



CAROLINA ENDOCRINE, P.A.

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www.carolinaendocrine.com

ADULT NEW PATIENT PACKET

Financial Policies & Office Information:

Thank you for choosing Carolina Endocrine, P.A. for your medical care. Our mission is to provide you with professional service and exceptional care. We intend to keep you well informed of office policies that may affect you and your care. You will be required to read and sign this form explaining our financial policies and office information prior to the initiation of medical care. If you would like to receive a copy of Carolina Endocrine, P.A.'s financial policies and office information, one of our front office staff will be happy to provide one for you.

**FULL PAYMENT, CO-PAYMENT, OR ANY OUTSTANDING BALANCE IS
DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, PERSONAL CHECKS, AND MASTERCARD/VISA/DISCOVER**

INSURANCE

In most cases, we will accept your insurance benefits. You are responsible for your portion of the bill (also known as co-payments/co-insurance) at the time of service. We cannot waive or discount this fee due to our contracts with insurance companies. **The balance is your responsibility whether your insurance company pays your claim or not.**

We cannot file a claim to your insurance company unless you give us your correct insurance information. Please present your insurance card at the time of check-in. It is necessary for us to keep a copy of the card in your medical records chart.

Your insurance policy is a contract between you and your insurance company. **We are not a party to that contract.** Please be aware that some, and sometimes all, of the services provided may **NOT** be covered by your insurance.

In the event that a charge is not covered by your plan, you will be billed the balance after we obtain an Explanation of Benefits from your insurance carrier. Our practice is committed to providing exceptional medical treatment for our patients and we charge the usual and customary fees for the services rendered. Therefore, outstanding charges are due upon receipt. Accounts with balances that remain unpaid 90 days from the original date a claim was filed to your insurance will be placed with a collection agency. You will be responsible for any collection costs and/or any reasonable attorney fees.

NON-CONTRACTED INSURANCE PLANS

Carolina Endocrine, P.A. welcomes those patients whose insurance companies are not contracted with this office (example: Medicaid, Blue Local, Duke Select, PHCS, and some independent plans) as "Self-Pay". We request payment at the time of service for all office visits and surgical procedures.

CONSENT FOR TREATMENT

I consent to treatment as determined necessary by the physician(s) and other healthcare providers at Carolina Endocrine, P.A. I understand that treatment may consist of a variety of procedures/services based upon my health needs. I also understand that the practice of medicine is not an exact science and that the clinic does not guarantee the results of treatment provided.

Financial Policies & Office Information Continued:

RETURN CHECKS

There will be a \$35.00 service charge for all returned checks. This service charge will be added to your account balance and will be your responsibility. There may be additional charges placed on your account by your bank.

OFFICE HOURS

Monday – Thursday: 8:00am – 12:00pm & 1:00pm – 4:30pm Friday 8:00am – 12:00pm

*We are closed for major holidays and at the discretion of the providers.

AFTER HOURS EMERGENCY CARE

Call 911 or go directly to the emergency room designated by your insurance company. Request endocrine services at hospital check-in. We do not provide after-hours coverage in our office.

MEDICAL ADVICE

Generally, our office will return calls within 2-3 business days, unless urgent.

REFILLS

Call your pharmacy and ask them to fax refill requests to our office at (919) 571-3290. **DO NOT wait until you are out of medicine to request a refill.** Please note that refill requests may take 24 to 48 business hours.

LABORATORY

For your convenience, a Quest Lab is located in our office for your laboratory needs. All insurances will be billed directly by Quest. It is your responsibility to understand your insurance plan. Should there be any unpaid claims for your lab services, you will be billed directly from Quest.

MISSED APPOINTMENTS

Please remember to call and cancel your appointment. Failure to do so prevents other patients from being seen. Our policy requires 24 hours' notice. Our office will charge \$100.00 fee if you fail to show up to your scheduled appointment or fail to provide 24 hours' notice when cancelling an appointment. Three consecutive "NO SHOWS" may jeopardize your future appointment availability and is subject to a discharge from our practice.

LATE ARRIVAL

If you arrive more than 10 minutes late for your appointment, you may be asked to reschedule or you may encounter a waiting period, as we must continue with patient care.

MEDICAL RECORDS & FORM FEES:

We are happy to provide you with copies of your medical records when needed; however, there is a fee for this service. There is a minimum base charge of \$10.00. The copying of medical records is \$0.75 for the first 25 pages and \$0.50 per additional pages. When a provider needs to complete any forms/paperwork, there is an administrative charge of \$20.00. These fees are payable upon request of service. Please allow 5-10 business days for our office to prepare your medical records. There is no charge if our office faxes your medical records to another medical provider upon receipt of your signed Medical Release form.

I have read, understand and accept the above Financial Policies & Office Information provided by Carolina Endocrine, P.A. and I am aware that I can receive a copy of this document I so desire.

Patient/Guardian Signature

Date

Printed Name of Patient/Guardian

HIPAA Disclosure Information Form

Patient Name: _____ Date of Birth: _____

I hereby authorize use or disclosure of my protected health information to the following individuals:

1. The following person/persons may receive disclosure of my protected health information:

Primary Person	Phone Number	Relationship to Patient
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Additional Person(s)	Phone Number	Relationship to Patient
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Additional Person(s)	Phone Number	Relationship to Patient
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UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, MENTAL HEALTH, OR SEXUAL ACTIVITY AND/OR PREVENTION WILL BE DISCLOSED:

CHECK ONE:

YES - DISCLOSE THIS INFORMATION: Initial: _____

DO NOT DISCLOSE THIS INFORMATION: Initial: _____

2. I may revoke this authorization by notifying Carolina Endocrine, P.A. **in writing** of my desire to revoke my current HIPAA disclosure. However, I understand that **any action already taken cannot be reversed**, and my revocation will not affect those actions.
3. This authorization expires on **12/31/20**____, **OR** upon the occurrence of the specific event listed below after which disclosures can no longer be made:

THIS FORM MUST BE COMPLETED IN FULL PRIOR TO SIGNING:

Patient/Guardian Signature

Date

Printed Name of Patient/Guardian

HIPAA Notice of Privacy Practices and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been enforced by our practice for years. This form is a condensed version. A more comprehensive version is posted in our office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our mission to provide you with professional service and exceptional care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov

Carolina Endocrine, P.A. has adopted the following policies:

1. Patient information is kept confidential except as is necessary to provide services or to ensure administrative matters related to your care is handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding that identifies a patient's condition or information that is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by phone text, e-mail, US mail, or by any means convenient for the practice and/or as requested by you.
3. Our practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of our office and review of documents that may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of our practice administrator or one of our providers.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both our practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
10. As a courtesy, we may share some limited health information with family members, such as appointment information, payment information, medication information, etc.

HIPAA Notice of Privacy Practices and Consent Form Continued

I do hereby consent and acknowledge my agreement to the terms set forth in the Notice of Privacy Practices Form and any subsequent changes of office policy. I understand that this consent shall remain in force from this time forward. However, I may withdraw or modify this consent at any time in writing.

IF YOU DO NOT WANT LIMITED HEALTH INFORMATION SHARED WITH FAMILY MEMBERS
INITIAL HERE: _____

CONSENT FOR TREATMENT

I consent to treatment as determined necessary by the physician(s) and other healthcare providers at Carolina Endocrine, P.A. I understand that treatment may consist of a variety of procedures/services based upon my health needs. I also understand that the practice of medicine is not an exact science and that the clinic does not guarantee the results of treatment provided.

CONSENT FOR PHONE MESSAGES AND/OR EMAIL

I consent for Carolina Endocrine, P.A. staff to send results through the secure patient portal and to leave messages on any and/or all phone numbers and/or e-mail addresses listed on my registration form.

IF YOU DO NOT WISH TO HAVE MESSAGES LEFT INITIAL HERE: _____

FINANCIAL RESPONSIBILITY

I understand that my actual charges may be different from any charge estimates given to me. I also understand that if I do not have health insurance coverage or have not provided accurate insurance information, I will be responsible for the payment of all charges. In addition, I understand that my insurance company(s) may not pay the full amount of all charges, and I will be responsible for paying the remainder.

