



THE ENDOCRINOLOGY GROUP, PLLC

Specializing in diabetes, thyroid, bone, lipid, and other hormonal disorders

1625 N. George Mason Dr., Suite 375 Arlington, VA 22205
Ph: 703.717.4170 Fax: 703.717.4171 www.endocrinologygroup.com

PATIENT REGISTRATION – Page 1 PLEASE PRINT

Date

A. PATIENT INFORMATION

Last Name, First Name, Middle Initial

SSN

Date of Birth

Age

Marital Status

Sex

Male Female

How do you wish to be addressed?

Address

Apt #

City

State

Zip Code

Home Phone Number

Email address

Work Phone Number

Cellular Phone Number

Name of Person to Contact in Case of an Emergency (Relation)

Emergency Contact Phone Number

Name of Primary Care Physician (PCP)

PCP's Address, Phone, Fax

Name of Referring Physician (if different from PCP)

Referring Physician's Address, Phone, Fax

B. EMPLOYER INFORMATION

Patient's Employer

Address

Must complete **SUBSCRIBER** and **SUBSCRIBER DATE OF BIRTH** for accurate billing:

C. PRIMARY INSURANCE

Insurance Carrier

Subscriber's Name and relationship to patient

Subscriber's Date of Birth and Subscriber's Employer

D. SECONDARY INSURANCE (If applicable)

Insurance Carrier

Subscriber's Name and relationship to patient

Subscriber's Date of Birth and Subscriber's Employer



THE ENDOCRINOLOGY GROUP, PLLC

Specializing in diabetes, thyroid, bone, lipid, and other hormonal disorders

1625 N. George Mason Dr., Suite 375 Arlington, VA 22205
Ph: 703.717.4170 Fax: 703.717.4171 www.endocrinologygroup.com

PATIENT REGISTRATION – Page 2 PLEASE PRINT

Names of Person(s) - you authorize to discuss your medical and payment information with:
(your health providers are automatically included)

(1) _____ Relationship: _____
(2) _____ Relationship: _____
(3) _____ Relationship: _____

I give permission for messages to be left at the following contact methods:

Home phone Yes No preferred method of contact
Cell phone Yes No preferred method of contact
Work phone Yes No preferred method of contact
Email Yes No (under construction)

RELEASE OF INFORMATION FOR PAYMENT OF SERVICES

I authorize this office to release all information necessary for payment of services rendered, including medical records. I authorize any payers to pay benefits directly to this office. Any insurance requirements such as referrals or prior authorization are strictly patient responsibility. I understand that I am financially responsible for all services regardless of insurance benefits, and am required to update my demographics and insurance with this office as necessary. I agree to promptly pay for the services rendered for me, or the above named patient. If I fail to meet my financial commitment to The Endocrinology Group, PLLC and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees.

Initial: _____

NOTICE OF PRIVACY PRACTICES

We keep a record of the healthcare services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. By your initials, you acknowledge receipt of the Notice of Privacy Practices.

Initial: _____

CANCELLATIONS-PRESCRIPTION-LOST ORDERS POLICIES

We reserve the right to charge a \$50/25 fee for missed New/FU appointments or appointments cancelled within 24 hours. I further agree to pay for lost lab orders or prescriptions.

Initial: _____

X

Patient (or Guardian) Signature authorizing medical evaluation / treatment.



THE ENDOCRINOLOGY GROUP, PLLC

Specializing in diabetes, thyroid, bone, lipid, and other hormonal disorders

Giang Bach, MD
Caroline Huang, MD
Christina Go, MD
Maria L. Ramirez, MD
Wendy Phillips, PA-C, CDE

1625 N. George Mason Dr., Suite 375
Arlington, VA 22205
Ph: 703.717.4170 Fax: 703.717.4171
www.endocrinologygroup.com

Date: _____

Name: _____

Age: _____

PLEASE WRITE THE NAMES OF ALL YOUR PHYSICIANS:

LIST YOUR PREFERRED PHARMACY/ ADDRESS / PHONE NO: _____

PLEASE LIST THE REASON(S) FOR ENDOCRINOLOGY EVALUATION.
WHAT ARE YOUR MAIN CONCERNS?

Physician Notes:

DRUG ALLERGIES (AND REACTION): _____

MEDICATIONS (INCLUDE ASPIRIN, VITAMINS, ANY SUPPLEMENTS)	PILL SIZE (I.E. MILLIGRAMS)	TIMES TAKEN (I.E. ONE @ BREAKFAST, TWO AT DINNER)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

DO YOU HAVE (OR HAVE YOU HAD) ANY OF THE FOLLOWING CONDITIONS?

