PLEASE READ THESE IMPORTANT INSTRUCTIONS

Complete the enclosed forms before the day of your visit and **bring** them with you to your appointment. Please plan to arrive 10 minutes early.

IT IS NOT NECESSARY TO BE FASTING FOR YOUR APPOINTMENT.

DIABETICS NEED TO BRING THE FOLLOWING TO THE APPOINTMENT

- Lab Results (A1c, Lipid panel, thyroid function tests, etc)
- Your glucose meter and blood sugar logs
- Medications- **Complete** the medication list thoroughly or **BRING** all medications that you may be taking. It is not necessary to bring the insulin bottle but do write down the correct and complete name (i.e. Novolog, Humalog, Humalin, Novalin, 70/30, 70/25, Lantus, etc)
- Your insurance cards and driver's license or photo ID for our records.

NON- DIABETICS NEED TO BRING THE FOLLOWING TO THE APPOINTMENT

- Lab Results (Lipid panel, thyroid function tests, any endocrine related test)
- Scan Reports (i.e. thyroid or adrenal)
- Ultrasound Reports (i.e. thyroid)
- MRI Reports (i.e. thyroid or adrenal)
- Bone Density studies (DEXA)- complete report with images
- Medications- **Complete** the medication list thoroughly or **BRING** all medications that you may be taking.
- Your insurance cards and driver's license or photo ID for our records.

If we do not have these reports at the time of your visit we will reschedule your appointment.

*If you choose to have your doctor fax them to us it is **your responsibility to verify** that the records have been received prior to the day of your appointment. Please note that faxed copies are not always readable and sometimes there are communication errors between fax machines and the records are not received therefore we prefer that you bring the copies with you.*
Please note that it will be a waste of your time and money if the doctor does not have the requested information to review with you at your appointment.

INSURANCE

- If you have a PPO or HMO insurance plan, **it is your responsibility** to verify with your insurance carrier that we are listed as a participating provider.
- Insured patients will be asked to pay any deductibles, co-insurance or co-payments designated by your insurance carrier at the time of the visit.
- **It is your responsibility** to obtain and bring a referral from your Primary Care Physician if your insurance requires a referral.

If a referral is required and you do not have one, we will reschedule your appointment.

INSURANCE CARRIERS THAT REQUIRE REFERRALS *This is not an all inclusive list. Patients should verify with their insurance carrier if referrals are required.*	**REFERRALS REQUIRED**	
	WRITTEN	**REFERRAL NUMBER**
Aetna Elect Choice EPO Plan		***X***
Aetna HMO		***X***
Aetna Managed Choice (POS) Plan	**X**	
Aetna Quality Point-of-Service (QPOS) Plan	**X**	
Blue Cross Blue Shield (aka BlueChoice) HMO	**X**	
Blue Cross Blue Shield (aka BlueChoice) POS	**X**	
CIGNA HMO	**X**	
Coventry Health Care HMO Evolutions	**X**	
Humana HMO/POS		***X***
Kaiser	**X**	
Medicaid Georgia Better Healthcare		***X***
TriCare Prime		***X***

NOTICE TO UNINSURED PATIENTS

- The goal of Eastside Endocrine is to provide quality medical care to all of our patients. We do not discriminate against patients that do not have medical insurance; however, we do feel that it is important for uninsured patients to be aware of the following:
- Expect the physician fee for your initial visit to be $365.00. Note that we do require payment on the day of your visit. We do not bill.
- An endocrine evaluation is specialized and generally requires additional diagnostic testing with either laboratory blood tests that can run several hundred dollars or x-ray scans that can run into thousands of dollars. The fees for these tests are above and beyond the physician's fees. We do not have control over the cost of diagnostic testing. Please understand that any tests ordered by the physician are required for him to evaluate and treat your problem. If you will not be able to comply with the testing he will not be able to provide you with the level of care that an endocrinologist is expected to provide.
- In addition to diagnostic testing prescription medication may be required and again we do not control the costs.
- The above information has been provided to avoid causing undue stress to any patient due to a financial burden that was not anticipated. We will provide the same quality care to all patients and believe it to be a waste of time and money for both the patient and the practice if a patient presents for the initial visit and then abandons care because they cannot proceed with diagnostic testing or prescription medication.

COMMUNICATION

The doctor must be able to communicate with the patient in order to render medical care. If you do not speak English you must bring an interpreter with you.

If you do not bring an interpreter we will reschedule your appointment.

CANCELLATION AND NO SHOW POLICY

Patients that do not show up for appointments or do not cancel within 24 hours of their appointment will be charged a **$50.00 No Show Fee.** Please note that patients that chronically miss scheduled appointments and do not comply with the recommended course of treatment, including lab testing, are discharged from the practice, which means Dr. Shenoy will no longer be their treating physician.

PERSONAL INFORMATION

First Name	Middle Name	Last Name
Street Address		
City	State:	Zip:	County:
Birth Date	Marital Status □ Single □ Married □ Divorced □ Widowed	
Sex	Social Security Number (*required for insurance purposes*)	
Home Phone	E-Mail Address	
Cell Phone	Pharmacy Name:	
Work Phone	Pharmacy Phone	
Spouse's Name:	Birth date	May we discuss your medical care with your spouse? □ Yes □ No
Cell Phone	Spouse's Employer	Work Phone

I authorize Eastside Endocrine, P.C. to release medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home phone	□ Yes	□ No	Work phone	□ Yes	□ No	Pager	□ Yes	□ No
Answering Machine	□ Yes	□ No	Voice Mail	□ Yes	□ No	Fax	□ Yes	□ No
Cell phone/voice Mail	□ Yes	□ No	Mail	□ Yes	□ No			

Please list names of people we can discuss your medical care with:

_____ Relationship: _____

_____ Relationship: _____

Emergency Contact- Person not living with patient (relative or friend)

Name	Relationship	Phone

EMPLOYMENT INFORMATION

Employer	Occupation	
Street Address	Phone#	
City	State	Zip

HEALTH INSURANCE INFORMATION

Primary Insurance Company	ID#
Subscriber's Name	Relationship to Patient
Subscriber's Birth date	Subscriber's Social Security # *(required for insurance purposes)*
Policy Group #	Group Name

Secondary Insurance Company	ID#
Subscriber's Name	Relationship to Patient
Subscriber's Birth date	Subscriber's Social Security # *(required for insurance purposes)*
Policy Group #	Group Name

PRIMARY CARE PHYSICIAN

Primary Care Physician	Phone #	
Address		
City	State	Zip

ARE YOU BEING REFERRED BY A DOCTOR? □ yes □ no

Name:
Address (if a doctor)

IF YOU WERE NOT REFERRED BY A DOCTOR WHO RECOMMENDED US TO YOU ?

□ Friend/Relative □ Insurance □Yellow Pages □ Other

EASTSIDE ENDOCRINE, PC
PATIENT REGISTRATION

The Physicians and Staff of Eastside Endocrine, P.C. Want You to Know How We Will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil & criminal penalties; and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after August 1, 2003 with the attached Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer.

PATIENT CONSENTS AND ACKNOWLEDGEMENTS

I hereby consent to treatment by Eastside Endocrine, P.C with the understanding that I will furnish accurate information regarding my health history and will cooperate when referred to other physicians or medical institutions for examination or testing. My noncompliance with these conditions may result in the refusal of further care from Eastside Endocrine, P.C.

I understand that chronically missing scheduled appointments is considered noncompliance of medical treatment and may result in the refusal of further care from Eastside Endocrine & Internal Medicine, P.C.

I hereby authorize Eastside Endocrine, P.C to release any information acquired in the course of my examination to other medical providers as needed to provide quality medical care including information of a psychiatric nature, substance abuse or HIV status.

I hereby authorize Eastside Endocrine, PC to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

I also authorize the release of any information necessary to process my medical claims including information of a psychiatric nature, substance abuse or HIV status.

I hereby authorize payment of medical benefits normally due to me to be paid directly to Eastside Endocrine, P.C for services rendered for which I have not paid.

If my current policy prohibits direct payment to Eastside Endocrine, P.C, I hereby also instruct and direct you to make out the check to me and mail it to Eastside Endocrine, P.C at the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. The payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees over and above this insurance payment.

I authorize Eastside Endocrine, P.C to initiate a complaint to the Insurance Commission for any reason on my behalf.

