VIRGINIA ENDOCRINOLOGY

Ben Phillips MD • Cynthia Ryan MD • Akta Mukherjee MD • Kristin Fabiato MD
Elizabeth Wallace MD • Anita Prakash MD • Samantha Hudson MD
Alexander Millis MD • Sarah Bearer MD • Laura Harris PA
Marsha Di Peppe FNP • Alejandra Lozada MD • Erin Myers PA

2384 Colony Crossing Place | Midlothian, VA 23112
3460 Mayland Court, Suite 100 | Henrico, VA 23233

(804) 423-3636 (tel) (804) 423-3637 (fax)
WWW.VIRGINIAENDO.COM

Patient Information	
Title (Mr., Mrs., Miss…)	
Last Name	
First Name	
Middle Name	
Address Line 1	
Address Line 2	
City	
State	
Zip Code	
Home Phone	( )
Work Phone	( ) x
Cell Phone	( )
Fax number	( )
Sign here if ok to leave a medical message at your home?	x
Sign here if ok to leave a medical message on your cell?	x
E-mail address	
Sign here if ok to email you a reminder for your appt?	x
Primary Care Doctor	
Referring Doctor	
Birthday (mm/dd/yyyy)	
Gender	
Social Security #	
Employer Name	
Emergency Contact	
Last Name	
First Name	
Home Phone	( )
Work Phone	( ) x
Relationship to Patient	

Insurance Information	
Insurance Company	
Name of Policy holder	
Policy holder's relationship to patient	
Policy holder's birth date	
Other Insurance Company	
Pharmacy	
Pharmacy Name	
Address	
City	
Telephone Number	( )
Fax Number	( )

NEW PATIENT CHECKLIST

☐ **Referral.** We require that you obtain a referral from your primary care physician and check with your insurance to verify your benefits coverage. Please request that the referral is faxed to (804) 423-3637.

☐ **Medical Records.** Please call your primary care physician's office and request them to fax a copy of your medical records to us.

☐ **Insurance Card.** Please bring your insurance card

☐ **Medications.** Please bring all of your medication bottles to your visit and/or a complete updated list.

☐ **Patients with Diabetes.** If you have diabetes, please bring your blood sugar meter and blood sugar record. For the week prior to your visit, we request that you check your sugars 4 times a day (before each meal and bedtime) and bring these numbers written down to your appointment.

☐ **Cancellation and Missed Appointments.** If you are not able to keep your appointment, we request that you call as soon as possible, so that we may be able to provide more timely care to other patients who could be scheduled into your reserved time slot.

☐ **At least 24 hours notice is required for the cancellation of all appointments. A $25 charge may be added to your account if 24 hours notice is not received prior to a missed appointment.**

- **UPON COMPLETION OF THIS FORM, IF POSSIBLE, PLEASE FAX TO (804) 423-3637.**
- **IF YOU ARE UNABLE TO FAX PRIOR TO YOUR VISIT, PLEASE COME 15 MINUTES PRIOR TO YOUR SCHEDULED**

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FORM #2: PERSONAL HEALTH HISTORY INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name (Last, First Middle)		**Gender:**
Primary care or Referring doctor Name		**Date of Birth**:
Reason for referral to our practice		

MEDICATIONS: List your prescribed drugs, over-the-counter drugs, vitamins, and herbal supplements below

Name of Drug, Vitamin, Herb, or over-the-counter meds	Strength (i.e. 20 mg, units, cc's…)	Frequency Taken (number of times per day)

MEDICAL HISTORY: Please list all your Medical Conditions and Diagnoses below:

ALLERGIES: Allergies or Adverse Reactions to medications or other substances – please list drug names with allergic reactions below

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SURGERIES		
Year	Surgery	Hospital

HOSPITALIZATIONS		
Year	Reason	Hospital

FAMILY HEALTH HISTORY (PLEASE FILL IN FOR THOSE MEMBERS WITH WHOM YOU ARE FAMILIAR)

Are you Adopted ☐ **YES** ☐ **NO** IF YOU ARE ADOPTED, YOU DO NOT NEED TO COMPLETE THE FOLLOWING

	LIVING/DECEASED	**AGE**	**SIGNIFICANT HEALTH CONDITIONS**
Mother			
Father			
Please list any other significant medical conditions that run in any other family members here			

SOCIAL HISTORY

Marital Status	☐ Single	☐ Partnered	☐ Separated
	☐ Married	☐ Divorced	☐ Widowed
Employment	☐ Occupation / Employer →	☐ Homemaker	☐ Student (where, year) →

Tobacco	☐ NO - I do not smoke and have never smoked		
	☐ YES - I previously smoked but no longer smoke	Quit date?	
		Previous # of packs per day?	
		Previous total # of yrs smoking?	
	☐ YES – I am currently smoking	Number of packs per day?	
		Number of years smoking?	

