



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. Endocrinology Services Northwest and/or contracted business associates may need to contact you for additional information or to collect any amounts you may owe. You give your express agreement and consent to allow Endocrinology Services Northwest and/or contracted business associates to call you at any telephone number provided or obtained, without limitation of wireless. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
6. 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.
7. There is a \$35.00 fee for all returned checks and for stop payments.
8. 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.
9. If you arrive more than seven minutes late to an appointment, you may be asked to reschedule.
10. 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.

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### CONSENT FOR TREATMENT

By signing below, you state that you have read and understand the above **CLINIC BILLING AND EXPECTATIONS**. 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 Endocrinology Services Northwest's **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 information

Limited medical information, such as: normal results (Abnormal results and sensitive information will never be left on voice message), generic recommendations, medication information or referral status or updates on any of the following phone numbers listed on patient information form:

Home     Mobile     Work

And/Or with the following person(s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

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. When translation services are utilized, you give express consent that it may be done using a wireless mobile device.

**Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.** If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

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: \_\_\_\_\_



Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender F M

Age \_\_\_\_\_ Occupation \_\_\_\_\_ Marital Status: S M D W

**Personal Medical History (add details below)**

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

Details/Comments:

Medical History - Other	Hospitalizations (include year)	Surgical History (include year)
Pregnancies (Year)	Form of birth control	Vasectomy <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No			Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No			Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Grandfather	<input type="checkbox"/> Yes <input type="checkbox"/> No			Children	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No			Children	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No			Other	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Grandfather	<input type="checkbox"/> Yes <input type="checkbox"/> No			Other	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Please List Last Date of Procedure**

**Health Habits**

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

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 \_\_\_\_

Have you completed an Advanced Directive?  Yes  No

If yes, date(s) \_\_\_\_\_

Have you completed a DNR?  Yes  No

If yes, date(s) \_\_\_\_\_

## 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
<b>Constitutional Symptoms</b>			<b>Skin</b>		
<input type="checkbox"/> / <input type="checkbox"/>	Fever		<input type="checkbox"/> / <input type="checkbox"/>	Skin Rash	
<input type="checkbox"/> / <input type="checkbox"/>	Chills				
<input type="checkbox"/> / <input type="checkbox"/>	Headache		<input type="checkbox"/> / <input type="checkbox"/>	Persistent Itch	
<input type="checkbox"/> / <input type="checkbox"/>	Weight Change		<input type="checkbox"/> / <input type="checkbox"/>	Skin cancer	
<b>Eyes</b>			<b>Musculoskeletal</b>		
			<input type="checkbox"/> / <input type="checkbox"/>	Joint Pain	
<input type="checkbox"/> / <input type="checkbox"/>	Double Vision		<input type="checkbox"/> / <input type="checkbox"/>	Neck Pain	
<input type="checkbox"/> / <input type="checkbox"/>	Pain		<input type="checkbox"/> / <input type="checkbox"/>	Back Pain	
<input type="checkbox"/> / <input type="checkbox"/>	Vision Change		<b>Ear / Nose Throat / Mouth</b>		
<input type="checkbox"/> / <input type="checkbox"/>	Cataracts/Glaucoma		<input type="checkbox"/> / <input type="checkbox"/>	Ear Infection	
			<input type="checkbox"/> / <input type="checkbox"/>	Sore Throat	
<b>Allergic / Immunologic</b>			<input type="checkbox"/> / <input type="checkbox"/>	Sinus Problems	
<input type="checkbox"/> / <input type="checkbox"/>	Hay Fever		<b>Genitourinary</b>		
<input type="checkbox"/> / <input type="checkbox"/>	Drug Allergies		<input type="checkbox"/> / <input type="checkbox"/>	Sexual Dysfunction	
<b>Neurological</b>			<input type="checkbox"/> / <input type="checkbox"/>	Urination Problems	
<input type="checkbox"/> / <input type="checkbox"/>	Tremors		<input type="checkbox"/> / <input type="checkbox"/>	Incontinence	
<input type="checkbox"/> / <input type="checkbox"/>	Dizzy Spells		<b>Respiratory</b>		
<input type="checkbox"/> / <input type="checkbox"/>	Numbness/Tingling		<input type="checkbox"/> / <input type="checkbox"/>	Wheezing	
<b>Endocrine</b>			<input type="checkbox"/> / <input type="checkbox"/>	Frequent Cough	
<input type="checkbox"/> / <input type="checkbox"/>	Excessive Thirst		<input type="checkbox"/> / <input type="checkbox"/>	Shortness of Breath	
<input type="checkbox"/> / <input type="checkbox"/>	Too Hot/Too Cold		<b>Hematologic / Lymphatic</b>		
<input type="checkbox"/> / <input type="checkbox"/>	Tired/Sluggish		<input type="checkbox"/> / <input type="checkbox"/>	Swollen Glands	
<b>Gastrointestinal</b>			<input type="checkbox"/> / <input type="checkbox"/>	Bleeding/clotting	
<input type="checkbox"/> / <input type="checkbox"/>	Change in habits		<b>Psychologic</b>		
<input type="checkbox"/> / <input type="checkbox"/>	Abdominal Pain		<input type="checkbox"/> / <input type="checkbox"/>	Are you generally satisfied with your life?	
<input type="checkbox"/> / <input type="checkbox"/>	Nausea/Vomiting		<input type="checkbox"/> / <input type="checkbox"/>	Impaired by depression or anxiety?	
<input type="checkbox"/> / <input type="checkbox"/>	Indigestion/Heartburn		<input type="checkbox"/> / <input type="checkbox"/>	Self-harming behavior?	
<b>Cardiovascular</b>			Other:		
<input type="checkbox"/> / <input type="checkbox"/>	Chest Pain				
<input type="checkbox"/> / <input type="checkbox"/>	Lower Extremity Edema				
<input type="checkbox"/> / <input type="checkbox"/>	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?

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Medical Provider Signature \_\_\_\_\_ Date \_\_\_\_\_