NEW PATIENT REGISTRATION

PLEASE COMPLETE ALL INFORMATION. PRINT AND SIGN WHERE REQUIRED

PATIENT INFORMATION

Last Name: _____ **Date of Birth**: _____
First Name: _____ **MI**: ____ **Assigned sex at birth**: □ Male □ Female
Maiden Name (if applicable): _____ □Unknown □Choose not to disclose
SSN: _____ **Gender Identity**:
(Providing your SSN is optional; however for patients with Medicare or Medicaid, may help determine eligibility for certain benefits)
□ Identifies as male
□ Identifies as female
Address: _____ □Transgender male (FTM)
_____ □ Transgender female (MTF)
City:_____ □ Gender non-conforming
State: _____ **Zip Code**: _____ □ Other, please specify: _____
Please put an (X) on your preferred contact # □ Choose not to disclose
Home: _____( ) **Pronouns**: □ she/her □ he/him □ they/them
Cell: _____( ) **Marital Status**: □ Single □ Married □ Divorced
Work: _____**Ext**._____( ) □ Separated □ Widowed □ Partner
Email: _____ **Are you hispanic/latino?**: □Yes □No □Decline
Communication: □ Leave a detailed voicemail **Race**: □ White □ Black/African American □Asian
□ Leave message with a call back number only □Asian Indian □ Native Hawaiian/Pacific Islander
Preferred Language: _____ □American Indian/Alaskan Native
□ Other (fill-in) _____ □ Decline

PRIMARY INSURANCE	SECONDARY INSURANCE
Ins. Company: _____	Ins. Company: _____
Policy ID #: _____	Policy ID #: _____
Subscriber Information (if different from patient)	Subscriber Information (if different from patient)
First Name: _____	First Name: _____
Last Name: _____	Last Name: _____
Date of Birth: _____ Sex: □ Male □ Female	Date of Birth: _____ Sex: □ Male □ Female
Address: _____	Address: _____
_____	_____
City:_____	City:_____
State: _____ Zip Code: _____	State: _____ Zip Code: _____

EMERGENCY CONTACT

#1 Person/Entity Name:_____ **Home Number**: _____
Relationship to Patient:_____ **Mobile Number**: _____
□ DO NOT discuss health information □ OK to discuss health information

#2 Person/Entity Name:_____ **Home Number**: _____
Relationship to Patient:_____ **Mobile Number**: _____
□ DO NOT discuss health information □ OK to discuss health information

NEW PATIENT REGISTRATION

OFFICE POLICIES

Thank you for choosing "Prime Endocrinology" for your endocrine care. Our office aims to provide you excellent medical care and customer service. We have implemented policies that will assist us to achieve our goals that we would like to bring to your attention:

1-New patients-please arrive 15 minutes before your appointment time. You must have a valid insurance card and current identification at the time of the first visit.

2- Insurance co-pays are due at the time of service: Patients who do not pay their co-pay are billed a $15.00 service charge in addition to their co-pay. If you have an outstanding balance at the time of your appointment, payment will be expected. We accept cash, checks, and all major credit cards for your convenience. There is a $25.00 service charge for a returned check. Insurances are billed as a courtesy and the patient has financial responsibility for payment in full for services rendered.

3- Insurance coverage: We recommend that you check with your insurance company whether we are listed under the network and what's your expected payment. As we are a specialist office, if your insurance company requires referral/authorization from your primary care physician, be sure that you have obtained a valid referral or authorization prior to your appointment. If you do not have a valid referral or authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

4- Appointment and Cancellation policy: We recommend arrival 15 minutes prior to the visit. Late arrivals will be seen only upon the discretion of the provider. We request the courtesy of an **advanced notification of 24 business hours.** If you fail to notify us of your inability to keep your appointment, a "no-show" for your appointment time will be noted in your chart. After two consecutive no-shows, you may be considered for discharge from the practice. All patients who fail to present for their visits or cancel within 24 hours of their appointment will be subject for a fee. The fee will be waived if they reschedule within 24 hours after the missed visit. The charge is $50.00 for the first visit and $25.00 for a follow-up visit.

5-Prescription refills: New prescriptions and prescription changes are available to you during your visit. Refill requests should be made directly to your pharmacy. Please do not wait until you are out of medication to request a refill and **allow 1 business day** for prescription refills.

6- Lab copies: Most of the time, your labs will be available to be seen through the patient portal online. Paper copies of your labs can be requested during your visit as well.

7- Medical records: If another practitioner is requesting your records, they can be sent electronically or faxed to the requesting provider at no charge after you sign a medical release. Otherwise, to obtain a copy of medical records, there is a fee of $1 per page to a maximum of $100 and may take up to two weeks. The records can be picked up at the office. Upon request they may be mailed Certified/Return Receipt for an additional cost of the mailing fee.

8- Online Communication: As a courtesy to our patients, we respond to your requests online through the patient portal. We recommend that the online communication be brief and limited to simple questions and answers. Please allow 24 - 48 hours for a response from our office. For urgent matters, we recommend that you call our office.

