

Please Initial:

___ **PAYMENT**: All current balances, co-payments, co-insurance and deductibles are due and payable PRIOR to services being rendered and are require by your insurance to be paid at each visit. We accept cash, check, Visa, MasterCard and American Express.

___ **PAYMENT**: If you have a plan that requires a referral, you will need a referral from your Primary Care Physician. If your insurance requires a referral that is generated through them, you must reach out to your primary care for them to call your insurance. Since we are the specialist, we cannot generate a referral for ourselves. If we have not received this referral prior to your arrival at our office, your appointment will be either rescheduled or your will be responsible for the entire bill. It is your responsibility to know if a referral is required and to obtain one.

___ **INSURANCE BENEFITS**: Please be aware that when a patient requires a visit to a specialist there are diagnostic procedures required for appropriate care that cannot be done by primary care physician. These procedures may be done during the normal course of exam by the specialist. Although necessary as part of routine exams, insurance companies often categorize these as procedures. The possible procedures which are often performed in this practice during your visit include, but are not limited to, ultrasound of the neck and fine needle aspiration. It is important to note that imaging testing done for screening or diagnostic reasons by your referring physician do not replace the need for independent examination by the specialist. Depending on your insurance policy provisions, these procedures and others may fall under a separate benefit other than your office co-pay; such as deductibles and co-insurance. In most cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Therefore, any estimate for services will be considered an estimate only and any payment will be considered a partial payment only until such time that the insurance company processes your claim. Your insurance is a contract between you and your insurance carrier; payment for services is ultimately your responsibility.

___**NO SHOW/CANCELLATION COURTESY**: We are committed to making you an appointment at your earliest convenience; likewise, we require a call at least 24 hours in advance if you are u unable to keep your appointment to allow for other patient to be seen. If you “no show” for your appointment or cancel with less than 24 hour notice, you will be charges a $50.00 fee. Multiple missed appointments or chronic rescheduling of appointments may result in our request for you to find another specialist.

___ **SURGERY RESCHEDULING**: We ask that you be firmly committed to your surgical date and time when scheduling. If you anticipate any personal or financial barriers to keeping your surgery date, we ask that you hold off on selecting the date until those issues are resolved. While we understand that emergencies happen, rescheduling and shuffling of a surgery schedule can be extremely disruptive to other patients.

___**SURGERY DEPOSIT:** If surgery is recommended, you will be required to pay your deductible and or coinsurance no later than 48 hours prior to the date of surgery, excluding the need for emergent procedures or next day surgery. Any quote received for surgery will be considered an estimate only and any payment will be considered a partial payment only until such time as the insurance company processes the claim. If you cancel your surgery for any reason, the deductible will be refunded. Any requests for a payment plan will need to be discussed with the office manager with signed terms of that plan on file, any payment plans will have to be arranged prior to date of service. It is important to understand that our office will inform you of expected charges from our professional fee's only. We are happy to assist if there are questions related to the billing practices of the surgical center or hospital, anesthesia or pathology, but those are billed separately through those entities and our office is responsible only for billing as it relates to the surgeon.

___ **PATIENT BALANCE POLICY:** After filing with the insurance company on file, we will promptly mail you a statement. Payment in full is due upon receipt of this statement and is a courtesy from our office. If you have any questions or dispute the balance it is your responsibility to contact our office within 30 days. If you are unable to pay the balance in full please contact the office manager to discuss a payment schedule or arrangements.

PATIENTS NAME ____

IF MINOR – Signature of parent or guardian: ____

Date: ____