Today's Date: _____

PATIENT INFORMATION

Date of Birth: _____ Age: _____ Sex: ____ Gender Identity: _____Sexual Orientation: _____

First Name: _____ MI: ___ Last Name: _____ SSN#:_____

Marital Status: S___ M___ D___ W___ Email Address: _____

Race: _____ Ethnicity (Circle One): Hispanic/Non-Hispanic Primary Language: _____

Street Address: _____ Mailing Address (If Different):_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work phone:_____ Employer/Occupation:_____

Emergency Contact: _____ Relationship: _____ Phone: _____

ACCOUNT RESPONSIBILITY (If different than above)

Who is responsible for this account? _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____

Cell Phone: _____ Home Phone: _____ Date of Birth: _____SSN#: _____

MEDICAL INSURANCE

Name of Primary Insurance Company: _____

Subscriber Name: _____ Group # _____

Member ID: _____ Subscriber Date of Birth: _____

Name of Secondary Insurance Company: _____

Subscriber Name: _____ Group # _____ Member ID: _____

Subscriber Date of Birth: _____ Medicare ID (If on Medicare): _____

CASH PAY POLICY

Patients without medical insurance are required to pay $175.00 at the time of service to see a specialist or have imaging performed. Please note that your balance may be more than the above stated amounts, and will be determined based on actual services rendered during your office visit. Any patient without medical insurance who is paying in cash for an office visit will receive 20% off of their end balance.

By signing below you state that you have read and understand the above cash pay policy.

Patient/Guardian Signature: _____

CLINIC BILLING AND EXPECTATIONS

Please sign below to indicate you have read and understand the following:

1. **Responsibility for payment of your account remains with you at all times**; and although you may have a pending insurance claim, we will require you to pay regardless of the circumstances involved. Please contact us immediately if there is a problem with your claim or if your claim is related to OREGON WORKERS COMP, AUTO RELATED, OR THE RESPONSIBILITY OF A THIRD PARTY PAYOR.

2. Copays and other estimated out of pocket amounts due are to be collected at the time of service.

3. You will receive a monthly statement showing itemized charges and the total amount due on your account. Payment in full is required within 30 days of the statement date, unless arrangements are made with our billing office.

4. If you need to set up a payment plan, our Praxis Main billing phone number is (877)708-1119.

5. A $100.00 fee will be charged to your account if you do not cancel your appointment 24 hours in advance. After three no show appointments, you will be subject to discharge from our practice.

6. There is a $35.00 fee for all returned checks and for stop payments.

7. No credit will be extended to patients having a past due account, or to patients who have been referred to a collections agency. If your account has been referred to a collections agency two times, you will be discharged from our practice.

8. If you arrive more than seven minutes late to an appointment, you may be asked to reschedule.

9. Endocrinology Services Northwest requires 2 business days to respond to all medication refill requests. Medications will not be refilled after clinic hours. Please contact your pharmacy to initiate refill requests.

CONSENT FOR TREATMENT

By signing below, I am requesting Endocrinology Services Northwest to provide health care related treatment and consultation to the below named patient, and that I may refuse treatment or services at any time. I understand Endocrinology Services Northwest does not guarantee any outcome for any services or treatments, either stated or implied.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian) : _____Date:_____

Acknowledgment
Privacy Policy Offered

My health information may be created or reviewed by Endocrinology Services Northwest and may be in the form of written or electronic records, or spoken words. My health records may include information on my health history, health status, test results, diagnoses, treatments, procedure, prescriptions and similar types of related health information.

I understand that I have the right to receive and review a written description of how Endocrinology Services Northwest will handle my health information. This written description is known as a **Notice of Privacy Practices**. This notice describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Endocrinology Services Northwest and my right regarding my health information. I may obtain a copy of the **Notice of Privacy Practices** at the reception desk or view it on the clinic website.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy or summary of the most current version of the Endocrinology Services Northwest **Notice of Privacy Practices** in effect will be posted in the waiting/reception area and on the clinic website.

By signing, I agree that I have reviewed and understand the above information and that I am entitled to receive a copy of Endocrinology Services Northwest's Notice of Privacy Practices.
Notice of Privacy Practices copies are available at the reception desk.

Patient Confidential Communication

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following.

