Academic Endocrine Metabolism & Nutrition, Inc.

2001 Gary Avenue, Suite #240
Wheaton, IL 60187

1315 Macom Drive, Suite 007
Naperville, IL 60564

Voice Telephone: 630/416-4501
Fax: 630/416-4504
Emergency: 630/901-1911

www.academicendocrinology.com

Patient's Name ____ **SSN #** ______________________

Birth Date _____________________________ Gender________________ Marital Status S M D W

Race: □ Caucasian/White □ African American/Black
□ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander
□ Asian □ Other ______________________

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Non-Latino □ Refused/Does not wish to disclose

Street Address _________________________________ City ____________________ Zip Code ________

(Area Code) Home Phone ______________________ Work Phone ______________________ Ext _______

Present Employer ____

Referred By ____

Primary Care Physician ____

Address ____

<u>Party Responsible for Patient's Insurance</u>

Name ____ SSN #________________________

Street Address ____

City/State ____ Zip Code ______________

Present Employer ____

Insurance Company ______________________________________ Plan # ____________________________

As a courtesy to our patients, insurance claims are filed on your behalf. It is your responsibility to give us accurate insurance information. You are responsible for paying your co-pay at the time of service. If a temporary insurance lapse necessitates a period of self-pay, payment in full is due at the time of service. **<u>In cases of HMO coverage, a form authorizing treatment must be brought to the office for every visit. This referral is your responsibility. Please call your insurance company and/or primary care physician ahead of time to determine if this is needed.</u>** If you do not have your referral form with you, you accept responsibility for payment for services rendered for every visit and/or procedure and are prepared to pay the fee at the time of the visit.

Professional services are rendered and charged to the patient, not to the insurance company. Insurance forms will be filed for you if you give us all of the necessary information. You will receive a statement from our office every month, which will show any insurance payments made and the balance due. If a payment on a claim is denied, reduced, or delayed beyond 90 days, you will be responsible for settling your balance with us. Payment in full is expected at that time.

As our patient, your signature is required to indicate acceptance of our office policies and to acknowledge that you have been advised of them. In addition, your signature will serve as our authorization to release to your insurance company information regarding only the services rendered. Your signature will also serve as an authorization for your insurance company to pay us directly, if we have filed your claims. Thank you. We look forward to serving you and your family.

Signature of Patient or Responsible Party ____ Date _______________________

HISTORY QUESTIONNAIRE

COMPLETED BY: ________________________ [STAFF] [PATIENT] [PHYSICIAN] ON: ___/___/___
NAME: ___________________________ [MALE] [FEMALE] AGE:_____ DATE OF BIRTH: ___/___/___

SOCIAL

Marital Status: [single] [married] [widowed __/__/__] [divorced __/__/__]
Occupation: [retired] [active] ______________________________

Do you: **[*Please circle No or Yes and explain if Yes*}**

Live with others	[no]	[yes]	→	who: ______________________
Have children	[no]	[yes]	→	# living____, # deceased _____ → from: __________
Get exercise	[no]	[yes]	→	hours per week: ______________
Use illegal drugs	[no]	[yes]	→	______________________
Use alcohol	[no]	[yes]	→	ounces per day ______________
Smoke	[no]	[yes]	→	packs per day _______________ stopped__________

PAST MEDICAL

Have you ever had:

Surgery	[no]	[yes]	→	date: ______________ hospital: ______________ for: ______________
Blood transfusion	[no]	[yes]	→	date: ______________ hospital: ______________ for: ______________
An illness	[no]	[yes]	→	date: ______________ hospital: ______________ for: ______________

Problems for which you have seen a physician or have been treated for:

				Medications prescribed		**Currently taking**	
Diabetes	[no]	[yes]	→	______________	→	[no]	[yes]
Cancer	[no]	[yes]	→	______________	→	[no]	[yes]
Tumor/lesion	[no]	[yes]	→	______________	→	[no]	[yes]
Scarlet fever	[no]	[yes]	→	______________	→	[no]	[yes]
COPD	[no]	[yes]	→	______________	→	[no]	[yes]
Blood pressure	[no]	[yes]	→	______________	→	[no]	[yes]
Heart problem	[no]	[yes]	→	______________	→	[no]	[yes]
Infections	[no]	[yes]	→	______________	→	[no]	[yes]
Pain	[no]	[yes]	→	______________	→	[no]	[yes]
Nervousness	[no]	[yes]	→	______________	→	[no]	[yes]
Arthritis	[no]	[yes]	→	______________	→	[no]	[yes]
Others______________				______________	→	[no]	[yes]

You have any allergies / reactions to:

Food(s)	[no]	[yes]	→	______________
Penicillin	[no]	[yes]	→	______________
Other antibiotics	[no]	[yes]	→	______________
Pain medications	[no]	[yes]	→	______________
Aspirin	[no]	[yes]	→	______________
Others			→	______________

FAMILY

Do any of your blood relatives have or have had any of these diseases or
Do any other problems run in the family:

Diabetes	[no]	[yes]	→	Type ____________	TB	[no]	[yes]
Cancer	[no]	[yes]	→	Location: __________	Thyroid disease	[no]	[yes]
Tumor/lesion	[no]	[yes]	→	Location: __________	High blood pressure	[no]	[yes]
Heart problem	[no]	[yes]	→	Type ____________	Stroke	[no]	[yes]

Other ______________________________

Your Father:	[living]	[died]	___/___/___	→	of ______________
Your Mother:	[living]	[died]	___/___/___	→	of ______________
Your Brothers:	[living]	[died]	___/___/___	→	of ______________
Your Sisters:	[living]	[died]	___/___/___	→	of ______________

HISTORY QUESTIONNAIRE

COMPLETED BY: ________________________ ☐ STAFF ☐ PATIENT ☐ PHYSICIAN ON: ____________

NAME: ____________________ ☐ MALE ☐ FEMALE AGE:______ DATE OF BIRTH: ___________

REVIEW OF SYSTEMS

POSITIVE RESPONSE = **CIRCLE** AND THEN EXPLAIN; FOR EXAMPLE: LOCATION

HAVE YOU RECENTLY NOTICED Constitutional Systems	→	**Change in Appetite**	**Change in Weight**	**Night sweats**	**Fatigue**
DO YOU HAVE Skin	→	**Sores that don't heal**		**Changes in skin moles**	
DO YOU HAVE All/Imm	→	**Seasonal allergies**			
HAVE YOU HAD RECENTLY Ears – Nose – Mouth - Throat	→	**Change in hearing** **Difficulty swallowing**	**Sinus problems** **Difficulty sleeping**	**Trouble with balance**	
HAVE YOU RECENTLY HAD Eyes / Head	→	**Loss of vision**	**Severe headaches**	**Blackouts or falling**	
DO YOU HAVE Redp	→	**Shortness of breath**	**Frequent coughs**	**Wheezing**	
DO YOU HAVE CV	→	**Chest pain**	**Swollen ankles**	**Inflamed veins**	
DO YOU HAVE GI	→	**Indigestion** **Change in bowel habits**	**Heart burn** **Diarrhea**	**Nausea** **Constipation**	**Abdominal pain** **Black stools**
DO YOU HAVE GU	→	**Painful urination** **Decreased force/flow**	**Blood in urine** **Vaginal discharge**	**Frequent urination at night** **Last pap smear:________**	
DO YOU HAVE Endo	→	**Lumps in your breasts**	**Breast discharge**	**Last mammogram:_____________**	
DO YOU HAVE Musclosk	→	**Back pain**	**Pain in joints**	**Stiffness**	
DO YOU FEEL Neuro	→	**Tingling**	**Loss of speech**	**Numbness of arms / legs**	
DO YOU FEEL Psych	→	**Anxious**	**Depressed**		
DO YOU Heme/Lymph	→	**Bruise easily**	**Swollen glands**	**Bleed a lot**	

Do you have any other signs symptoms or problems other than above? ☐ No ☐ Yes

Please explain:

____

____

Reviewed last : by / date ____

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NEW PATIENT HISTORY FORM

Name: ____ Date of Birth: _____________________

1. Reason for Visit: ____
____

2. Current Medications and Dosages: ____
____
____

3. Allergies to Medications and Reactions: ____
____

4. Past Medical History & Other Health Problems: ____
____
____

5. Previous Surgeries & Dates: ____
____
____

6. Past & Present Treatment for Question #1. ____
____
____

7. Family History of:			
	Thyroid Conditions	Yes _____	No _____
	Diabetes	Yes _____	No _____
	Growth Problems	Yes _____	No _____
	*Other Endocrine-related Problems	Yes _____	No _____

*If yes, please describe: ____

8. History of Alcohol, Drug, or Tobacco Use: Yes _____ No _____

9. History of Psychosocial Problems Yes _____ No _____

If yes, please describe: ____

Please bring with you a copy of any medical records or lab work previously done relating to the reason for your visit. For an adult, this will include x-rays, blood tests, & surgical procedures etc. For a child, this will include all of the above information in addition to a copy of the child's growth chart.