9. After-hour phone calls: We are happy to answer the phone during our regular business hours, which is Monday to Friday, 8:30 am till 4:30 pm and we are closed for lunch between 12:00 pm and 1:00 pm. If you call our office after 4:30 pm or over the weekend, we advise that you leave a message and we will respond to you the next business day. If you have a matter that requires urgent medical attention, we advise that you visit the nearest Emergency Room.

I read the office policies for Prime Endocrinology and I agree to all of them

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Signature of patient or patient representative Today's Date

NEW PATIENT REGISTRATION

ELECTRONIC MAIL CONSENT FORM

Before allowing electronic mail ("email") communications with Prime Endocrinology, LLC please read and agree to the following information regarding the risks and conditions of email use:

The Risks of Using Electronic Mail

We offer patients and other individuals the opportunity to communicate by email. However, transmitting patient information by email has a number of risks that should be considered. These include, and are not limited to, the following risks:

- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Email senders can easily misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email may exist even after sender or recipients have deleted their copy.
- Employers and on-line services have a right to archive and inspect emails transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used as evidence in court.

Conditions for the Use of Electronic Mail

We will use reasonable and appropriate means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by our intentional misconduct. Thus, individuals must consent to the use of email for information. Consent to the use of email includes agreement with the following conditions:

1. All emails to or from patients concerning diagnosis or treatment may be printed out and made a part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
2. We may forward emails internally to the practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. We will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
3. Although we will endeavor to read and respond promptly to an email, we cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, patients should NOT use email for medical emergencies or other time-sensitive matters.
4. If the individual's email requires or invites a response, and the individual has not received a response within a reasonable time period, it is the individual's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
5. Individuals should not use email for communication regarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse

6. Individuals are responsible for informing us of any types of information that they desire not to be sent by email, in addition to those out in the above paragraph.
7. The individual is responsible for protecting his/her password or other means of access to email. We are not liable for breaches of confidentiality caused by the individual or any third party.
8. We will not engage in email communication that is unlawful, such as unlawfully practicing medicine across state lines.

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9. It is the individual's responsibility to follow up and/or schedule an appointment if warranted.

Communicating by email

To communicate by email, patients and other individuals shall:

1. Limit or avoid the use of his/her employer's computer.
2. Inform us of changes in his/her email address.
3. If the sender is a patient of ours, to put the patient's name in the body of the email.
4. Review the email to make sure that it is clear and that all relevant information is provided before sending.
5. Take precautions to preserve the confidentiality of email, such as using screen savers and safeguarding his/her computer password.
6. Withdraw consent only by email or written communication to the practice.

Acknowledgment and Agreement

I acknowledge that I have read and fully understood this consent form. I understand the risks associated with the communication of email between Prime Endocrinology and me, and consent to the conditions outlines herein. In addition, I agree to the instructions for communicating by email outlined herein, as well as any other instructions that Prime Endocrinology may impose to communicate using email.

Please select one of the following regarding email communication:

□ I do wish to be communicated via email

□ I do not wish to be communicated via email

Please select one of the following regarding our patient portal:

□ I do wish to receive a link to create a patient portal account

□ I do not wish to receive a link to create a patient portal account

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Signature of patient or patient representative Today's Date

NEW PATIENT REGISTRATION

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____
D.O.B: _____ SOCIAL SECURITY NUMBER: _____
ADDRESS:_____
TELEPHONE: Home: _____Cell:_____

I hereby authorize:

_____
Phone: _____Fax: _____

To disclose my health information to Prime Endocrinology LLC,
Dr. Sudha Ganne, MD at 103 Parker Road Suite B, West Long Branch NJ 07764
Phone: 732-222-0307 Fax: 732-222-0394

The information to be disclosed to and used by the above is for the following purpose:

_____
This authorization is limited to the following dates of treatment:
FROM _____ TO _____
Information to be disclosed:

□ COMPLETE RECORD	□ CLINIC RECORDS	□ REHAB. RECORDS
□ EMERGENCY ROOM RECORD	□ CONSULTATIONS	□ PATHOLOGY
	□ PROGRESS NOTES	□ BILLING INFO.
□ OPERATIVE REPORT	□ LAB, X-RAYS & TESTS	□OTHER_____
□ DISCHARGE SUMMARY		

I understand that the information to be disclosed includes my identity, diagnosis and treatment including Alcohol, Drugs, Genetic testing, Behavioral or Mental Health Services, Reproductive Rights, Sexually Transmitted & Infectious Diseases, AIDS and HIV information, as applicable.
It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Dr.Sudha Ganne of Prime Endocrinology LLC. I understand that this revocation will not apply to the extent of any actions that the practice has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or Condition: _____.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
If I have questions about disclosure of my health information, I can contact Dr.Sudha Ganne of Prime Endocrinology LLC at 103 Parker Road Suite B, West Long Branch NJ 07764 Phone: 732-222-0307

PATIENT SIGNATURE:_____ DATE: _____
LEGAL REPRESENTATIVE:
Name: _____ RELATION: _____ DATE: _____

NEW PATIENT REGISTRATION

PLEASE READ CAREFULLY, INITIAL NEXT TO EACH STATEMENT AND SIGN

CONSENTS

1. _____ I have read and received a copy of this practice's Notice of Privacy Practices and the office policies.