I give permission to Endocrinology Services Northwest to leave messages regarding appointments, billing and medical information on any of the following phone numbers:

_____

I give permission to Endocrinology Services Northwest to share health and billing information with:

_____

Relationship: _____

This release will be revoked by written permission only. I understand that I must send a written request to Endocrinology Services Northwest in order to revoke this request.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian) : _____Date:_____

FORMULARY BENEFITS MANAGEMENT (PBM) CONSENT FORM

Formulary Benefit data are maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below I give permission for Endocrinology Services Northwest to access my pharmacy benefits data electronically through RxHub. This consent will enable Endocrinology Services Northwest to:

- Determine the pharmacy benefits and drug copays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies
- Download a histories list of all medications prescribed for a patient by any provider

In summary, we ask your permission to obtain formulary information and information about other prescriptions by other providers using RxHub. This consent will be in place until revoked in writing.
I give permission for Rx History consent: (yes/no) _____

Care Management Services Financial Agreement

With the transformation of health care across the country, there were new government billing guidelines established in 2015 for services identified as "Care Management". These services are non-face to face and include but are not limited to: follow ups for emergency room visits, inpatient hospitalizations, as well as coordination of care for ongoing chronic conditions. Examples: Diabetes, Hypertension.

These services are rendered by multiple means, to include but are not limited to: telephone and/or email contact, directly with client or their designated health contact, other health care professionals, as well as verbal and written reports.

These services are billable to your insurance plan; their payment processing will depend on your individual plan coverage. By signing below you agree to allow us to provide these services for you.

I give permission for care management services: (yes/no) _____

By signing below you state that you have read and understand the above statements regarding PBM consent and Care Management Services financial agreement.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian) : _____Date:_____

Patient History Form

Appointment Date:

Endocrinology NorthWest

Name _____ Birth date____/____/____ Gender F M

Age_____ Occupation_____ Marital Status: S M D W

Personal Medical History (add details below)

Past/Now		Past/Now		Past/Now		Past/Now	
❑ / ❑	Diabetes	❑ / ❑	Fever/Chills	❑ / ❑	Chest Pain	❑ / ❑	Lower extremity cuts
❑ / ❑	Thyroid Disease	❑ / ❑	Weight gain:____lbs	❑ / ❑	Irregular heart beat	❑ / ❑	Diffuse muscle pain
❑ / ❑	High Cholesterol	❑ / ❑	Weight loss:____lbs	❑ / ❑	Leg swelling	❑ / ❑	Joint Pain
❑ / ❑	Angina/Heart Attack	❑ / ❑	Feeling too Hot/Cold	❑ / ❑	Nausea/Vomiting	❑ / ❑	Leg pain while walking
❑ / ❑	High Blood Pressure	❑ / ❑	Visual Changes	❑ / ❑	Diarrhea	❑ / ❑	Tremor
❑ / ❑	Heart Murmur	❑ / ❑	Eye Pain	❑ / ❑	Constipation	❑ / ❑	Headaches
❑ / ❑	Hepatitis	❑ / ❑	Voice Changes	❑ / ❑	Stomach Pain	❑ / ❑	Seizures
❑ / ❑	Rheumatic Fever	❑ / ❑	Difficulty swallowing	❑ / ❑	Frequent Urination	❑ / ❑	Depression
❑ / ❑	HIV +/ AIDS	❑ / ❑	Mass in Neck	❑ / ❑	Painful Urination	❑ / ❑	Anxiety
❑ / ❑	Cancer (type_____)	❑ / ❑	Shortness of Breath	❑ / ❑	Sexual Dysfunction	❑ / ❑	Increased Stress
❑ / ❑	Cataracts	❑ / ❑	Wheezing	❑ / ❑	Skin Rash	❑ / ❑	Irregular periods(Fem)
❑ / ❑	Chemical Dependency	❑ / ❑	Persistent cough	❑ / ❑	Hair Changes	❑ / ❑	

Details/Comments:

Medical History - Other | **Hospitalizations (include year)** | **Surgical History (include year)**

Pregnancies (Year) | **Form of birth control** | **Vasectomy ❑ Yes ❑ No**

Medication Allergies/Intolerances-List names & what happens

If no allergies check this box ❑

_____ _____ _____

_____ _____ _____

Please list all Medications you are on, including vitamins, herbal supplements & birth control.

Medication name ~ Dose (e.g. mg/pill) ~ How many times per day?

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Family Medical History

If living, list health problems. If deceased, cause of death. Please include age.

