

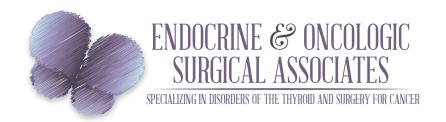
NEW PATIENT INFORMATION

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:		
	our records sent?	
Reason for today's Visit:		
	he problem began/was discove	
Fthnicity:		

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 CORRESPO	NDENCE	
O.K. to leave mess	age with detailed information	
	ch call back number only	
WORK PHONE		
O.K. to leave mess	age with detailed information	
Leave message with	n call back number only	
CELL PHONE		
O.K. to leave messa	age with detailed information	
Leave message with	n call back number only	
WRITTEN CORRESPONI	<u>DENCE</u>	
O.K. to mail to hom	e address	
O.K. to mail to wor	k address	
O.K. to email		
	nber	
<u>AUTHOR</u>	IZATION TO DISCUSS PROTECTED HEA	LTH INFORMATION
I hereby grant permissi	on to Dr. Carolyn Garner, staff and co	ntract agencies to openly discuss
my healthcare informa	tion with the following persons. I undo	erstand that this authorization
may only be revoked in	n writing. <u>(This section MUST BE COMP</u>	PLETED in order to discuss care
with anyone other than	n you, including your spouse, children,	parents, etc.)
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Signature of Patient or	Guardian	-



AUTHORIZATION TO RELEASE INFORMATION

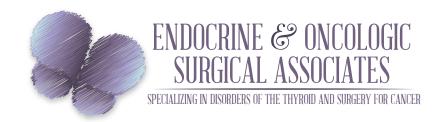
Endocrine and Oncologic Surgical Associates is authorized to release or request from any hospital or insurance company having coverage on me, any other physician involved in my care, or to the employer if coverage is under a group insurance plan, any medical records or insurance information pertaining 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.

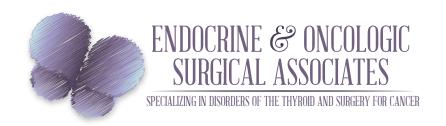
I HAVE BEEN PROVIDED WITH THE OFFICE POLICY INFORMATION PACKET AND HAVE AGREED WITH THESE POLICIES BY SIGNING BELOW.

SIGNATURE OF PATIENT OR GUARDIAN	DATE	



MEDICATIONS LIST	DOSAGE
MEDICATION ALLERGIES:	

PHARMACY OF CHOICE:		



REVIEW OF SYMPTOMS

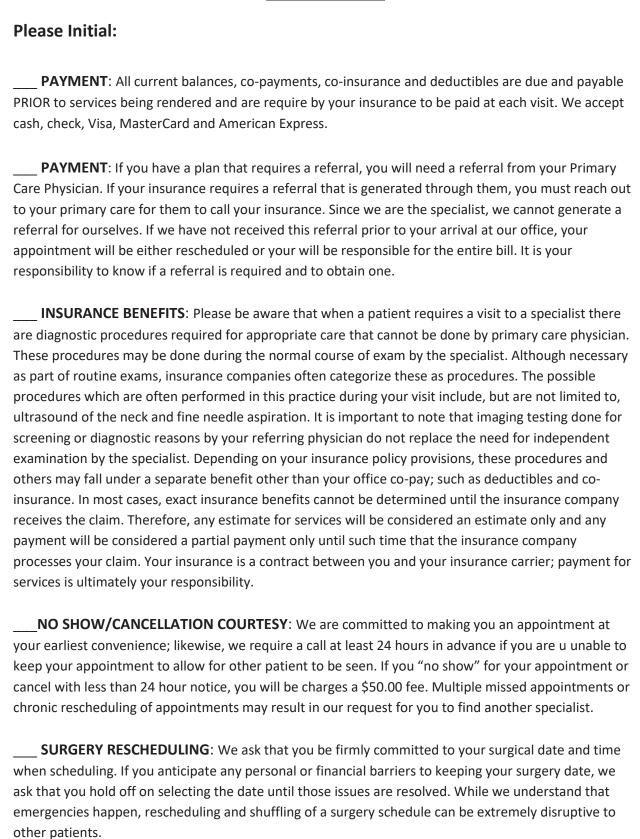
Check All That Apply

CONSTITUTIONAL	RESPIRATORY	NEUROLOGIC
☐ Nausea	Cough	Attention deficits
Low Energy	Snoring	Numbness
VomitingDifficulty Sleeping	GASTROINTESTINAL	Confusion
WeaknessWeight GainWeight Loss	HeartburnAbdominal PainMUSCULOSKELETALMuscle stiffness	PSYCHIATRIC Anxiety Panic attacks Suicidal ideation Depression
EARS/NOSE/THROAT Inability to shout/sing	Muscle crampingNumbness	☐ Insomnia
 Sensation that something is stuck in your throat 	Joint painJoint swelling	ENDOCRINE Cold intolerance
Pain with speakingVoice changes (hoarseness/raspy)	DERMATOLOGIC Dry Skin	Heat intoleranceGoiterHypothyroid
Chocking sensationClearing throat often	Hair LossBrittle Nails	HEMATOLOGIC
☐ Ear pressure and pain	BREAST Breast mass	Easy Bruising/BleedingSwollen glands
CARDIOVASCULAR Chest pressure/pain Light headedness Tachycardia Palpitations	 Breast Pain Breast swelling Nipple pain/inversion Nipple Discharge 	□ Nights sweats

PHARMACY OF CHOICE: _____



Financial Policy



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:
Thirton Signature of parent of guardiani
Date: