CAROLINA ENDOCRINE, P.A.

Welcome to Carolina Endocrine, P.A.

It is our pleasure to welcome you to Carolina Endocrine, P.A.. Dr. Michael Thomas, Dr Julia Warren-Ulanch, Nicole McDermott, PA-C, Courtney C. Koppenal, PA-C and staff look forward to assisting you with your endocrine needs. Enclosed you will find the patient registration sheets that need to be completed before your visit. Copies may also be obtained from our website at www.carolinaendocrine.com. If you have any questions regarding this information please contact our office at (919) 571-3661, or ask at the time of your appointment. Feel free to mail or fax back your completed forms to our confidential fax at (919) 571-3290. You may also bring them with you at the time of your appointment.

Please remember to bring to your appointment:

- Insurance Cards
- Photo ID
- Medications you are currently taking. This should include any over the counter medications as well as vitamins. If you bring a list, please be sure to write down the dosage and refills remaining.
- Completed Registration forms.

We appreciate your assistance in trying to make your visit with us as efficient as we can. We understand that your time is as valuable as ours. If you can not make your current appointment time please call us 48 hours prior to your visit at (919) 571-3661.

Please let us know if you have any questions or concerns before your visit. We look forward to seeing you!

Sincerely,

Carolina Endocrine, P.A. Staff

Patient Name: _____

Appointment Date: _____ Time:_____ am/pm.

Registration @ _____ am/pm.

T / W / N / C

(Office use only)

Carolina Endocrine, P.A.

Patient Registration Form

Name _____ Chart # _____
First Middle Last

Date of Birth _____ Age _____ Social Security # _____ Male / Female (circle one)

Marital Status (circle one) Single Married Widowed Divorced Separated

Home Address

_____
Street City State Zip

Billing Address (if different from home address)

_____
Street City State Zip

Home Phone# _____ Work Phone# _____ Cell Phone # _____

Email Address (required if using patient portal): _____

Emergency Contact _____ Phone _____

Primary Care Physician (Name and Phone) _____

Referring Physician (Name and Phone) _____

Preferred Pharmacy Name and Phone # _____

How did you hear about us _____

Employment:

Employer (Name and Address) _____

Responsible Party (if patient is under 18 we must have a person legally responsible):

Name _____ Relationship _____

Address _____ Phone _____

Policy holder Insurance Information:

INSURANCE INFORMATION	PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insurance Company		
Name of Policy Holder/Subscriber		
Date of Birth of Policy Holder		
Employer of Policy Holder		

Authorization to Release Information:

I, the undersigned, consent to medical evaluation and treatment by Carolina Endocrine, P.A. I authorize payment of medical benefits to Carolina Endocrine, P.A. for any services provided by the physician and/or staff. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or its agents, information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims or benefits.

Patient's Signature or Responsible Party _____ **Date** _____

Carolina Endocrine, P.A

2605 Blue Ridge Road suite 190
Raleigh NC 27607

Office Policies & Procedures

This is a description of our office policies and procedures. After reviewing and signing, please let one of our staff members know if you have any questions. We appreciate your understanding of these policies.

Financial Policy

Payment for all co-pays, coinsurances and any other fees are due at the time of your visit. We reserve the right to reschedule appointments if these payments are not made at time of service. We accept cash, personal checks, MasterCard and Visa. Please make certain that you bring one of these forms of payment with you each time you visit our office. If you are unable to make proper payments at the time of service, please let the receptionist know **PRIOR** to being seen so we can make payment arrangements.
There is a $25 fee for all returned checks. You may request a copy of your records for a $10 fee.

As a service to our patients, we will file insurance claims for almost all insurance companies. We apologize for not being able to participate in all insurance plans for all of our patients. We currently have contracts with the following carriers:

BCBS **State Health Plan** **Medcost**

Aetna **Tricare** **Cigna** **United Healthcare** **Wellpath**

Medicare (Dr. Julia Warren-Ulanch only, under 18 years of age)
Medicaid (Dr. Julia Warren-Ulanch only, under 18 years of age)

For Medicare patients, please remember that you have an annual deductible to meet (starts January 1st), then you are responsible for 20% of your bill. There will be some exceptions if you have secondary insurance coverage.

Cancellation of Appointments

A minimum of 48 hours notice is required to cancel any appointment with Carolina Endocrine, P.A. A $25 cancellation fee will be billed to you should you fail to notify us. This policy helps us accommodate patients who need to be seen urgently. We appreciate your understanding in this matter.

Radioiodine patients will be responsible for a $50 fee if canceling and/or rescheduling without a minimum of 24 business hours. The costly testing/treatment supplies for radioiodine are ordered specifically for each patient.