	YES	NO		YES	NO
DIABETES			THYROID Problems		
HIGH BLOOD PRESSURE			KIDNEY Problems		
HIGH CHOLESTEROL			LIVER Problems		
HEART Problems			ANEMIA		
STROKE			STOMACH ULCER		
CANCER			HEARTBURN		
ASTHMA			OSTEOPOROSIS		
EMPHYSEMA or COPD			SEIZURES		
ARTHRITIS			ANXIETY		
BLINDNESS			DEPRESSION		

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU HAVE OR ANY REASONS YOU SEE A DOCTOR:

PLEASE LIST ANY OPERATIONS YOU HAVE HAD, AND THE YEAR PERFORMED:

FOR WOMEN ONLY:

Last Menstrual Period: ___/___/___

Are your cycles regular (or in the past)? Yes No

Number of pregnancies: ___ #births: ___ #miscarriages/abortions: ___

HAS ANY FAMILY MEMBER BEEN DIAGNOSED WITH:

	YES	NO	WHO HAS THIS? (i.e. FATHER, SISTER, ETC)
DIABETES			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
HEART Problems			
STROKE			
OBESITY			
CANCER			
THYROID Problems			
OSTEOPOROSIS			
MOOD Problems			
OTHER:			

Physician Notes:

PERSONAL & SOCIAL HISTORY

Who do you live with? _____

Do you have children?

- Yes – Ages _____
 No

What is your occupation? _____

Do you smoke cigarettes, pipes, cigars or chew tobacco?

- Yes – number of packs per day: _____
 Used to, but none since: _____
 Never

Do you drink beverages that contain alcohol?

- Yes - glasses/beers _____ daily/weekly (circle)
 Used to, but none since: _____
 No

Have you ever used recreational drugs?

- Yes - what kind _____
 Used to, but none since: _____
 Never

Do you exercise on a regular basis?

- Yes – What kind? _____
How often? _____ min, _____ times/wk
 No

Your height: __ feet __ inches

What is your current weight: _____ lbs

What is the most you have ever weighed: _____ lbs

HAVE YOU RECENTLY HAD PROBLEMS WITH ANY OF THE FOLLOWING:

GENERAL

- Weight loss Yes No
Weight gain Yes No
Fatigue Yes No
Decr. appetite Yes No
Fever Yes No

HEAD, EYES, EARS, THROAT

- Headache Yes No
Blurred vision Yes No
Eye pain Yes No
Problems hearing Yes No
Voice changes Yes No
Neck swelling Yes No
Swallowing problems Yes No

Heart

- Chest pain or discomfort Yes No
Racing heart beats Yes No
Leg swelling Yes No
Leg pain w/ walking Yes No

RESPIRATORY

- Cough Yes No
Short of Breath Yes No

SKIN/BREASTS

- Rashes Yes No
Vitiligo (white skin changes) Yes No
Breast tenderness Yes No
Breast fluid leakage Yes No

GASTROINTESTINAL

- Abdominal pain Yes No
Change in bowel Yes No
Constipation Yes No
Diarrhea Yes No
Nausea/vomiting Yes No
Heart burn Yes No

GENITOURINARY

- Urinary difficulties Yes No
Nighttime urination Yes No

WOMEN ONLY

- Change in your periods Yes No
Low sexual desire Yes No

MEN ONLY

- Problems with erections Yes No
Pain/lump in testicles Yes No
Low sexual desire Yes No

MUSCULAR SKELETAL

- History of broken bones Yes No
Back Pain Yes No
Joint Pain Yes No
Gout Yes No

PSYCHIATRIC

- Depressed mood Yes No
Anxiety Yes No
Problems sleeping Yes No

NEUROLOGY

- Dizziness Yes No
Seizures Yes No
Numbness Yes No
Tingling sensations Yes No

ENDOCRINE

- Problems with heat Yes No
Problems with cold Yes No
Excessive thirst Yes No
Frequent urination Yes No
Changes in hair Yes No

Person completing form (if not patient): _____



THE ENDOCRINOLOGY GROUP, PLLC

Specializing in diabetes, thyroid, bone, lipid, and other hormonal disorders

Giang Bach, MD *Caroline Huang, MD*
Christina Go, MD *Maria L. Ramirez, MD* *Wendy Phillips, PA-C, CDE*

