# ENDOCRINOLOGY ASSOCIATES, INC.

**Carl H. Bivens, M.D., F.A.C.P., F.A.C.E.**
**Michael H. Koch, M.D., F.A.C.E.**
**D. James Bailey, III, M.D., F.A.C.E.**
**James R. Mulinda, M.D., F.A.C.P., F.A.C.E.**

Dear Patient,

You have been scheduled for the following appointment:

| | |
|---|---|
| **Patient Name** | |
| **Doctor Name** | |
| **Appointment Date** | |
| **Appointment Time** | |

Enclosed you will find your patient history sheets, as well as your personal data sheet. Please complete these items and bring them to your scheduled appointment.

Please allow two hours for your appointment. If you cannot keep your appointment, please notify the office as soon as possible. There will be an office charge for appointments not kept without prior notice of cancellation.

Please make sure the following are completed before arriving at your appointment:

1. New patient information has been completed.
2. Bring a photo ID or alternate form of identification to the office on your appointment date. Alternate forms of identification include a Social Security card, birth certificate, passport, or school ID. Other forms may be accepted at the discretion of Endocrinology Associates, Inc.
3. Check with your insurance to make sure you understand what your co-pay will be to see a specialist, as well as to see if our doctor is a provider in your insurance network.
4. Check with your primary care doctor for a referral if needed. Bring your insurance card(s).
5. Bring a completed medication list and blood glucose records to your appointment.
6. Bring medical records from previous doctor(s) or make sure they have been sent.

If these requirements are not met, we may be required to reschedule your appointment.

As a courtesy to you, our office files directly to your insurance carrier(s). This, however, does not relieve you from the financial responsibility of your medical bill. You will be expected to pay your co-pay before you leave the office at each visit. We will be unable to schedule any return appointments until your co-pay has been received. If you do not have insurance, please understand that you will be expected to pay at least $100.00 at the time of your visit. Should you have any questions, please contact our office.