I have provided correct information and supplied all cards necessary to file insurance claims on my behalf. I understand that I am financially responsible to Eastside Endocrine, P.C for charges not covered by this assignment. If the insurance companies fail to make prompt payment I understand that I am obligated to pay for all services rendered and hereby give my personal guarantee of payment to Eastside Endocrine, P.C.

I acknowledge that I have received a copy of Eastside Endocrine, P.C.'s Notice of Privacy Practices and have been given an opportunity to ask questions.
A photocopy of this Agreement shall be considered as effective and valid as the original.

Signature of Patient or Personal Representative_____ **Date:** _____

If Personal Representative, give relationship to patient:_____

EASTSIDE ENDOCRINE, PC
PATIENT REGISTRATION

EASTSIDE ENDOCRINE, P.C. FINANCIAL POLICY

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy.

- Co-payments for office services are required at the time your register. We accept cash, checks and Mastercard or Visa.
- As a courtesy, we will process and file your insurance claims for services at no cost to you.
- For services that are covered by insurance, the practice requires payment of approximately 20% for the total estimated charges or the co-payment specified by your insurance carrier. All deductibles must be paid in full.
- For services that are not covered by insurance, the practice requires payment of 100% of total charges unless payment arrangements have been worked out in advance.
- Returned checks are subject to a handling fee of $30. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.
- Accounts 90 days past due will be turned over to an outside collection agency.
- Missed appointments or failure to cancel/reschedule within 24 hours will accrue a $50 fee.

You must realize:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.
2. It is the patient's responsibility to know if their insurance has a "participating provider list" and to verify if doctors they see are on that list and understand how that affects their benefits.
3. It is the patient's responsibility to obtain required referrals and/or prior authorizations from their primary care physician (PCP) and to track the effective dates and number of visits authorized.
4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage of our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING

Signature:_____ Date:_____

(Patient and/or Responsible Party)

ALLERGIES:_____

CHIEF COMPLAINT (why you are here today)_____

_____

_____

_____

Medication not currently taking but have taken in the last three months:_____

SURGICAL HISTORY:_____

_____

CHILDHOOD DISEASES (please check if you had any of the following)

□ Asthma □ Malaria □ Mumps □ Rheumatic Fever
□ Chicken Pox □ Measles □ Polio □ Typhoid Fever
□ Other_____

FAMILY HISTORY (including parents, grandparents, children)

□ Cancer □ Heart Disease □ Kidney Disease □ Thyroid Disease (goiter)
□ Diabetes Mellitus □ High Blood Pressure □ Strokes □ Osteoporosis
□ Other_____

SOCIAL HISTORY

Marital Status:	Occupation:	
Tobacco use?	Alcohol use?	Drug Use?
Amount:	Amount:	Amount:
Type:	Type:	Type:

DO YOU HAVE ANY OF THE FOLLOWING COMPLAINTS?

SYMPTOM	YES	NO	SYMPTOM	YES	NO	SYMPTOM	YES	NO
abdominal pain			decreased vision			nasal discharge		
acne			diarrhea			nausea		
awake to void at night			difficulty in initiating urination			oily skin		
blindness			dizziness- lightheadedness			palpitations		
blood in stools			dry skin			rashes		
blood in urine			ear infections			shortness of breath at rest		
burning on urination			excess hair growth			shortness of breath with exertion		
chest pains at rest			excess urination			sinusitis- stuffy nose		
chest pains with exertion			head injury			sore throats		
choking on liquids			Headaches			speech disorder		
choking on solids			heartburn			swelling in legs or feet		
chronic cough			hemorrhoids			trouble swallowing		
constipation			how many pillows used at night			vertigo- whirling sensation		
coughing blood			impotence			vomiting		
daily fever			increased skin pigmentation			weight gain		
daily sputum production			indigestion			weight loss		
decrease in size of stream			itching			wheezing		
decreased hearing			memory loss					

EASTSIDE ENDOCRINE, P.C.
MEDICAL HISTORY
Dr. Signature:_____

PATIENT'S NAME:_____
DATE OF BIRTH:_____
DATE COMPLETED:_____

MAJOR DISEASES- Do you have or have you had any of the following? (Give dates)