Consent to release medical information

2. _____ I give consent to release medical information to the following parties: Third party payors covering the medical services, other health care professionals, institutions involved in my care, the proponent of any legally sufficient subpoena, or in response to a court order, employees and agents of the practice, pharmacies and other parties as otherwise required by law.

Consent to use Surescripts

3. _____I authorize "Prime Endocrinology" to use SureScripts, Inc. a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy.

Assignment of Benefits

4. _____I hereby assign all medical benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), to issue payment check(s) directly to " Prime Endocrinology" for the medical services rendered to myself.

Consent to treat

5. _____ I give permission for Prime Endocrinology to give me medical treatment. I understand that I have the right to discuss all medical treatments with my provider and to refuse any procedure or treatment.

Financial Policy

6._____ I understand that "Prime Endocrinology" will bill my insurance for the visit as a courtesy. I am still responsible to pay all expenses in case the insurance does not submit the payment on time.

Releasing medical information to friends and family

7. _____ I hereby give authorization to release information and/or discuss my medical condition including my protected health information with the person(s)/entities listed per my request under emergency contacts.

This authorization can be revoked at any time upon my request in writing.

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Signature of patient or patient representative Today's Date

NEW PATIENT REGISTRATION

MEDICAL HISTORY

REASON FOR VISIT:

□ Diabetes ___1 ___2
□ Weight issues
□ Hypothyroidism
□ Hyperthyroidism
□ Goiter
□ Thyroid nodules
□ Thyroid cancer
□ PCOS/hirsutism
□ Gestational diabetes
□ Irregular periods
□ Adrenal insufficiency
□ Adrenal adenoma
□ Parathyroid disease/hypercalcemia
□ Osteoporosis
□ Pituitary adenoma
□ Other _____

CURRENT MEDICATIONS/VITAMINS: □ check here if you have a separate list

NAME	DOSE	FREQUENCY

SURGICAL HISTORY (please include the year)**:**

LAST COLONOSCOPY (45+): _____

SMOKING HISTORY

Do you or have you ever smoked tobacco? ☐ Current ☐ Past ☐ Never
If you are a current/past smoker, how many years have/did you smoke tobacco? _____years
If past smoker, when did you quit? _____ months or _____ years
Do you or have you ever used any other forms of tobacco or nicotine? □ Yes □No
Do you use any illicit or recreational drugs? □ Yes □No

ADVANCE DIRECTIVE/LIVING WILL

Do you have a living will/advance directive? □ Yes □ No If yes, please provide a copy to the office.

FAMILY HISTORY:

NEW PATIENT REGISTRATION

Family Member	Medical Conditions
Mother	
Father	
Brother(s)	
Sister(s)	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

CARE TEAM:

NAME	SPECIALTY	PHONE	ADDRESS

For diabetics ONLY, please list your ophthalmologist and last visit date:

_____

_____

MAIL ORDER PHARMACY: _____

LOCAL PHARMACY NAME: _____
ADDRESS: _____
PHONE NUMBER: _____

NEW PATIENT REGISTRATION

PHQ-9 DEPRESSION SCREENING

Over the last two weeks, how often have you been bothered by any of the following problems?

☐ check here if you do not wish to participate in this screening

Little interest or pleasure in doing thing

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble falling or staying asleep, or sleeping too much

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling tired or having little energy

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Poor appetite or overeating

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling bad about yourself - or that you are a failure or have let yourself or your family down

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Thoughts that you would be better off dead or of hurting yourself in some way

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

NEW PATIENT REGISTRATION

STEADI- FALL RISK ASSESSMENT

(ONLY COMPLETE IF 65 AND OLDER)

☐ check here if you do not wish to participate in this screening

Have you fallen in the past year?

☐ Yes ☐ No

Do you use or have you been advised to use a cane or walker to get around safely?

☐ Yes ☐ No

Do you sometimes feel unsteady while walking?

☐ Yes ☐ No

Do you steady yourself by holding onto furniture when walking at home?

☐ Yes ☐ No

Do you worry about falling?

☐ Yes ☐ No

Do you need to push with your hands to stand up from a chair?

☐ Yes ☐ No

Do you have trouble stepping up onto a curb?

☐ Yes ☐ No

Do you often have to rush to the toilet?

☐ Yes ☐ No

Have you lost some feeling in your feet?

☐ Yes ☐ No

Do you take medicine that sometimes makes you light-headed or more tired than usual?

☐ Yes ☐ No

Do you take medicine to help you sleep or improve your mood?

☐ Yes ☐ No

Do you often feel sad or depressed?

☐ Yes ☐ No