# ENDOCRINOLOGY ASSOCIATES, INC.

**PATIENT NAME:** _____ **MAIDEN:**_____ **SEX:**_____
FIRST MIDDLE LAST IF APPLICABLE M/F

**ADDRESS:** _____
STREET/ROUTE#/P.O. APT.# CITY STATE ZIP CODE

**HOME PHONE:** (_____)_____ **WORK/CELL:** (_____)_____ **FAX:** _____

**DOB:** _____ **AGE:**____ **STUDENT ?** ____ **MARITAL STATUS:** ____ **E-MAIL:** _____

**SSN:**_____ **PATIENT'S EMPLOYER:** _____

**SPOUSE NAME:** _____ **SPOUSE DOB:** _____ **SPOUSE SSN#:** _____

**SPOUSE EMPLOYER**_____ _ **WORK/CELL PHONE:** _____

**COMPLETE THIS SECTION IF PATIENT IS A MINOR:**

**FATHER'S NAME:** _____ **MOTHER'S NAME:**_____

**FATHER'S SSN#:**_____**MOTHER'S SSN#:** _____

**FATHER'S EMPLOYER:**_____ **MOTHER'S EMPLOYER:**_____

**PERSON RESPONSIBLE FOR PAYMENT:**_____**SSN:**_____**DOB:**_____

**ADDRESS**_____**RELATIONSHIP TO PATIENT:** _____
STREET/ROUTE#/PO BOX APT# CITY STATE ZIP CODE

**EMERGENCY CONTACT INFORMATION:**

**NAME:**_____**PHONE#:**(_____)_____**RELATIONSHIP TO PATIENT:**_____

**NAME:**_____**PHONE#:**(_____)_____**RELATIONSHIP TO PATIENT:**_____

**REFERRING PHYSICIAN:**_____ **PHONE:**(_____)_____

**PRIMARY CARE PHYSICIAN:**_____**PHONE:**(_____)_____

**PLEASE PROVIDE ALL REQUESTED INSURANCE INFORMATION**

Primary Insurance Company:_____

Policyholder Name:_____ DOB:_____

Identification #:_____Group #_____

Insurance Company Address:_____ Phone(_____)_____

Secondary Insurance Company: _____

Policyholder Name:_____ DOB:_____

Identification #:_____Group #_____

Insurance Company Address:_____ Phone(_____)_____

Tertiary Insurance Company:_____

Policyholder Name:_____ DOB:_____

Identification #:_____Group #_____

Insurance Company Address:_____ Phone(_____)_____

# ENDOCRINOLOGY ASSOCIATES, INC.

## DEEMED CONSENT TO HIV BLOOD TESTING

Should a healthcare worker be exposed to my blood/body fluid in a way that would allow transmissions of infection due to blood-borne disease (i.e. HIV, Hepatitis B) or other communicable disease, then I understand, according to Virginia State Law, that for the safety, health, and possible treatment of that person(s), samples of my blood or body fluid may be tested for evidence of infection. I also understand that healthcare workers, including physicians, are obligated to submit to a blood test for certain infectious disease (i.e. HIV, HBV) if I am inadvertently exposed to their body fluids during the course of examination.

**I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT:**

_____ _____

Patient/Patient Representative Signature Date

## CONSENT FOR PAYMENT AND BILLING

Our office strives to provide quality medical care for all our patients. Your insurance company may not make payments for certain "non-covered" medical services that you receive from our physicians. We think the decision on what is medically necessary should be between you and your physician. We are requesting that you sign this form as your Agreement to be financially responsible for payment of your bill, regardless of insurance company reimbursement.

_____ _____

Patient/Patient Representative Signature Date

I hereby authorize **Endocrinology Associates, Inc.** to furnish information to insurance carriers concerning my illness and treatment. I hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Patient/Patient Representative Signature Date

## MEDICARE LIFETIME FORM

Patient Name: _____

Medicare #: _____

I request that payment under the Medicare Insurance Program be made to Dr. _____ for any services furnished by this physician/provider. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine those benefits or the benefits payable to related services.

_____ _____

Beneficiary/Beneficiary Representative Signature Date

# ENDOCRINOLOGY ASSOCIATES, INC.

## Your Medical Records and Your Rights to Privacy

HIPAA stands for the Health Insurance Portability and Accountability Act. This act, implemented by the Department of Health and Human Services, provides important rights and protection for you as a patient. Under Federal guidelines, this act went into effect on April 14, 2003.

As a patient, the release of your medical information is limited to those parties directly involved in your care or the payment of your care. If you would like a copy of your rights as a patient under HIPAA, they are available in our office for your use. In order to provide your treatment coordination, conduct payment reimbursement, and perform activities related to our practice's business and administrative duties, you will need to sign a consent to disclose your Protected Health Information for the purposes of treatment, payment, and healthcare operations. This consent will cover information disclosure to medical providers, pharmacists, opticians, insurance companies, and hospitals

We request that you list friends or relatives that have permission to access your health information if they were to call our practice on your behalf. These individuals will also be allowed to authorize your treatment at office visits. ***By law, we are unable to disclose any part of your health information or account information with any individual unless their name appears on the following list. You have the right to change or modify this list at any time.***

| **Name** | **Relationship** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

_____ _____
Patient/Patient Representative Signature Date

## Consent for Treatment and Disclosure

I understand that as part of my healthcare, **Endocrinology Associates, Inc.** originates and maintains health records describing my health history, symptoms, examination/test results, diagnosis, treatment, and any plans for future care and treatment, as well as any pertinent information regarding my care. I understand that this information serves as the following:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided for
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that the full Consent for Disclosure and Information Practices is available to me if I request a copy from the practice. I understand that if I wish, I may review the Consent for Disclosure and Information Practices before signing this consent. I understand that **Endocrinology Associates, Inc.** reserves the right to change their notice and practices. I also understand, as the patient, that I reserve the right to restrict how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that the practice is not required to agree to these requested restrictions. I understand that if I refuse to sign this consent, **Endocrinology Associates, Inc.** may decline to provide me with treatment.