1625 N. George Mason Dr, Suite 375 Arlington, VA 22205
Ph. 703.717.4170 Fax 703.717.4171 www.endocrinologygroup.com

OFFICE POLICY

- Our office hours are Monday - Friday, 8:30 AM - 4:30 PM.
- **Making an appointment** may be done by calling our office (and online in the future). Our services are available to all who seek them.
- **It is our goal** to see you at the time of day for which your appointment was made. The appointment that is scheduled is reserved for you only. We ask for your cooperation – if you know that you will be late – that you call the office to let us know.
- Payment is due at the time of your visit. We accept cash, checks, and credit cards.
- A penalty fee (\$25.00 followup visit / \$50.00 new patient visit) may be charged for cancelling an appointment without 24 hours notice.
- There will be a fee of \$35.00 for returned checks.
- Requests for copies of medical records will incur a charge to cover staff and material costs in duplicating the chart.
- Lost lab orders requiring replacement will incur a \$5 charge
- **After hour** and weekend calls to the physicians are available and reserved for EMERGENCIES ONLY.
- Requests for appointments, medication refills, and laboratory results should only be made during office hours.
- Please allow physicians one business day to return non-urgent phone messages.

Laboratory results

Our staff will always communicate with you (via follow-up appointment, letter, or phone call) regarding the results of your blood work or studies. If you do not hear from our office regarding your results in the expected time frame – it is the patient's responsibility to contact us to ensure the results were not lost, misdirected, etc.

Prescription refills

Prescriptions are **electronically submitted** directly to participating pharmacies. Provide the name, address, phone, and fax numbers of your pharmacy so we can establish the electronic connection. E-prescribing minimizes errors and provides quicker service to our patients.

Please note that our office will only refill prescriptions prescribed by our office.

Patients are responsible for ensuring that all requested prescriptions are addressed at time of appointment.

Due to the overwhelming burden placed on our staff addressing prescription requests and the interference it causes to provide ongoing medical attention to our patients, the following policy is strictly enforced:

Any prescription refill requested by patient or pharmacy, which is necessitated by the loss of a previously issued prescription, cancellation of a scheduled appointment by the patient, or lack of a scheduled follow-up appointment will result in a charge of \$5.00 per prescription. These prescriptions will be available in our office for pick-up only, and will cover only the period of time until the next recommended appointment. Such prescriptions will not be called or faxed to your pharmacy, or mailed out.

Diabetes prescriptions – please note that all diabetes supplies, as well as NPH/ Regular insulins are available as *non-prescription* items. We are happy to provide prescriptions so that your insurer will help cover supply costs.

INSURANCE / FINANCIAL RESPONSIBILITY

- Please familiarize yourself with the terms of your insurance, including plan benefits, co-payments, preauthorization requirements, and choice of laboratory facility.
- Ultimately, it is the patient's responsibility to check with their insurance plan to confirm our participation.
- **If your insurance company requires a referral for consultation – ensure that the referral is received prior to the visit or you will be responsible for fees incurred should insurance deny coverage** (please note – cancelled appointments within 24 hours of the scheduled visit will incur the cancellation penalty charge). If you need assistance with your insurance requirements, our staff will make every effort to help you.
- If your insurance company does not cover a particular service, you will be held responsible for payment.
- Balances and co-pays are expected to be paid in full at the time of the visit. Co-pays may not cover your total payment. After receiving an Explanation of Benefits for service rendered, patients are expected to pay their portion of the bill in full **within 2 weeks**.
- If we do not participate in your insurance plan, then you will be expected to pay for services at the time of visit. We are happy to provide you the necessary paperwork needed to submit for out-of-network benefits.

THE ENDOCRINOLOGY GROUP, PLLC

Specializing in diabetes, thyroid, bone, lipid, and other hormonal disorders

1625 N. George Mason Drive, Suite 375, Arlington, VA 22205
Office: (703) 717-4170 Fax: (703) 717-4171 www.endocrinologygroup.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website www.endocrinologygroup.com, calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and

undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government

programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you \$15.00 for each page and \$50.00 per hour to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the

person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: Caroline Huang, MD

Telephone: 703.717.4170

Address: 1625 N. George Mason Dr., Suite 375, Arlington, VA 22205

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
202.619.0257
Toll Free: 877.696.6775