DISEASE	NO	YES	WHEN	DISEASE	NO	YES	WHEN
Alzheimer's (Dementia)				Hepatitis			
Angina Pectoris				Herpes (Genital)			
Angioplasty				Hiatal Hernia			
Arthritis- Lupus Erythematosis				Hypertension or High Blood Pressure			
Arthritis- Osteoarthritis				Kidney Stones			
Arthritis- Rheumatoid				Macular Degeneration			
Asthma- adult				Multiple Sclerosis			
Bladder Cancer				Nephritis (Bright's Disease)			
Bleeding Disorders				Osteoporosis:			
Brain Tumor				Overactive Thyroid			
Breast Cancer				Pancreatitis			
Bronchitis				Parkinson's			
Cardiac Bypass Grafting				Peptic Ulcer Disease			
(# of Vessels)				Pneumonia			
Cataracts				Prostate Cancer			
Chlamydia				Prostate Enlargement			
Cholesterol:				Pyelonephritis (kidney infections)			
Colon Cancer				Reflux			
Congestive Heart Failure				Retinal Detachment			
Convulsions				Retinitis Pigmentosa			
Crohn's Disease				Seizures (Grand Mal)			
Cystitis (bladder infections)				Seizures (Petit Mal)			
Depression				Spinal Cord Injury			
Diabetes Mellitus				Stomach Cancer			
Diabetic Eye Disease				Stroke			
Diverticulitis/Diverticulosis				Syphilis			
Emphysema				Thyroid Cancer			
Gall Stones				Tuberculosis			
Glaucoma				Ulcerative Colitis			
Goiter				Under active Thyroid			
Gonorrhea				Valvular Heart Disease			
Heart Attack				Other:			
Heart Catheterization							

DO YOU HAVE DIABETES? **IF YOU HAVE DIABETES, PLEASE ANSWER THE FOLLOWING QUESTIONS**

How long have you had diabetes?	Have you had dietary instruction?
How many meals do you have each day?	How many snacks to you have each day?
How many times a day do you check your blood sugar?	When do you check your blood sugar? □Breakfast □Lunch □Dinner □Bedtime
Do have low blood sugars?	Do you use disposable needles and syringes more than once?
Do you have annual eye exams done by an ophthalmologist?	When was your last eye exam by an ophthalmologist done?
Do you get a flu vaccine done annually?	Do you get a Pneumovax every 5 years?

Do you have or have you ever had

□ Diabetic Ketoacidosis	□ Coma from High Blood Sugar	□ Diabetic Eye Disease
□ Diabetic Kidney Disease	□ Diabetic Gastropathy or Gastroparesis	□ Diabetic Enteropathy
□ Diabetic Neuropathy (numbness or loss of sensation) in the feet or legs		

FOR FEMALES ONLY

age at first period	last menstrual period	frequency of menses	length of period
number of pads or tampon per day on heaviest day		Date of last pap smear	
number of pregnancies	number of miscarriages	number of abortions	vaginal discharge
Are you now or could you possibly be pregnant? □ yes □ no		Are you trying to get pregnant? □ yes □ no	

EASTSIDE ENDOCRINE, P.C.
MEDICAL HISTORY
Dr. Signature:_____

PATIENT'S NAME:_____
DATE OF BIRTH:_____
DATE COMPLETED:_____

PATIENT'S LIST ALL YOUR MEDICATIONS

ALLERGIES:

MEDICATION	DOSAGE (MG, UNITS, ETC	HOW DO YOU TAKE THIS MEDICATION? (example 1 a day, 1 twice a day)	PHYSICIAN NOTES

INSULIN REGIMEN			INSULIN PUMP REGIMEN		
Insulin Name	Units	When? (morning, evening, meals)	Insulin		
		AM	Time Schedule	Basal Rate	Mealtime
		PM			Units to
		Breakfast			Gm of Carbs
		Lunch			
		Dinner			
		Bedtime			
If you use a sliding scale, what is your formula?					*Sliding Scale Formula*
Sliding scale for Blood Sugar greater than					BS>
Blood sugar minus 100 divided by					BS-100/

EASTSIDE ENDOCRINE, P.C.
MEDICATION LOG
Dr. Signature:_____

PATIENT'S NAME:_____
DATE OF BIRTH:_____
DATE COMPLETED:_____