_____ _____
Patient/Patient Representative Signature Date

# Endocrinology Associates, Inc.

**1030 South Jefferson Street, Suite 200, Roanoke Virginia 24018**
**Phone (540) 344-3276 Fax (540) 342-4055**

**CARL H. BIVENS, M.D., F.A.C.P, F.A.C.E.**
**MICHAEL H. KOCH, M.D., F.A.C.E.**
**D. JAMES BAILEY, III, M.D., F.A.C.E.**
**JAMES R. MULINDA, M.D., F.A.C.P., F.A.C.E.**


## HEALTH HISTORY

**NAME**:_____ **AGE**:_____

**ADDRESS**:_____

**REFERRING PHYSICIAN**: _____ **FAMILY PHYSICIAN**: _____

**CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING. INCLUDE DATES IF POSSIBLE.**

### PAST ILLNESSES

| | | |
|---|---|---|
| Epilepsy | Cancer | Pancreatitis |
| Rheumatic Fever | Diabetes | Bronchitis |
| Kidney Trouble | Heart Disease | Emphysema |
| Kidney Stones | Mental Disorders | Hernia |
| Pneumonia | Eye Disease | Ulcer |
| Thyroid Disease | Tuberculosis | Liver Disease |
| Allergies | Yellow Jaundice | Other |
| Cataracts | Female Trouble | Other |

### OPERATIONS

| | |
|---|---|
| Appendectomy | Tubes Tied |
| Hernia Repair | Ruptured Disc |
| Breast Biopsy | Hemorrhoidectomy |
| D&C | Gallbladder |
| Hysterectomy | Other |
| Abortion | Other |

MEDICATIONS: TAKING NOW _____
ALLERGIES _____

List any significant injuries _____ Accidents _____
Fractures _____

CHILDREN: Number_____ Sexes_____ Ages_____ Birth Weights _____
Total number of pregnancies _____ Miscarriages or Abortions _____

HOSPITALIZATIONS (other than above) _____

SPECIAL STUDIES: Chest X-ray _____ Stomach X-ray_____ Colon X-ray _____ Kidney X-ray _____
Gallbladder X-ray_____ Thyroid Scan _____ EKG_____ Brain Wave _____ Glucose Tolerance _____

PERSONAL HISTORY: How long married_____ Spouse's age_____ Spouse's Health_____
# of marriages _____ Widow(er)?_____ For how long_____ Cause of spouse's death_____
Alcohol_____ Tobacco_____ Packs/day_____ How long have you smoked?_____
Exercise: How much and what kind?_____

SOCIAL HISTORY: Education _____ Church Attendance _____
Occupation: Present _____ Past _____
Veteran _____ Number of Family at Home _____
Previous Residence _____

## FAMILY HISTORY:

| | Living | Dead | Age(s) | State of health now or cause of death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Sisters (number) | | | | |
| Brothers (number) | | | | |

**Has any family member had any of the following? (check and identify which relative)**
**Diabetes _____ Thyroid disease_____**
**High blood pressure _____ Obesity_____**
**Kidney stones_____ Other tendencies_____**

## REVIEW OF SYSTEMS

**MAIN PROBLEM TODAY**:_____

**Do you have any of the present problems or change in symptoms? If so, check those that apply:**

### Endocrine Review of Symptoms:

**Loss of Strength _____**
**Weight over last year: Up _____; Down_____**
**Appetite _____**
**Sleeping _____**
**Depression or Nervousness_____**
**Headaches _____**
**Vision _____**
**Shoe size _____**
**Breast discharge _____**
**Room temperature preference _____**
**Bowel movement frequency _____/day**
**Goiter _____**
**Heart pounding _____**
**Childhood radiation treatment _____**
**Unusual Thirst _____**