Patient/Guardian Signature

Date

Printed Name of Patient/Guardian

List of Providers for Release of Medical Records

**** PLEASE WRITE YOUR NAME AND DATE OF BIRTH BELOW EVEN IF YOU ARE NOT REQUESTING WE RELEASE MEDICAL RECORDS TO ANY PROVIDERS ****

Patient Name: _____ Date of Birth: _____

Provider's First & Last Name	Medical Specialty	Practice Name	Office Phone Number	Office Fax Number
	Primary Care Provider			

I authorize for Carolina Endocrine, P.A. to release my records to the providers listed above. I understand that I may revoke this authorization at any time by providing my written revocation to Carolina Endocrine, P.A. My revocation will not apply to information already retained, used, or disclosed in response to this authorization. The information to be released or disclosed may include information relating to sexually transmitted diseases, HIV/AIDS, alcohol and drug abuse, and/or mental health. I authorize the release or disclosure of this type of information. My signature is required to validate this voluntary authorization. If I do not sign this authorization, Carolina Endocrine, P.A. will still provide treatment and seek payment for services.

Patient/Guardian Signature

Date

Printed Name of Patient/Guardian

Carolina Endocrine, P.A.
Adult Medical History Form

Name: _____ DOB: _____ Age: _____ Date: _____

Reason for today's visit: _____

PERSONAL MEDICAL HISTORY (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Low vitamin D | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> High calcium | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Thyroid nodule | <input type="checkbox"/> Low calcium | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Thyroid cancer | <input type="checkbox"/> Pituitary tumor | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Adrenal tumor | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Cancer (type: _____) |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Polycystic ovarian syndrome | <input type="checkbox"/> High cholesterol | |
| <input type="checkbox"/> Low testosterone | <input type="checkbox"/> Heart attack | |

SURGICAL HISTORY

Procedure	Date	Procedure	Date
1.		5.	
2.		6.	
3.		7.	
4.		8.	

MEDICATION ALLERGIES: _____

MEDICATIONS List all medications you are currently taking with dosage (including vitamins and supplements)

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

FAMILY HISTORY Check if adopted or family history unknown

Please check all that apply	Father	Mother	Grandfather		Grandmother		Brother(s)	Sister(s)
			Paternal	Maternal	Paternal	Maternal		
Thyroid disease								
Diabetes								
Osteoporosis								
Heart disease								
High blood pressure								
Cancer								
If yes, type:								

SOCIAL HISTORY

Occupation: _____ Marital status: Married Divorced Widowed Single
 Have Children: No Yes If yes, # of pregnancies _____ # of live births _____
 Exercise: No Yes If yes, # of hours per week _____
 Tobacco use: Never smoked
 Currently smoking # of packs per day _____ # of years _____
 Quit smoking Age started _____ Age stopped _____
 Alcohol use: No Yes If yes, specify # of drinks per week: _____

Carolina Endocrine, P.A.

Review of Systems Form

PATIENT NAME: _____ DOB: _____ TODAY'S DATE: _____

Are you currently experiencing any of the following symptoms? (please check all that apply)

Constitutional

- Fatigue
- Weight loss
- Weight gain
- Insomnia
- Fever
- Chills

Endocrine

- Excessive sweating
- Flushing
- Heat intolerance
- Cold intolerance
- Frequent urination
- Frequent thirst
- Change in shoe or ring size

Skin

- Dry skin
- Hair loss
- Unwanted hair
- Breast discharge
- Breast mass or lumps

Ears/Eyes/Nose/Throat

- Blurred vision
- Double vision
- Dry eyes
- Difficulty swallowing

Neck

- Neck pain
- Neck fullness
- Change in neck appearance
- Sensation that something is stuck in throat

MUSCULOSKELETAL

- Muscle aches/weakness
- Joint pain
- Bone pain

Respiratory

- Cough
- Shortness of breath
- Wheezing
- Snoring

Cardiovascular

- Chest pain
- Palpitations
- Fainting
- Swelling of legs or feet

Gastrointestinal

- Abdominal pain
- Nausea
- Diarrhea
- Vomiting
- Constipation
- Bloating

Genitourinary

- Urinating at night
- Frequent urination
- Absence of cycles
- Irregular cycles
- Testicular pain
- Testicular mass
- Low libido
- Erectile dysfunction
- Infertility

Neurological/Psychiatric

- Tremor
- Tingling/numbness
- Difficulty concentrating
- Headaches
- Anxiety
- Depression
- Frequent crying

Heme/lymph

- Bruise easy
- Night sweats