AUSTIN THYROID & ENDOCRINOLOGY OFFICE POLICIES

New Patient Registration Form

ACCOUNT #

Patient Information

Last Name		First Name		Middle Name
Address(Street or Box)		City	State	Zip
Cell Phone #		Home Phone #		Sex (Check One) ☐ Male ☐ Female
Date of Birth	Age	Social Security #		Driver's License #
Marital Status (Check One) ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Email		
Insurance Name		Occupation /Employer Name		
Primary Care Physician Name		Referring Physician Name		

How did you hear about Austin Thyroid & Endocrinology?

☐ Family/ Friend ☐ Hospital ☐ Insurance ☐ Internet/Website ☐ Location/Drive By ☐ Radio ☐ TV
☐ Google Search ☐ Physician Referral ☐ Magazine

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patien**t or **legal guardian**. If you would like to add additional contacts (other than the patient or legal guardian) that Austin Thyroid & Endocrinology (ATE) is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like (ATE) to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

_____ _____ _____
Contact Name Relationship to Patient Contact Phone Number

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

_____ _____ _____
Contact Name Relationship to Patient Contact Phone Number

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

My preferred method of communication regarding my **medical conditions** is indicated below (**check multiple**):

☐ Cell Phone ☐ Home Phone ☐ Online Portal

If the above method of communication is by phone, please check the appropriate box below (**check one**):

☐ Leave a confidential message with detailed information.

☐ Leave a message with a call-back number only.

My preferred method of **appointment reminders**: (**Check One**) _____(initial)

☐ Phone Call ☐ Text ☐ Email

V9 6/4/20

_____ _____
Patient Signature Date

Patient Information
Due to the many changes in healthcare and our ability to comply with those changes and the growth in our practice, we have designed the following policies and procedure for our office.

Appointments
New appointments are scheduled by phone or by making a request on our website. Return visits are scheduled at the end of your visit at checkout. You will receive a reminder 7 days ahead via phone, text, or email, followed by a second one the day before your appointment. Please call us at least 48 hours ahead to cancel your appointment. If you miss three appointments in a row, you may be discharged from our practice since we cannot provide proper healthcare without you. No shows and late cancellations (made less than 48 hours prior to the appointment) are charged $25.

Lab reporting and Review
When labs or imaging studies are ordered at the new patient visit, they will be discussed 7 to 14 days later at a face-to-face visit in our office. This allows us to discuss treatment options and formulate a plan for patient care. Labs ordered at a routine follow-up visit will be reported to you only if they are abnormal, in which case the contact will be through the portal or by phone with instructions. Test results are confidential medical records and will only be given to the patient. If you would like to designate another person to receive your test results, please ask the receptionist for a HIPAA consent form. Please allow 2 weeks for the processing and review of abnormal labs. Please note that we will not contact you for normal labs. We will not review labs done outside and reviewed by another physician by phone; you will be asked to schedule a visit to discuss the labs.

Nurse Call Backs
To avoid phone tag, the best way to contact our nurses is on the patient portal. Nurses are in clinic from 8:00am-noon and 1pm-4pm. Please leave a phone message if there is no answer. Messages are checked in the morning and after lunch, and we make an effort to reach you the same day or the next business day.

Prescriptions/Refills
Refills will done at the time of your office visit. We will provide 30 and/or 90 day prescriptions at the time of the visit. We utilize electronic prescriptions, so if you are using a mail order company, please notify them when you like your prescriptions filled and shipped. If you need a refill between visits, please do not contact our office. Contact your pharmacy, they will send a refill request on your behalf. Please allow 48 hours for processing of these refills. If your insurance changes and your prescriptions need to be rewritten, there will be a $25 charge. This is not a covered insurance benefit and will be due at the time of pickup or mailing. We will not sign for generic substitutions between visits. All prescription functions must be taken care of at the time of your visit.

Medical Records/Completion of Forms/Letters
We require signed consent to release medical records. A fee is associated with copying of records. Records sent to another provider are sent free of charge in accordance with HIPAA covered entity exclusion. Records may be requested by insurance companies and disability providers; these are released with the consent you have provided to these agencies. If you are requesting the physician to fill out a form for you, a fee of $25 is charged.

Insurance Companies
We are in-network providers for many insurance companies. Insurance companies make changes frequently, so to ensure coverage, please contact your insurance company prior to your visit to determine network status. It is your responsibility to ensure that you are covered before your appointment. You are financially responsible for all charges incurred during your office visit. If your insurance does not cover your visit, you will be billed. If your account is put into collections for non-payment, you will be expected to make a payment on your account prior to scheduling an appointment. All co-pays, co-insurance & deductible payments are due at the time of service.

Letters
If you request that we generate a letter or any document on your behalf, your account will be charged $25. The fee is due when the request is made. This is not a covered insurance benefit and will be billed directly to the patient.

Lost Items
Should you misplace any items generated by this office there will be a $10 charge for replacing them. This is not an insurance benefit and is due at the time of the request. This includes lost prescriptions, labs requisitions, and physician orders for testing.