Blood Relative	Alive	Age	Illness or Cause of Death	Blood Relative	Alive	Age	Illness or Cause of Death
Mother	❑Yes❑No			Sibling	❑Yes❑No		
Grandmother	❑Yes❑No			Sibling	❑Yes❑No		
Grandfather	❑Yes❑No			Children	❑Yes❑No		
Father	❑Yes❑No			Children	❑Yes❑No		
Grandmother	❑Yes❑No			Other	❑Yes❑No		
Grandfather	❑Yes❑No			Other	❑Yes❑No		

Please List Last Date of Procedure

Procedure	Date	Date	Date	Date
Colonoscopy				
Mammogram				
DEXA Scan				
Upper Endoscopy				
Aortic Ultrasound				
Flu Shot				
Pneumonia Vaccine				
Cardiac Stress Test				

Have you completed an Advanced Directive? ❑ Yes ❑ No

If yes, date(s)_____

Have you completed a DNR? ❑ Yes ❑ No

If yes, date(s)_____

Health Habits

Do you use tobacco products?

❑ Past ❑ Present ❑ Never

How much per day? _____Packs_____Cans_____Cigars_____Pipe

Are you exposed to second hand smoke at home?

❑ Past ❑ Present ❑ Never

Do you use alcohol?

❑ Past ❑ Present ❑ Never Number of drinks per week_____

Recreational drug use?

❑ Past ❑ Present ❑ Never

Caffeine, tea, soda? (Caffeinated)

❑ Past ❑ Present ❑ Never Number per day_____

Review of Systems (new or ongoing)

Please check "yes" or "no". Do you now or have you ever had any problems related to the following. If yes, describe.

Yes / No	Description	If yes, describe	Yes / No	Description	If yes, describe
Constitutional Symptoms			**Skin**		
❑ / ❑	Fever		❑ / ❑	Skin Rash	
❑ / ❑	Chills				
❑ / ❑	Headache		❑ / ❑	Persistent Itch	
❑ / ❑	Weight Change		❑ / ❑	Skin cancer	
Eyes			**Musculoskeletal**		
			❑ / ❑	Joint Pain	
❑ / ❑	Double Vision		❑ / ❑	Neck Pain	
❑ / ❑	Pain		❑ / ❑	Back Pain	
❑ / ❑	Vision Change		**Ear / Nose Throat / Mouth**		
❑ / ❑	Cataracts/Glaucoma		❑ / ❑	Ear Infection	
			❑ / ❑	Sore Throat	
Allergic / Immunologic			❑ / ❑	Sinus Problems	
❑ / ❑	Hay Fever		**Genitourinary**		
❑ / ❑	Drug Allergies		❑ / ❑	Sexual Dysfunction	
Neurological			❑ / ❑	Urination Problems	
❑ / ❑	Tremors		❑ / ❑	Incontinence	
❑ / ❑	Dizzy Spells		**Respiratory**		
❑ / ❑	Numbness/Tingling		❑ / ❑	Wheezing	
Endocrine			❑ / ❑	Frequent Cough	
❑ / ❑	Excessive Thirst		❑ / ❑	Shortness of Breath	
❑ / ❑	Too Hot/Too Cold		**Hematologic / Lymphatic**		
❑ / ❑	Tired/Sluggish		❑ / ❑	Swollen Glands	
Gastrointestinal			❑ / ❑	Bleeding/clotting	
❑ / ❑	Change in habits		**Psychologic**		
❑ / ❑	Abdominal Pain		❑ / ❑	Are you generally satisfied with your life?	
❑ / ❑	Nausea/Vomiting		❑ / ❑	Impaired by depression or anxiety?	
❑ / ❑	Indigestion/Heartburn		❑ / ❑	Self-harming behavior?	
Cardiovascular			Other:		
❑ / ❑	Chest Pain				
❑ / ❑	Lower Extremity Edema				
❑ / ❑	High Blood Pressure				

For Women: **Do you perform regular (monthly) self-breast exams? ❑ Yes ❑ No**

Breast Exam by Provider		
Mammogram		
PAP Smear/Pelvic Exam		
Last Menstrual Period		
Hormone Treatment		

For Men: **Do you perform regular (monthly) self-exam of testicles? ❑ Yes ❑ No**

PSA Blood Test		
Prostate/Testicle Exam		

What is your main reason for coming in today?

Patient Signature_____ **Date**_____

Medical Provider Signature_____ **Date**_____