

## Endocrine Consultants LLC

70 Jungerman Circle  
Saint Peters, MO 63376  
(636) 441-7174

PATIENT INFORMATION					
NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE		
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN			
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)			
ADDRESS		ADDRESS			
CITY, STATE ZIP		CITY, STATE ZIP			
WORK PHONE		WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)					
NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX	
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE		
RELATIONSHIP TO PATIENT					

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY	POLICY #	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT \$	
CITY, STATE ZIP	DEDUCTIBLE \$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)		
NAME OF INSURANCE COMPANY	POLICY #	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT \$	
CITY, STATE ZIP	DEDUCTIBLE \$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

I request that payment of authorized Medicare and/or insurance benefits be made either to me or on my behalf to the doctor or group indicated on the claim for any services furnished by the physician. I understand that execution of this assignment in no way relieves me of my financial responsibility. I understand I am financially responsible for payment of this account regardless of insurance or third party involvement. If the account is sent to an attorney or collection agency, I will be responsible for any agency or collection fee and/or court cost.

SIGNATURE OF PATIENT/GUARDIAN

DATE

**Endocrinology, Diabetes & Metabolism**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Social Security Number \_\_\_\_\_ Occupation/Employer \_\_\_\_\_

Marital Status:    Single        Married        Divorced        Separated        Widow / er

Spouses Name \_\_\_\_\_ Spouses Occupation / Employer \_\_\_\_\_

Spouses Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Number of Children \_\_\_\_\_ Ages of Children \_\_\_\_\_

Other Contacts – Name / Relationship / Phone Number \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Person / Persons who are authorized to receive medical information regarding you \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referring Physician \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

Names of Other Physicians Involved in your care \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Drug Allergies or Adverse Reactions \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

Reason for Visit \_\_\_\_\_

Previous Medical Problems and Surgeries


Current Medications with Dosage and Frequency / Supplements / Over the Counter Medications


Family History

Disorder	Yes / No	Who?	Disorder	Yes / No	Who?
Diabetes			Pituitary Problems		
Heart Disease			Genetic Disorders		
Cancer			High Cholesterol		
Thyroid Disease			Osteoporosis		
High BP			Parathyroid Problems		
Kidney Stones					

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Habits

Tobacco use: Never\_\_ Currently\_\_ Quit / When \_\_\_\_\_ Cigarettes\_\_ Cigar\_\_ Pipe\_\_ Chew\_\_  
 How many packs? \_\_\_\_\_ Years Smoked \_\_\_\_\_

Alcohol use: Never\_\_ Occasionally\_\_ Daily\_\_ Heavily\_\_ How much and type? \_\_\_\_\_

Recreational Drugs: Never\_\_ Occasionally\_\_ Daily\_\_ Heavily\_\_ How much and type? \_\_\_\_\_

Exercise: Yes\_\_ No\_\_ Type \_\_\_\_\_  
 How long / day and # of times / week \_\_\_\_\_

For Women Only

Age at fist period \_\_\_\_\_ Are periods – Regular? \_\_\_\_\_ Heavy? \_\_\_\_\_ Painful? \_\_\_\_\_

Last Menstrual Period \_\_\_\_\_ #of times pregnant \_\_\_\_\_ # of live births \_\_\_\_\_

Age at Menopause \_\_\_\_\_ Method of Contraception \_\_\_\_\_

Medical History: Do you currently have problems with

PROBLEM	YES	NO	DESCRIBE
Weakness or fatigue			
High Cholesterol			
High Blood Pressure			
Skin			
Eyes / Ears / Nose / Mouth / Throat			
Heart / Chest Pain			
Lung / Breathing			
Stomach / Bowel			
Liver / Spleen / Pancreas			
Kidney / Urinary			
Pituitary Gland			
Adrenal Glad			
Female or Male Organs			
Breast			
Emotional / Psychiatric			
Parathyroid Gland			
Thinning of bones / Osteoporosis / Fr			
Headaches			
Neurological Disease / Stroke			
Allergies			
Arthritis			
Anemia			
THYROID			If yes please answer the following
Overactive (Hyperthyroidism)			
Underactive (Hypothyroidism)			
Radiation for any reason to neck			
Thyroid scans or radioactive iodine			
Other Treatments for thyroid probl			



**Endocrine Consultants, LLC  
Policy**

**PAYMENT POLICIES**

All patients must complete our Patient Information Forms before seeing the doctor. **Payments is due at the time of service unless other arrangements are made in advance.** We are required by contract with your insurance company to collect your co-pay at the time of your office visit. You will be asked to pay your copay and any past due balance before you are seen. If necessary a payment plan can be arranged. We accept cash, check, VISA, Mastercard, & Discover. **Please note:** there is a \$25.00 charge for all returned checks.

