



7500 Beechnut Suite 252, Houston, Texas - 77074
 Tel: (281) 779-4243 Fax: (281) 779-4245
www.endoclinicstx.com

Welcome to Endocrinology Clinics of Texas, P.A.

We appreciate the opportunity to participate in your healthcare. We provide specialized care in the areas of thyroid disease, osteoporosis and bone disorders, diabetes and pre-diabetes states, adrenal gland disorders, pituitary disorders, non-surgical reproductive endocrinological disorders such as polycystic ovary syndrome (PCOS) and male testicular dysfunction and evaluation of infertility. We also diagnose and manage a variety of other endocrine disorders.

We look forward to seeing you at our clinic. Please take the following steps and bring the necessary forms to ensure that we are prepared for your visit and can most optimally meet your needs. We encourage you to check our website from time to time for updates.

- Please confirm with your referring physician that a request for your consultation and all related medical records have been sent.
- Bring your insurance card.
- Bring a form of co-payment with you. We accept cash, check, and major credit cards.
- If your insurance requires, please be prepared to apply payment towards your deductible.
- Please bring a list of your current medications (names and doses) or the bottles of your current prescriptions including non-prescription medications such as herbal remedies and vitamins.
- Please complete and bring the required forms.
- If you have diabetes, please ensure that we have an estimate of your recent hemoglobin A1C levels (HbA1C).



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PATIENT INFORMATION

Date: _____

Last Name _____ First, Middle
Name _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail
Address _____

Address _____
Street or PO Box _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security
Number _____

Marital Status _____ Gender: ☐ Male ☐ Female

Employer _____

Occupation _____

List Emergency Contact

Name _____ Contact
Phone _____

SPOUSE/PARTNER/GUARDIAN INFORMATION

Last Name _____ First, Middle
Names _____

Home Phone _____ Work
Phone _____

Cell Phone _____ E-mail
Address _____

Address _____
(if different from above) Street or PO Box _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____

Employer _____
Occupation _____

INSURANCE INFORMATION

How do you intend to pay for your visit?

☐ Cash

☐

Check

☐

Credit Card

☐

Insurance

Primary Health Insurance:

Insurance

Company _____

Mailing

Address _____

Policy or ID Number _____

Group

Number _____

Insured Name _____

Relationship to insured ☐ Self ☐ Spouse

☐

Child

Secondary Health Insurance:

Insurance

Company _____

Mailing

Address _____

Policy or ID Number _____

Group

Number _____

Insured Name _____

Relationship to insured ☐ Self ☐ Spouse

☐

Child

Preferred Pharmacy information including address (or location) and phone

Mail order Pharmacy (if

applicable) _____

Local Pharmacy name & phone

number _____

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned hereby authorizes the release of any medical or other information necessary to process this claim. I also request payment of government benefits to Endocrinology Clinics of Texas, P.A. I furthermore authorize payment of medical benefits to Endocrinology Clinics of Texas, P.A. for services rendered to myself or to my minor child or for those whom I have guardianship or Power of Attorney for.

Signature of patient or
patient responsible party for patient
signature

Printed name and relationship to
if signature is not Patient's



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Patient Name _____ Date _____

Date of Birth _____

Main Concern(s)/Reason for visit
today _____

ALLERGIES (Please include type of reaction to each allergy listed) _____

Current Medications (Both prescription and over-the-counter including herbal, vitamins, etc)
Please include another page if needed. Disregard if you maintain a separate list. Please bring your list.

NAME OF MEDICATIONS AND THEIR DOSES

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

CURRENT MEDICAL CONDITIONS

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

PREVIOUS MEDICAL PROBLEMS OR HOSPITALIZATIONS, SURGERIES, PROCEDURES
(Please include dates)

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

FAMILY HISTORY (List any health problems of your closely related family members)

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

PERSONAL AND SOCIAL HISTORY

OCCUPATION _____

Smoking ☐ Current ☐ Ex-smoker ☐ Lifetime non-smoker

If a current or an ex-smoker number of packs of cigarettes per day smoked _____

Number of years smoked (add up all the years and discount the breaks if any) _____

If ex-smoker, when did you quit (year) _____

Do you consume alcoholic beverages? ☐ Yes ☐ No

If "yes" how much _____

Do you exercise? ☐ Yes ☐ No

If yes, Average duration of each session _____; Number of sessions/week _____

Types of exercise activities _____

REVIEW OF SYSTEMS

Circle if any of these apply. Feel free to annotate on this page or a separate sheet if you would like to elaborate or clarify.