Alcohol	☐ NO - I do not drink any alcohol		
	☐ YES – I previously drank alcohol but no longer drink alcohol	Quit Date?	
		Type of alcohol?	
		Number of drinks per week?	
	☐ YES – I drink alcohol	Type of alcohol?	
		Number of drinks per week?	

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Name: , Date of Birth:

	DO YOU HAVE THE FOLLOWING SYMPTOMS?			IF YES, PLEASE EXPLAIN:
GEN	Weight Gain	○ No	○ Yes	
	Weight Loss	○ No	○ Yes	
	Fatigue	○ No	○ Yes	
EYE	Loss of Vision	○ No	○ Yes	
	Double Vision	○ No	○ Yes	
	Bulging Eyes	○ No	○ Yes	
ENT	Hearing Loss	○ No	○ Yes	
	Hoarse Voice	○ No	○ Yes	
	Loss of smelling	○ No	○ Yes	
CARD	Chest pain	○ No	○ Yes	
	Palpitations	○ No	○ Yes	
	Leg Swelling	○ No	○ Yes	
PULM	Shortness of breath	○ No	○ Yes	
	Coughing	○ No	○ Yes	
	Wheezing	○ No	○ Yes	
ABDO	Difficulty swallowing	○ No	○ Yes	
	Abdominal Pain	○ No	○ Yes	
	Nausea / Vomiting	○ No	○ Yes	
	Constipation	○ No	○ Yes	
	Diarrhea	○ No	○ Yes	
UROL	Frequent Urination	○ No	○ Yes	
	Difficulty Urinating	○ No	○ Yes	
	Urinating at night	○ No	○ Yes	
	Kidney Stones	○ No	○ Yes	
	Problems with Erections	○ No	○ Yes	
GYN	Irregular menstrual cycles	○ No	○ Yes	
	Post-menopausal	○ No	○ Yes	
	Hot flashes	○ No	○ Yes	
MSK	Joint Pain	○ No	○ Yes	
	Back Pain	○ No	○ Yes	
	Fractures	○ No	○ Yes	
	Muscle Cramping	○ No	○ Yes	
	Loss of height	○ No	○ Yes	
NEUR	Headaches	○ No	○ Yes	
	Tremors	○ No	○ Yes	
	Numbness in hands / feet	○ No	○ Yes	
HEME	Easy bruising	○ No	○ Yes	
	Frequent Nosebleeds	○ No	○ Yes	
PSYCH	Depression	○ No	○ Yes	
	Trouble Sleeping	○ No	○ Yes	
	Eating Disorders	○ No	○ Yes	
DERM	Acne	○ No	○ Yes	
	Dry Skin	○ No	○ Yes	
	Extra facial hair growth	○ No	○ Yes	

- **UPON COMPLETION OF THIS FORM, IF POSSIBLE, PLEASE FAX TO (804) 423-3637.**
- **IF YOU ARE UNABLE TO FAX PRIOR TO YOUR VISIT, PLEASE COME 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME AND BRING THIS TO THE FRONT DESK. THANKS!**

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DIABETES FORM:

IF YOU HAVE DIABETES, PLEASE COMPLETE THIS FORM AS WELL

Name (Last, First Middle)						**Date of Birth:**	
What year were you diagnosed with diabetes							
How old were you when you were diagnosed with diabetes							
Have you had any diabetes complications, like	Eye problems (diabetic retinopathy)?	○ No ○ Yes					
	Nerve problems (diabetic neuropathy)?	○ No ○ Yes					
	Kidney problems (diabetic nephropathy)?	○ No ○ Yes					
	Heart problems, stroke, or blood vessel blockages?	○ No ○ Yes					
What pills (and doses) do you take for diabetes							
If you are insulin, what year did you start taking insulin							
Please list the insulin type, dose, and times of the day that you take it							
How many times a day do you check your sugars							
During the last month, what have been your sugars been: (generally speaking)							
Fasting / pre-breakfast sugars	Lowest		Highest		Usual		
Pre-lunch sugars	Lowest		Highest		Usual		
Pre-dinner sugars	Lowest		Highest		Usual		
Bedtime sugars	Lowest		Highest		Usual		