Patient Phone Calls and Prescription Refills

It is our policy to refill medications at the time of your visit as we do not routinely refill prescriptions by phone. It is your responsibility to bring your medications bottles to every visit to ensure you receive the refills needed. However, should you need to, please have your pharmacy FAX a request to our office at (919) 571-3290. Please allow 2-3 business days for you request to be processed.

Acknowledgment of Office Policies & Procedures

I, the undersigned, acknowledge the Policies of Carolina Endocrine, P.A. I understand that I am financially responsible for all charges relating to co-payments, deductibles and non-covered services at the time of my visit. I authorize my insurance benefits to be paid directly to Carolina Endocrine, P.A. I acknowledge that if I have insurance coverage other than those listed above, or if I am uninsured, that I am responsible for all charges incurred in this office at the time of service. I understand that all unpaid balances that are 90 days past due will be turned over for collection, unless payment arrangements have been made.

Patient's Signature or Responsible Party **Date**

CAROLINA ENDOCRINE, P.A.

Notice of Privacy Practice

1. **Our Pledge Regarding medical Information**

The privacy of you medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. **Our Legal Duty**

Law Requires Us to:

A. Keep your medical information private.
B. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
C. Follow the terms of the current notice

We have the Right to:

A. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
B. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

A. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. **Use and Disclosure of Your Medical Information**

The following section describes different ways that we use and disclose medical information. Not every use of disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Options:

We may use and disclose your medical information for our health care options. This may include measuring and improving quality, evaluation the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification:

We may use and disclose medical information to notify or help notify a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray, or medical information for you.

Disaster Relief:

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances:

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:

Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical 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 share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authority's charges with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction or the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products or to conduct activities required by the Food and **Drug Administration**. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being par of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure, or disciplinary actions, or other authorized activities.

Appointment Reminders:
We may use and disclose medical information for purpose of sending you appointment postcards or otherwise reminding you or your appointments.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by law certain laws (such as the reporting of certain types of wounds) pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement officials, reports regarding suspected victims crimes at the request of a law enforcement official, reports death, crimes on our premises, and crimes in emergencies.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and describe or recommend treatment alternatives.

4. **Your Individual Rights**

You Have the Right to:

A. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access.
B. Receive a list of all times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
C. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
D. Request that we communicate with you about your medical information by different mean or to different locations. Your request that we communicate your medical information to you by different mean or at different location must be made in writing to our Privacy Officer.
E. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
F. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

5. **Questions and Complaints:**

If you have questions about this notice, please ask the receptionist to speak with our Privacy Officer. If you think we may have violated your rights, you may speak to our Privacy Officer and submit a written complaint. You may submit a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

Carolina Endocrine, P.A.

Michael J. Thomas, M.D.
Julia Warren-Ulanch, M.D.
Nicole M. McDermott, PA-C
Courtney C. Koppenal, PA-C

Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned hereby acknowledges that a copy of the HIPAA laws and guidelines has been provided to them by Carolina Endocrine, P.A.

I authorize Carolina Endocrine's staff to leave medical, appointment and/or account information pertaining to my care by the following methods. This authorization expires one year from the date signed. I will assume the responsibility to notify them of any changes in this information:

Home Phone Voicemail: Yes / No

Work Phone Voicemail: Yes / No

Cell Phone Voicemail: Yes / No

Person(s) authorized to speak with:_____

Other: _____

_____

***Which medical provider referred you to our office**? _____

Please list **all other medical providers** we are authorized to speak with, give medical information and/or billing information to on your behalf should you request us to do so (**do not include who referred you**):

Name of Doctor/Provider	Practice Name	Tel Number
1.		
2.		
3.		

_____
Patient's Signature or Responsible Party

_____
Witness Signature

_____
Date

Carolina Endocrine, PA

Adult Medical History Form

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

Occupation: (retired) (active):_____ Circle: Married Divorced Widowed Single

***Reason for Today's Visit:**_____

Do you: (Please circle Yes or No and explain if Yes)

Live w/Others	No	Yes	_____
Have Children	No	Yes	# Living _____, # deceased_____ from _____
Exercise:	No	Yes	Hours per week:_____.
Smoke:	No	Yes	Amt/Day _____. Stopped? When? _____
Alcohol:	No	Yes	Oz's/Day_____

Medications:

List any medications you are currently taking with dosage (include over the counter & vitamins):

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

Drug Allergies:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past Medical History:

Have you ever had surgery or been Hospitalized? Please list below.