*****Please bring this completed form with you to your visit.**

OUR PROMISE OF PRIVACY AND CONSENT TO PATIENT RECORDS
(HIPAA)

<u>Our office is fully committed to compliance with HIPAA guidelines by:</u>

1. Providing appropriate **security** for our patient records.

2. Protecting the **privacy** of our patient's medical information.

3. Providing our patients with proper **access** to their medical records.

4. Appropriately maintaining our patient information and billing process in compliance with national hipaa **standards.**

If you ever have any questions or concerns about your services or charges, we encourage you to call and ask for your Compliance Officer**.**

PATIENT CONSENT FORM

The Department of Health and Human Services has established "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.
As our patients we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.
We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent
You may refuse to consent to the use of discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.
If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.
You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

I authorize the office of Academic Endocrine Metabolism & Nutrition, Inc. to continue making confirmation calls to remind me of my upcoming appointments.

____________________	_________________________	______________
Name of Patient (Printed)	Signature of Patient or Guardian	Date

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HIPAA AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

To release the personal health information of:

Patient's Name______________________________ Phone#: ______________ Date of Birth:__________

Address: ________________________________ City: ____________ State: _____ Zip: _________

To release to: **Academic Endocrine Metabolism & Nutrition, Inc.**
2001 Gary Ave. Suite 240
Wheaton, IL 60187 Phone #: 630-416-4501 Fax #: 630-416-4504

To release from: Releasing Entity:________________________________ Phone #: ______________

The purpose of this disclosure is: ❑ At the request of the individual ❑ Other: ________________________

The dates of patient care covered by this Authorization are: ________________________________

Release the Following Information:

❑ Discharge Summary ❑ Pathology Report(s) ❑ Emergency Record(s) ❑ History & Physical

❑ Radiology Report(s) ❑ Itemized Billing Statement ❑ Consultation(s) ❑ Lab Report(s)

❑ Operative Report(s) ❑ Cardiology Report(s) ❑ Progress Notes ❑ Treatment Plan(s)

❑ Other Records as specified: ____

❑ Entire Medical Record (Except for Records Concerning Highly Confidential Information).

Release of Highly Confidential Information:

By checking any of the boxes next to a category of Highly Confidential Information listed below, I specifically authorize the use and/or disclosure of the category of Highly Confidential Information indicated next to the box:
(please check all that apply–leaving a box unchecked may result in no information being disclosed for any purpose).

❑ Mental Illness or Developmental Disability

❑ Abuse of an Adult with a Disability

❑ Sexually Transmitted Diseases (STD's)

❑ Genetic Testing

❑ Sexual Assault

❑ Substance (i.e., alcohol or drug) Abuse

❑ Child Abuse and Neglect

❑ HIV/AIDS Testing or Treatment (including the fact that an HIV test ordered, performed or reported, regardless of whether the result of such tests were positive or negative).

This Authorization will remain in effect:

❑ From the date of this Authorization until: ________________________ (Not over one year).

❑ Until the Releasing Entity fulfills the request or 120 days from the date this Authorization is signed, whichever occurs earlier.

I understand that:

• The information disclosed pursuant to the Authorization may be subject to redisclosure by the Recipient and may no longer be protected by applicable federal and Illinois law.
• I may refuse to sign this Authorization for any reason and the Releasing Entity may not condition my treatment on whether I sign this Authorization unless my treatment is research-related or I am to receive health care solely for the purpose of creating protected health information for disclosure to the Recipient identified in this Authorization.
• I have the right to revoke this Authorization in writing at any time. The revocation will be effective immediately upon the Releasing Entity in reliance on this Authorization before it received my written notice of revocation.

______________________________________ ____________________
Signature of Patient Date

______________________________________ ____________________
Signature of Parent/Legal Guardian Relationship to Patient

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Office Policy for No-Show Appointments

Patients who do not show up for their appointments take the place of others, who may have urgently needed to be seen. As a result, we request that you give us a 24-hour notice for all cancellations, so that others may be accommodated.

Otherwise, the no-show policy for our office is as follows:

- For all no-show appointment, there will be a charge of $50 for the time slot that we were unable to fill when you were a "no-show."

- For the third no-show appointment, it will be up to the physician's discretion as to whether a discharge letter is sent, disengaging you from our practice and allowing you 30 days to enroll with a new physician.

Exceptions may be made on a case-by-case basis. Thank you for your understanding and cooperation in this matter.

Sincerely,

Academic Endocrine Metabolism & Nutrition, Inc.

____
Signature of Patient or Responsible Party (if Patient is a minor)

____
Date

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*** For patients 18 years and older ***

I, ____, give all associates of Academic Endocrine
(Patient's Name)

Metabolism & Nutrition, Inc. permission to discuss all aspects of my diagnosis and medical

treatment with: ____________________________ ________________________________
(Name of Individual) (Relationship to Patient)

____ ________________________
(Patient's Signature) (Date)