Weight ☐ gain How much did you gain? _____ lbs; over what period? _____

☐ loss How much did you lose? _____ lbs; over what period? _____

Appetite ☐ Increased ☐ Decreased ☐ Normal

Thirst ☐ Increased ☐ Decreased ☐ Normal

Fatigue ☐ Yes ☐ No

Fever ☐ Yes ☐ No

SKIN ☐ Excessively Dry ☐ Excessively Moist

Change in skin color ☐ Yes ☐ No

Easy bruising ☐ Yes ☐ No

New stretch marks ☐ Yes ☐ No

Skin Rash ☐ Yes ☐ No

Acne ☐ Yes ☐ No

Excessive body hair growth ☐ Yes ☐ No

Scalp Hair loss ☐ Yes ☐ No

Do you feel unusually hot or cold? ☐ Yes ☐ No

EYES

Change in appearance ☐ Yes ☐ No

Loss of Vision ☐ Yes ☐ No

Blurry Vision ☐ Yes ☐ No

Double vision ☐ Yes ☐ No

HEAD, NOSE, THROAT

Headache ☐ Yes ☐ No

Change in Hat/head size ☐ Yes ☐ No

Change in dental bite ☐ Yes ☐ No

Inability to smell ☐ Yes ☐ No

Hoarseness of voice ☐ Yes ☐ No

Difficulty to swallow ☐ Yes ☐ No

Lump in neck ☐ Yes ☐ No

Snoring ☐ Yes ☐ No

BREAST

Pain ☐ Yes ☐ No

Lump ☐ Yes ☐ No

Discharge ☐ Yes ☐ No

CHEST

Chest pain or discomfort ☐ Yes ☐ No
Difficulty breathing ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No

ABDOMEN

Diarrhea ☐ Yes ☐ No
Pain ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Nausea ☐ Yes ☐ No
Vomiting ☐ Yes ☐ No
Peptic ulcers ☐ Yes ☐ No

KIDNEY AND GENITAL SYSTEM

Excessive urination ☐ Yes ☐ No
Pain on urination ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No
Decrease in libido ☐ Yes ☐ No
Difficulty in erections (men) ☐ Yes ☐ No
Abnormal menses (women) ☐ Yes ☐ No
Excessive bleeding during menses ☐ Yes ☐ No
Reduced blood loss during menses ☐ Yes ☐ No
Are you pregnant (for women)? ☐ Yes ☐ No
Last Menstrual period (for women) _____
Method of Contraception :

MUSCLE ☐ Cramps ☒ Weakness ☐ aches

BONES and EXTREMITIES ☐ change in hands or feet size
☐ fractures ☐ bone pains ☐ joint pains ☐ calf pain on walking or running

BLOOD DISORDERS

Do you have anemia? ☐ Yes ☐ No



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CONDITIONS OF TREATMENT

Patient Name _____

Date of Birth _____

- I. Insurance Verification and/or Pre-Authorization - Many insurance companies require pre-authorization for various procedures. Endocrinology Clinics of Texas P.A. will assist the patient in obtaining the necessary pre-authorizations when needed, but it is ultimately the patient's responsibility to determine if your insurance company requires this. Failure to obtain necessary pre-authorization or second opinions may result in a reduction or rejection of benefits by the insurance company.
- II. Assignment of Insurance Benefits - I hereby authorize my insurance company to pay Endocrinology Clinics of Texas P.A. directly. I understand that I am responsible for charges not covered by my insurance company including late penalty charges. I agree that a photocopy of this authorization is as effective as the original.
- III. Confidentiality - Confidential information expressly identifies the medical nature of the service rendered to a patient, and includes all information and records obtained in the course of treatment. It includes information from history and physician examination, diagnosis, treatment rendered, laboratory and radiology results, progress notes, and miscellaneous medical reports.
- IV. Medicare authorization: Patient's certification authorization to release information and payment request – I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient named above to release such information to the Social Security Administration or its intermediaries or carriers, effective from (today's date) _____ forward.
- V. Authorization for disclosure of Information for Purpose of Service Reimbursement - I hereby authorize Endocrinology Clinics of Texas P.A. to disclose all or part of the medical record of the above patient to any company that may be responsible for payment of all or part of that patient's medical charges. Disclosure of the medical record may be necessary to determine eligibility for benefits and to obtain reimbursement for health care services. I hereby release Endocrinology Clinics of Texas P.A. from all legal responsibility or liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing.
- VI. Financial Agreement - I understand that in consideration of the services rendered, I am obligated to pay Endocrinology Clinics of Texas, P.A. in accordance with its regular rates, terms, or contractual agreements. I understand that I am responsible for any service "not covered" by insurance and that the obligation to pay for medical services may not be deferred for any reason. If the account is referred to any agency for collection, I agree to pay all collection expenses.
- VII. I have read and understand this financial agreement. I have had an opportunity to ask questions and, at my request, received a copy of my signed form. I accept the responsibility of its terms.