1._____
2._____
3._____

Problems for which you have seen a physician or been treated for: (please circle yes or no)

Diabetes:	Yes	No	Nervousness/Anxiety	Yes	No
Cancer:	Yes	No	Pain	Yes	No
Respiratory	Yes	No	Heart	Yes	No
Blood Pressure	Yes	No	Other _____		
Thyroid	Yes	No			

Family History:

Is there a family history of any of the following (please circle):

Mother:	Diabetes	Cancer of _____	Heart Disease	Thyroid Disease	Living / Deceased
Father:	Diabetes	Cancer of _____	Heart Disease	Thyroid Disease	Living / Deceased
Brother:	Diabetes	Cancer of _____	Heart Disease	Thyroid Disease	Living / Deceased
Brother	Diabetes	Cancer of _____	Heart Disease	Thyroid Disease	Living / Deceased
Sister:	Diabetes	Cancer of _____	Heart Disease	Thyroid Disease	Living / Deceased
Sister:	Diabetes	Cancer of _____	Heart Disease	Thyroid Disease	Living / Deceased
Other:	Diabetes	Cancer of _____	Heart Disease	Thyroid Disease	Living / Deceased
Other:	Diabetes	Cancer of _____	Heart Disease	Thyroid Disease	Living / Deceased

Provider Initials _____ Reviewed completed forms with patient.

Carolina Endocrine, PA

ADULT REVIEW OF SYSTEMS

Name: _____ Age: _____ DOB: _____ Today's Date _____

Circle any positive response and then explain (e.g. location):

CONSTITUTIONAL SYMPTOMS:	Change in appetite	Chills	Change in weight	Fatigue
	Night sweats	Weakness	Fever	Trouble sleeping
SKIN/BREASTS:	Change in skin texture	Hair loss	Change in breast size or symmetry	Breast discharge
	Change in perspiration (sweating)	Rash	Itching	Breast tenderness
	New or unwanted hair growth	Change in complexion	Acne	Lumps in your breasts
ALLERGY/IMMUNOLOGIC:	Seasonal Allergies	Drug Allergies		
EARS- NOSE- MOUTH-THROAT:	Difficulty swallowing	Trouble w/ balance	Lumps or swollen glands in neck	Neck pain/stiffness
	Change in the appearance of neck	Hearing problems	Sinus problems	
EYES / HEAD:	Loss of Vision	Dry Eyes	Double vision	Eye Pain
	Blackouts or falling			
RESPIRATORY:	Shortness of breath	Frequent cough	Coughing up blood	Wheezing/Asthma
CARDIOVASCULAR:	Palpitations (heart fluttering or racing)	Swollen ankles/legs	Trouble sleeping in lying flat	Shortness of breath at night
	Chest pain			
GASTROINTESTINAL:	Indigestion	Abdominal pain	Constipation	Bloody stools
	Heart burn	Nausea	Vomiting	Black stools
	Change in bowel habits	Diarrhea		
GENITOURINARY:	Painful urination	Sexual problems	Trouble urinating	Change in libido
	Blood in urine	Frequent urination at night		
Women:	Menstrual problems	Menopausal symptoms	Fertility problems	
	Last menstrual period:	Number of pregnancies:	Number of live births:	
ENDOCRINE:	Frequent thirst	Frequent urination	Change in tolerance to heat or cold	Change in energy level
MUSCULOSKELETAL:	Joint pain	Back pain	Muscle cramps/aches	Bone pain
	Stiffness			
NEUROLOGICAL:	Loss of consciousness	Tingling or altered sensation	Seizures	Memory loss
	Loss of speech	Numbness of arms /legs	Severe headaches	Difficulty concentrating
	Dizziness	Tremors		
PSYCHIATRIC:	Anxious	Depressed	Crying spells	Disoriented
HEMATOLOGIC/LYMPHATIC:	Swollen glands	Bruise easily	Increased incidence in bruising	Problems with excessive bleeding

Do you have any other signs or symptoms or problems other than above? No Yes Please explain:

Provider Initials _____ Reviewed completed forms with pt.

Directions

From I-40 West

Exit 289 to Wade Avenue. Take Blue Ridge Road Exit. Turn left at the top of the ramp onto Blue Ridge Road. Turn left onto Lake Boone Trail. Turn Right onto Lake Drive (behind Blue Ridge Pharmacy). Turn Right into parking lot.

From I-40 East

Take Inner Beltline I-440 toward Raleigh. Exit 5 to Lake Boone Trail. Take a right at the stop sign onto Lake Boone Trail. Continue on Lake Boone Trail through the Blue Ridge Road Intersection. Turn Right onto Lake Road (behind Blue Ridge Pharmacy). Turn Right into parking lot.

Across from Rex Hospital, Raleigh, NC
2605 Blue Ridge Road, Suite 190
Raleigh, NC 27607

Phone: (919)-571-3661

Fax: (919)-571-3290