Social Media

Our clinic uses social media to provide endocrine specific health information to our patients. Remember that whatever you post on social media (Facebook, Twitter, Google, etc.) is published for the world to see. For your own privacy and that of your family, you should consider carefully how much personal medical information you choose to broadcast to the world. If you post a comment on the social media of Austin Thyroid & Endocrinology, you agree to indemnify Austin Thyroid & Endocrinology for any damages, losses, liabilities, judgements, costs or expenses arising out of a claim by a third party relating to any material you have posted. In addition, by posting these comments, you give Austin Thyroid & Endocrinology the right to reproduce, distribute publish, display, edit, modify and otherwise use your comments for any purpose in any form and on any media.

Complementary and Alternative medicine (CAM)

After a thorough evaluation in conventional Medicine Dr Scumpia might provide CAM methods including but not limited to evaluation (BIA, Fibroscan, BMR, CIMT , PhysioAge , biomarkers and others etc.) or treatment (Nutritional products , IPD, First Line therapy , and others etc.) The products are exempt from FDA under the DSHEA (Dietary Supplement and health education Act). These items are not intended to evaluate and treat but have been found to help in some cases.

Phone calls

If you do not keep your appointment and /or had tests done by another MD and want Dr Scumpia and her staff to call you and discuss results and /or plan of care without making an appointment, there will be a charge of $25-$75 depending on the length of the conversation. This is not a covered benefit by your insurance

Audio/Video Recording in office

There is no audio/video recording allowed inside Austin Thyroid & Endocrinology building without expressed written consent from the practice.

Excessive appeals

If an appeal for a diagnostic or treatment procedure will require more than one attempt and/or escalating the request to the medical director of the insurance it will generate a $25 fee to cover the excessive time spent by Dr Scumpia and her staff because your insurance refused to certify the procedure or treatment from the beginning .This is not a covered benefit by your insurance

Consent for evaluation and treatment

I understand that I have a choice in the facilities and /or products used to provide evaluation and treatment for my condition. I also acknowledge and agree that in rendering care of my condition ,ATE may choose to use products in which they have ownership interest and that I have the right to choose to have my evaluation and treatment with other health care facilities . I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as the results of examination, evaluation or treatment.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received the Austin Thyroid & Endocrinology Notice of Privacy Practices, which describes how the practice may use and disclose my healthcare information. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I consent to the use and disclosure of my information for the purposes described in the notice, to the extent permitted by law.

_____

Patient Name (PRINTED) DOB

_____ _____

Patient Signature Date

Financial Policy

Thank you for choosing us to assist you in managing your healthcare. We are committed to providing you quality healthcare and ask that you acknowledge and respect our financial policies as stated below:

- Payment is due at the time of service. We accept cash, checks, Visa, MasterCard, American Express, and Discover.
- Copays, deductibles, and non-covered procedures must be paid at the time of service, per your contract with the insurance company. Copay, coinsurance, and deductible are determined by your insurance company.
- Referrals. If your insurance company requires a referral from your primary care physician, you are responsible to obtain one. If a valid referral is not on file, you need to sign a referral waiver on the appointment day. If we do not receive your referral within 5 days of your appointment, you will be responsible for the cost of services rendered.
- As a courtesy, we will submit a claim to your insurance on your behalf. Please understand that your insurance policy is a contract between you or your employer, and the insurance company. **We are not a party to that contract.** Our relationship is with you, the patient. We cannot become involved in disputes between you and your insurer regarding deductibles, co-insurance, non-covered charges, secondary insurance and "usual and customary" charges.
- We are contracted with certain managed care and preferred provider plans. We are contracted to follow the guidelines for reimbursement and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
- All charges are your financial responsibility. Not all services are benefits. It is your responsibility to verify coverage prior to the appointment. Payments for non-covered services are expected at the time services are rendered.
- If you have not received your insurance explanation of benefits within 30 days of your appointment, please contact your insurance company to expedite payment. Unpaid claims are your financial responsibility. If you insurance company has not paid within 45 days, you may be billed for the charges.
- Outstanding balances, insurance co-pays, co-insurances, and yearly deductible not met will be collected prior to your visit.
- If you have a balance on your account, you will receive a patient statement. A second one follows at 3 weeks, a third one at 6 weeks. If you have not paid your balance after the third statement, your account is sent to collections, and a $25 collection charge is added to your account.
- Returned checks are assessed a $25.00 fee per check. We may convert this to an electronic transaction to recoup.
- Missed appointments are charged a $25.00 no show fee. Late cancellations, that is, cancelling an appointment less than 24 hours ahead, are also charged a $25 no show fee. Stress tests, FNA, and Echos are assessed a $75.00 fee for no shows or late cancellations.
- As with many medical offices, Austin Thyroid & Endocrinology & Dr. Scumpia have a financial interest in some products and vendors to which you may be referred or offered as a part of your medical care. These include Metagenics products, Ideal Protein products, Cornerstone products, Ortho Molecular products, or HMR products. You have the option to use a healthcare facility or products other than those listed without being treated any differently. If you have any questions regarding this notice, ask Dr. Scumpia.