Patient Signature _____

Date _____



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CO-PAY AND DEDUCTIBLE POLICY

We ask that all office visits and services be paid for at the time they are provided. The exceptions to this are patients covered by companies with whom we have signed participating agreements. If your insurance is an HMO, you are required to obtain an authorization from your referring healthcare provider before we can see you. This would allow us to see you during a specific time period and for a specific number of visits. It is extremely important that we know this information before your appointment. We will make every effort to help you with this. If we do not have an authorization at the time of your visit, you will be asked to sign a waiver that makes you responsible for services performed on that day. If you do not wish to sign the waiver, ***your appointment will be rescheduled.*** Please come prepared to pay your co-pay whenever you are seen.

For non-HMO insurances with whom we participate, please come prepared to pay your co-payment and deductibles. Arrangements can be made when expenses require installment payments.

I have read and understand this policy and accept the responsibility of its terms.

Patient Signature _____

Date_____



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LATE ARRIVAL AND NO SHOW POLICY

Patient Name _____

Date of Birth _____

We, at Endocrinology Clinics of Texas, PA strive to provide high quality health care to all of our clients in a timely manner. Failure to keep scheduled appointments is costly not only to the clinic but also to you as a patient. Late arrivals beyond 30 minutes of your expected appointment can cause significant inconveniences not only to the healthcare providers, but also to other patients. We routinely recommend that you plan to arrive at least 30 minutes in advance to your first visit if you have had a chance to complete the paperwork from our website. In the event you do not have access to internet our staff would have asked you to arrive at least 60 minutes prior to your appointment to complete the paperwork. Follow-up visits should be relatively simpler, and we recommend that you arrive at least 15 minutes prior to your appointment. This letter is to inform you of our policy concerning "No Shows" and late arrivals.

Patients who are unable to keep their appointments are requested to give 24- hour notice prior to their appointments. We realize it is not always possible to provide this notice and we will consider this on a case by case basis. Providing such notice allows the clinic time to offer other persons the opportunity to see our providers, thus using the clinic time more efficiently. If an established patient fails to provide notice twice, it will be necessary to charge them a \$25.00 fee that will be billed to his/her account. If a patient has confirmed his/her appointment and fails to keep that appointment, there will be a \$50.00 fee billed to his/her account. If a patient fails to keep his/her appointments on a regular basis, or has missed 3 consecutive appointments, he/she will be considered dismissed from the practice, and a letter of dismissal will follow.

Late arrivals defined as arrivals 30 minutes past the scheduled appointment will need to be rescheduled. However, depending on the workflow of the clinic, we may or may not be able to accommodate you. This can only be determined by the clinic staff after your arrival.

I have read and understood this policy, and accept the responsibility of its terms.

Patient Signature_____

Date_____



Privacy Notice (HIPPA)

IMPORTANT: 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.

Endocrinology Clinics of Texas, P.A. is required by law to protect certain aspects of your health care information known as Protected Health Information or PHI and to provide you with this Notice of Privacy Practices. This Notice describes our privacy practices, your legal rights, and lets you know, how *Endocrinology Clinics of Texas, P.A.* is permitted to

1. Use and disclose PHI about you
2. How you can access and copy that information
3. How you may request amendment of that information
4. How you may request restrictions on our use and disclosure of your PHI.

In most situations we may use this information described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

PLEASE READ THE FOLLOWING DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT HIPPA Privacy Officer listed below and someone will contact you.