**Hair: Loss of_____; Excessive_____**
**Skin _____**
**Pain in Bones _____**
**Pain in Joints _____**
**Itching _____**
**Shaky, sweaty spells _____**
**Acne _____**
**Tanning _____**
**Salt craving _____**
**Nighttime voiding _____**
**Sexual drive _____**
**Intercourse frequency _____**
**Age when periods started _____ stopped _____**
**Last period _____**
**Contraception _____**

### General Review of Systems:

**Hearing loss _____**
**Chest pain _____**
**Shortness of breath _____**
**Number of pillows used _____**
**Cough _____**
**Abdominal pain _____**
**Sore throat _____**

**Tarry stools _____**
**Vomiting _____**
**Gas _____**
**Heartburn _____**
**Bleeding tendency _____**
**Vaginal discharge _____**
**Other _____**

# CONSENT FORM

## For Use and Disclosure of Protected Health Information
## For Treatment, Payment, or Healthcare Options

I understand that as part of my healthcare, Endocrinology Associates, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A course of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and, prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested, other than the exception noted in the *Notice of Information Practices.* I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon. Any patient, guardian, or personal representative has the right to receive confidential communications of protected health information by alternative means or at alternative locations. Such request must be in writing and the Practice must accommodate reasonable request.

With this consent, Endocrinology Associates, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO (treatment, payment, or healthcare options) such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results, among others.

With this consent, Endocrinology Associates, Inc. may mail to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Endocrinology Associates, Inc. may e-mail to me appointment reminders and patient statements. I have the right to request that Endocrinology Associates, Inc. restrict how it uses or discloses my Protected Health Information to carry out TPO. However, the Practice is not required to agree to my requested restrictions except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out of pocket, but if it does, it is bound by this Agreement.

By signing this form, I am consenting for Endocrinology Associates, Inc. to use and disclose my Protected Health Information to carry out my TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Endocrinology Associates, Inc. may decline to provide treatment to me.**

Print Patient Name: _____ Account Number: _____

Signature of Patient or Legal Guardian: _____
Date: _____

# Endocrinology Associates, Inc.

1030 South Jefferson Street, Suite 200, Roanoke, Virginia 24018
Phone (540) 344-3276 Fax (540) 342-4055


**This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.**

## NOTICE OF INFORMATION PRACTICES

1. **Endocrinology Associates, Inc. may use and disclose protected health information for treatment, payment and healthcare options. Treatment examples include, but are not limited to, referrals to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers or collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.**

2. **Endocrinology Associates, Inc. is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health uses or court orders.**

3. **An authorization from the patient is required for uses or disclosures for marketing purposes and for any disclosure constituting the sale of protected health information. No other use or disclosure of a patient's protected health information will be made without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.**

4. **Patients have the right to opt out of any communication involving fundraising. In the event of a breach of unsecured protected health information, a notification will be provided.**

5. **Endocrinology Associates, Inc. will abide by the terms of the notice currently in effect at the time of the disclosure.**

6. **Endocrinology Associates, Inc. reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Endocrinology Associates, Inc. will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.**

7. **Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.**

8. **Any patient, guardian or personal representative has the right to inspect and obtain their medical record.**

9. **Any patient, guardian or personal representative has the right to request amendments be made to their medical record.**

10. **Any patient, guardian or person representative has the right to request a six-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request, and a reasonable charge may be assessed for any copies after the first request in a 12-month period.**

11. **Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out of pocket: but if the Practice does agree, the Practice must abide by those restrictions.**

12. **Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the Practice, please contact the Privacy Officer at the address and/or phone number listed above. All complaints will be addressed and the results will be reported to the Private Officer.**

13. **It is the policy of Endocrinology Associates, Inc. that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.**

| | |
|---|---|
| **Effective date** | **Name of Patient** |
| **Date** | **Signature of Patient or Legal Guardian** |