I have read and understand the financial policy and agree to its terms. I understand that the practice may amend these terms from time to time. I hereby assign all medical and surgical benefits to which I am entitled to Austin Thyroid & Endocrinology. I hereby authorize my insurance carriers (Medicare, Tricare, and other public or private insurance or health plan) to issue payment directly to Austin Thyroid & Endocrinology for medical services rendered to me and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Patient Signature Date

Authorization to Release Information

I hereby authorize Austin Thyroid & Endocrinology to release any information needed to insurance carriers regarding my illness and treatment, process insurance claims for diagnosis and treatment, and allow a copy of my signature to be used by insurance companies for processing claims. This authorization will remain in effect until revoked by me in writing.

_____ _____

Patient Signature Date

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

Patient Info

Patient Name _____ Birth Date: _____/_____/_____ Age _____

Daytime Phone Number (_____) _____ o Home o Cell o Office

Your Pharmacy _____ Pharmacy Location _____

If you were REFERRED by another DOCTOR, please provide doctor's name: _____

Medications

Allergies or Medical Alerts:

Name of Medication/Vitamins	Dose	QTY.	FREQ.	COMMENTS	Verified

Medical History

- ☐ Headaches / how often? _____
- ☐ Migraines / how often? _____
- ☐ Blurred, Double or Tunnel Vision
- ☐ Eye Pain
- ☐ Frequent Thirst / Often Thirsty
- ☐ Frequent Urination
- ☐ Eating Disorder past or now
- ☐ Anxiety and/or Nervousness
- ☐ Fatigue / Feeling Tired / Low Energy
- ☐ Weight Loss - how much? _____
- ☐ Weight Gain - how much? _____
- ☐ Difficulty Swallowing / Hoarseness
- ☐ Tremors / Shaking
- ☐ Perspiration /Sweating? High / Low?
- ☐ Hot Flush / Night Sweats
- ☐ Cold or Heat Intolerance
- ☐ Diarrhea / Constipation
- ☐ Fast or Irregular Heart Beat?
- ☐ Hair Loss
- ☐ Abnormal Body/Facial Hair?
- ☐ Kidney Stones *
- ☐ Fractures / Broken Bones
- ☐ Bone Pain / Joint Pain
- ☐ Change is Skin Color
- ☐ Dizziness / Fainting
- ☐ Menstrual Dysfunction
- ☐ Sexual Concerns
- ☐ Numbness / Tingling
- ☐ Pain in Legs - Walking
- ☐ Poor Leg Circulation *
- ☐ Edema / Swelling
- ☐ Indigestion / Reflux *
- ☐ Nausea/Vomiting
- ☐ Memory Concerns
- ☐ Muscle Weakness
- ☐ Salt Craving
- ☐ Ulcers / Pelvic Pain
- ☐ Asthma/Lung Problems
- ☐ Prostate Disease *
- ☐ Skin Disorders *
- ☐ Seizures/Convulsions *
- ☐ Anemia *
- ☐ Diabetes
- ☐ Gestational DM
- ☐ Thyroid disease
- ☐ Heart Disease
- ☐ Cancer _____
- ☐ Osteoporosis/Bone Loss
- ☐ High Cholesterol – ever *
- ☐ High Blood Pressure *
- ☐ Diverticulosis or Crohns *
- ☐ Arthritis/Rheumatism *
- ☐ Sleep Apnea *
- ☐ Depression *
- ☐ Stroke/TIA *
- ☐ Hepatitis *

Female History

Pregnancy History:

Birth Control _____

Number of times pregnant ____

Births _____ Miscarriages ____

☐ Pregnant? ____ wks gestation

Menstrual Flow:

Last Menstrual Period _____

☐ Irregular Menses

☐ Painful Menses / Cramps

☐ Heavy or Abnormal Bleeding

Last Pap Smear _____ yr

Pap ◯ Normal ◯ Abnormal

Last Mammogram _____ yr

Mamo ◯ Normal ◯ Abnormal

Family History

	Father	Mother	Children	Sisters / Brothers	Fathter's Mother	Fathter's Father	Mother's Mother	Mother's Father
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐

Social History

MARITAL STATUS ? ◯ Married ◯ Single ◯ Other _____

Number of CHILDREN ? _____

Used TOBACCO ? ◯ No ◯ Yes Pack / Day ____ ___ How long? _____

Do you drink ALCOHOL? ◯ No ◯ Yes ◯ Frequently ◯ Sometimes ◯ Rarely

Used illicit DRUGS before? ◯ No ◯ Yes

Are you EMPLOYED? ◯ No ◯ Yes What do you do? _____ _____

Routine EXERCISE ? ◯ No ◯ Yes Days each Week _____

Are you on a special DIET ? ◯ No ◯ Yes ☐ Low Fat / Salt ☐ Low Carb ☐ Other

Had a Bone Density Test? ◯ No ◯ Yes Year _____ Normal ? ◯ No ◯ Yes

Surgeries / Procedures					
Year it occurred ?	**Year**____	**Year**____	**Year**____	**Year**____	**Year**____