Shikha Bharaktiya, MD
Endocrinology Clinics of Texas, P.A
8200 Wednesbury Ln Ste 105
Houston, TX 77074
Tel: (713) 271-2030
Fax: (713) 271-2351

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.

Purpose of this Notice: This Notice describes your legal rights, advises you of our privacy practices, and lets you know how *Endocrinology Clinics of Texas, P.A.* is permitted to use and disclose Protected Health Information (PHI) about you.

Uses and Disclosures of PHI: *Endocrinology Clinics of Texas, P.A.* may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission.

Examples of our use of your PHI:

For treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Use and Disclosure of PHI Without Your Authorization: *Endocrinology Clinics of Texas, P.A* is permitted to use PHI without your written authorization, or opportunity to object in certain situations, including:

1. For *Endocrinology Clinics of Texas, P.A.*'s use in treating you or in obtaining payment for services provided to you or in other health care operations;
2. For the treatment activities of another health care provider;
3. To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
4. To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
5. For health care fraud and abuse detection or for activities related to compliance with the law;
6. To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew;
7. To a public health authority in certain situations (such as reporting a birth, death or disease as required

- by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease as required by law;
9. For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
 10. For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
 11. For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;
 12. For military, national defense and security and other special government functions;
 13. To avert a serious threat to the health and safety of a person or the public at large;
 14. For workers' compensation purposes, and in compliance with workers' compensation laws;
 15. To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
 16. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
 17. For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law;
 18. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization, (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information based upon that authorization.

Patient Rights: As a patient, you have a number of rights with respect to the protection of your PHI, including:

- I. **The right to access, copy or inspect your PHI:** This means you may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have forms available for you to request access to your PHI. We will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer liaison listed at the end of this Notice.
- II. **The right to amend your PHI or The right to request amending your PHI:** You have the right to ask us to amend written medical information that we may have about you. If errors are found, we will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information, but only in certain circumstances. For example, if we believe the information is correct and no errors exist, your request will be denied. If you wish to request that we amend the medical information that we have about you, you should contact in writing the privacy officer listed at the end of

this Notice.

- III. **The right to request an accounting of our use and disclosure of your PHI:** You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, such as our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact the privacy officer listed at the end of this Notice.
- IV. **The right to request that we restrict the uses and disclosures of your PHI:** You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. However, if you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide you with emergency treatment. *Endocrinology Clinics of Texas, P.A* is not required to agree to any restrictions you request, but any restrictions agreed to by *Endocrinology Clinics of Texas, P.A* are binding on *Endocrinology Clinics of Texas, P.A*.

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request: If we maintain a web site, we will prominently post a copy of this Notice on our web site and make the Notice available electronically through the web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

Revisions to the Notice: *Endocrinology Clinics of Texas, P.A* reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting the Privacy Officer identified below.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to the privacy officer listed at the end of this Notice. Individuals will not be retaliated against for filing a complaint.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact **HIPPA Privacy Officer** listed below:

Shikha Bharaktiya, MD
Endocrinology Clinics of Texas, P.A
8200 Wednesbury Ln Ste 105
Houston, TX 77074
Tel: 281-779-4342
Fax: 281-779-4245

Effective Date of the Notice:



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PRIVACY NOTICE SIGNATURE FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name of Patient: _____ Birth date: _____

Print Name of Authorized Representative (if applicable):

Signature of Patient or Authorized Representative:

Date: _____

Comments of Endocrinology Clinics of Texas, P.A. regarding why a written acknowledgement was not obtained:



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PATIENT RECORD OF DISCLOSURES

HIPPA Privacy Law gives individuals the right to determine who and how one would like to receive protected health information (PHI). The individual can decide the method of preferred communication of confidential information and also restrict the use of certain other forms of communication. For instance, you could choose to have your medical information communicated to you through your cell phone rather than the home phone. This form will help the healthcare provider determine what method of communication should be used for the transmission of PHI. It is also your responsibility to ensure that our offices have the most current contact information.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____

- ☐ OK to leave a message on the answering machine with detailed information
☐ Leave message with call-back number only

Written Communication (Regular mail)

- ☐ O.K. to mail to my home to my home address
☐ O.K. to mail to my work/office address
☐ O.K. to fax to this number _____

Work Telephone: _____

- ☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

Other Friends/Family _____

Patient Signature _____ Date _____

Print Name _____ Birthdate _____