SOUTH ORANGE COUNTY ENDOCRINOLOGY PATIENT INFORMATION SHEET

Marital Status: Single Married Divorce Widow

Full Name: ______________________________

Gender: Male Female

Address: ______________________________

City, State, Zip: ______________________________

Date of Birth: ______________________ **Age:** __________

Cell Phone: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Email: ______________________________

Referring Physician: ______________________________

Pharmacy phone and address: ______________________________

Nearest relative not living with you in case of Emergency: ______________________________

Phone: ______________________ **Relationship:** ______________________

SOUTH ORANGE COUNTY ENDOCRINOLOGY AUTHORIZATION TO RELEASE

INFORMATION AND ASSIGNMENT TO PAY PROVIDER DIRECTLY

I hereby authorize payment directly to South Orange County Endocrinology of the insurance benefits to which I am entitled. I understand that I am financially responsible for charges not covered by this assignment. A photocopy of this authorization will be considered as valid as the original.

Patient Signature: ______________________ **Date:** ______________________
(Parent/Guardian if patient is a minor)

I hereby authorize South Orange County Endocrinology to provide information to insurance carrier and/or referring or family physician concerning my condition and treatments rendered. A photocopy of this authorization will be considered as valid as the original.

Patient Signature: ______________________ **Date:** ______________________
(Parent/Guardian if patient is a minor)

Dear Patient, Please Read This and Sign Below

Per HIPPA regulations, we are required to ask you to sign **Acknowledgment of Receipt of Notices of Privacy Practices.** You have the right to refuse our request, in which case, we must document your refusal for the record.

Sign your acknowledgment below for having reviewed your **Notice of Privacy Practices** and then return this page to our staff. **Thank You**

PATIENTS ACKNOWLEDMENT OF RECEIVING NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided my personal copy of my health care providers Notice of Privacy Practices to read and keep as my own.

____

Patients Name

____

Signature of Patient or Parent Responsible Party

____

Patients Date of Birth

____

Print Name of Patient or Parent Responsible Party & Relationship to Patient

____

Today's Date

Patient Liability Financial Agreement

South Orange County Endocrinology is dedicated to providing the very highest level of care and service to all of our patients. South Orange County Endocrinology and our staff will make every effort to ensure that you receive quality medical care which is medically necessary; however, please be aware that your health plan or designated medical group makes the final determination regarding your care.

We will bill your insurance company for the healthcare services you receive in our office, less any co-payment(s) or deductibles(s), and with the exception of private insurances. In the event that your insurance company denies payment for services as a result of **BUT NOT LIMITED TO,** any of the reasons listed below, you will be held financially responsible for the charges incurred.

Payment may be denied if your health plan or medical group determines:

- The care given is not medically necessary.
- The care given is a non-covered benefit.
- The recipient is ineligible to receive the insurance benefit.
- Services not covered for a **non-participating provider.**

Please remember, it is the patient responsibility to know how his/her insurance works and South Orange County Endocrinology will not be held responsible for any financial decisions made by said insurance company. Your coverage is a contract between you and your insurance company. Disputes are to be taken up with your insurance company and are not our responsibility.

Should we terminate our contract with your insurance company, please be aware that it is your responsibility to verify that information prior to **EVERY** visit not ours. Also, due to contracts between you and your insurance, we are **NOT** required to notify you when we terminate with insurance.

Therefore, any services which are denied for reasons such as, but not limited to, "non-covered" or "not medically necessary" will be financial responsibility of the patient.

I also agree that should I refuse to or fail to pay any co pay's, deductibles, or outstanding balances and I am sent to a collection agency, I will also be responsible for any collection fees set forth by South Orange County Endocrinology. (Breakdowns of the fees are available upon request.)

I have read the above information and understand its content and will accept financial responsibility for such services

Signature: ______________________________ **Date:** __________________

Appointment/Cancellation/No Show Policy

South Orange County Endocrinology

Appointments:

Office/virtual visits are by appointment only please call **(949)770-4177**. Please **arrive 10 minutes early** for your appointment. Patients who are late for an appointment may be asked to reschedule at the physician's discretion. All scheduled appointments **MUST** be confirmed 24 hours in advance. If we don't have a conformation **we will have to cancel your appointment without notice**. Remember to bring all your prescriptions, over-the-counter medicines, vitamins, and supplements to each office visit. If you would not like to bring all your medications please bring a **current medication list**. This will enable Dr. Marcus to review the medications at each visit. We kindly ask to **call the office back when we are leaving messages to confirm your appointment**. It is the patient's responsibility to schedule follow up appointments.

Cancellations:

We would like to thank you for being a patient in our office. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, **please give us at least a 24 hours' notice**. This courtesy makes it possible to give your reserved time to another patient who would like it. We know your time is valuable.

Missed Appointments (Non-Cancelled)

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. We track missed (non-cancelled) appointment. A **"NO SHOW/LATE CANCELLATION"** is defined as missing an appointment without cancelling 24 hours before scheduled time. There will be a charge for a missed non-cancelled appointment. **The fee is $100. No refunds will be given**. Repeated missed appointments may result in a letter discharging you from the practice. We will offer a 30 days of emergent care only and transfer your records when you find a new doctor.

Payment

Payment is due in full at the time of service **no exceptions**.

____________________ ____________________ ____________________

Patient Name **Signature** **Date**

HIPPA

HIPPA is an acronym for **"Health Insurance and Accountability Act."** HIPPA was enacted to ensure the privacy and confidential handling of medical information for all patients in the U.S. It applies to all medical and mental health providers.3

HIPPA laws can be complicated but absolutely must be adhered to. HIPPA requires that all persons you collect medical information from either directly or indirectly (such as by filling a prescription) be notified of their rights to privacy and receive a "Notice of Privacy Practice's" which is sometimes also called "Notice of Information Practices."

The statement must tell your patient/clients what you do with their information and it either must be signed by the patient, or the patient must sign on HIPPA consent from that they have received a copy of your privacy practices prior to signing HIPPA consent.

How we collect information about you: South Orange County Endocrinology (SOCE) and its employees all collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What we do **NOT** do with your information: Information about your financial situation and medical conditions and care that you provide to us in writing in email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPPA consent form.

How we do **USE** your information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between SOCE and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify our medical information is accurate; determine the type of medical supplies, devices, medications, or insurance.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason

including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicated attempted fraud, your non-medical information can be given to legal authorities including police investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information we do **NOT** collect: We do not use cookies on our website to collect from our site visitors. We do not collect information about site visitor except for one hit counter on the main index page (www. http://socendocrinology.com) that simply records the number of visitor and no other data. We do use some affiliate programs that may or may not capture traffic date through our site. To avoid potential data capture that you visited a diabetes website simply does not click on any of our outside affiliate links.

Limited right to use non-identifying personal information from biographies, letters, notes, and other sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of SOCE. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purpose that is directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without patient/client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purpose, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to use will ever publicly used without your direct or indirect consent.

I ____ (name) have read and understood above HIPPA laws.

____

Patient signature and date

South Orange County Endocrinology
24422 Avenida de la Carlota Suite 375
Laguna Hills, CA 92656
Tel (949) 770-4177 | Fax (949) 472-0305
Email: SOCEndocrinology@gmail.com

Original Date:	Feb 3, 2010
Dates Revised:	

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*: ☐ M ☐ F **DOB:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or referring doctor: | **Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	