**INSURANCE**

You will be asked to present your insurance card for every visit. We may accept your insurance upon receipt of proper documentation and verification of insurance coverage. If you have two insurance plans, the copay for the primary insurance may be collected at the time of service. Once your insurance company has paid its portion of your bill, any remaining balance must be paid within 30 days. We will not become involved in disputes between you and your insurance company regarding covered charges, deductibles, copays, secondary insurance, etc other than to supply the necessary information for your visit.

**MISSED APPOINTMENTS**

Please allow a 24 hour notice for cancellations of your appointments. We reserve the right to charge a \$25.00 missed appointment fee. This charge is not covered by insurance companies. As a courtesy, we make an effort to remind you of your appointments whenever possible. It is your responsibility to cancel or reschedule at least 24 hours prior to your appointment.

**TELEPHONE CALLS**

Please have all routine prescription refills taken care of during our office hours. Non-emergency calls through the exchange will be billed as a \$10.00 teleph one consultation. This also includes calls from your pharmacy to renew overdue prescriptions after normal office hours. Our office hours are Monday – Thursday 8:30AM – 4:30PM and Friday from 8:30AM – 12PM.

**FMLA & DISABILITY FORMS**

There is a charge of \$25.00 for each FMLA or disability form that is filled out by the doctor. Pre-payment is required.

By signing below, I agree to the Endocrine Consultants, LLC policy.

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Patient Signature

Date

## Privacy Statement

Safeguarding your health information is important to us. This statement summarizes some of the Endocrine Consultants, LLC privacy practices that describe how, when and why we may use and disclose your health information, as well as your rights regarding your health information.

The Health Insurance Portability and Accountability Act of 1996, which is the federal law commonly known as "HIPAA," provides certain protections for any of your health information that can be specifically identified as yours. HIPAA permits, and our privacy practices allow, us to use your individually identifiable health information or share it with another health care provider or an insurance company in the following circumstances:

- To treat and care for you, including contacting you for appointment reminders;
- To obtain payment from you or your insurance company; or
- In connection with our health care operations, which are operational activities typically carried on by health providers like quality assessment and improvement, review and/or training of health care professionals, business planning, customer service, grievance resolution, and other general administrative activities.

HIPAA also permits us to use certain health information for the following activities:

- For fund-raising for our facilities;
- When required by law;
- When permitted by HIPAA for such activities including 1) For public health safety 2) To Law enforcement related to its criminal investigations 3) For judicial and administrative proceedings 4) For organ donation 5) For research
- We will also follow other federal and state laws when they provide extra protections regarding your health information.

If our use of disclosure is not for one of the activities described above and is not otherwise permitted under HIPAA, we will ask you to complete a written authorization before we use or release your health information.

When receiving services from us, you will also be able to decide whether to remain listed in our patient history directory and whether we can discuss your health information with your family or friends.

Even if you have provided us with your authorization, you may withdraw that authorization, in writing, at any time to stop our future disclosures of your health information. Information disclosed before you revoke your authorization will not be returned and any actions that we have already taken based on prior authorizations will not be affected.

### Your rights regarding your health information

- 1) **Restricting a Use/Disclosure.** You may request a restriction on how we use or disclose your health information. We are not required to agree to your request and any approved restriction may be followed only to the extent permitted by law.
- 2) **Requesting Confidential Communications.** You may request reasonable changes in how or where we may contact you to remind you of an appointment, for lab results or other health information.
- 3) **Inspecting and Obtaining Copies of Your Health Information.** You may ask, in writing, to look at and/or receive a copy of your health information. There may be a fee associated with your request.
- 4) **Requesting a Change in Your Health Information.** You may request, in writing, a change or addition to your health information. The law limits the types of changes that may be made and we may not erase or delete any information in your records.
- 5) **Requesting an Accounting of Disclosures of Your Health Information.** You may ask, in writing, for an accounting of certain types of disclosures made of your health information. Disclosures made with your authorization will not be included in the accounting.

**You will not be penalized or retaliated against for filing a complaint or voicing a privacy concern.**