PNEUMONIA VACCINATION:	What year did you get your last pneumonia vaccine?	
	If you have **not** had a pneumonia vaccination: The Centers for Disease Control (CDC) recommends that all people with diabetes receive a pneumonia vaccination to reduce your chance of getting a bacterial pneumonia infection. It protects against 23 types of pneumococcal bacteria. It is recommended once before the age of 65 and once after the age of 65 but not within 5 years of a previous pneumonia vaccination.	Do you want a pneumonia vaccination during your initial clinic visit? ○ No ○ Yes
FLU SHOT:	Have you had a flu shot during this flu season (between October and February)? If so, in what month and year did you have it?	
	If you have **not** had a flu shot: A yearly flu shot is recommended to people with diabetes. Side effects include redness or pain at the site of injection and some people develop fevers and muscle aches. Severe allergic reactions have been reported rarely. DO NOT TAKE THE FLU SHOT IF YOU ARE ALLERGIC TO EGGS.	Do you want a flu shot during your initial clinic visit? ○ No ○ Yes
CHOLESTEROL: The American Diabetes Association recommends that people over the age of 40 with diabetes take a cholesterol medicine, no matter what your cholesterol. They are known to prevent heart disease. Are you taking a cholesterol medicine?		○ No ○ Yes
EYE EXAM: It is recommended that all people with diabetes have a yearly eye exam. When was your last eye exam? (month/year)		

- **Please bring your BLOOD GLUCOSE METER and your GLUCOSE LOG to your visit**
- **Please bring all of your medications with you to your visit**
- **Please fax these forms to (804) 423-3637 prior to your visit, or come 15 minutes prior to your appt**

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PATIENT NAME: _____ **SUGAR LOG FOR THE MONTH OF:** _____

DATE	PRE-BREAKFAST			PRE-LUNCH			PRE-DINNER			BEDTIME			OTHER
	TIME	SUGAR	INSULIN	TIME	SUGAR	INSULIN	TIME	SUGAR	INSULIN	TIME	SUGAR	INSULIN	STEPS
1													
2													
3													
4													
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FORM #3: AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO VIRGINIA ENDOCRINOLOGY

Patient's Name:		Date of Birth:	
Previous Name:		Social Security #:	
I request and authorize (Primary care doctor or referring physician)			

To release healthcare information of the patient named above to:

Virginia Endocrinology
2384 Colony Crossing Place
Midlothian, Virginia 23112
(804) 423-3636 phone
(804) 423-3637 fax

This request and authorization applies to:

☐	All healthcare information
☐	Healthcare information relating to the following treatment, condition, or dates:

SIGN IN THE SPACE BELOW

Patient Signature:		**Date Signed:**	

THIS AUTHORIZATION EXPIRES 12 MONTHS AFTER IT IS SIGNED

- **UPON COMPLETION OF THIS FORM, IF POSSIBLE, PLEASE FAX TO (804) 423-3637.**
- **IF YOU ARE UNABLE TO FAX PRIOR TO YOUR VISIT, PLEASE COME 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME AND BRING THIS TO THE FRONT DESK. THANKS!**

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION FROM VIRGINIA ENDOCRINOLOGY TO FAMILY MEMBERS

Patient's Name:			
Date of Birth			
I authorize the Virginia Endocrinology to release medical and billing information, either in person, over the phone, or in writing, to the following people:			
Name:		Name:	
Home Phone #:		Home Phone #:	
I understand that the person(s) that I have named above to receive private health information may be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect it			
SIGN IN THE SPACE BELOW			
Patient Signature:		**Date Signed:**	
THIS AUTHORIZATION EXPIRES 5 YEARS AFTER IT IS SIGNED			

CANCELLATION AND MISSED APPOINTMENT POLICY

Our practice philosophy is to provide comprehensive patient care by reserving dedicated blocks of time for each patient. Therefore, if you are not able to keep your appointment, we request that you **call as soon as possible** to let us know. This will allow us to provide more timely care to other patients who could be scheduled into your reserved time slot.

At least 24 hours notice is required for the cancellation of all appointments. A $25 charge will be added to your account if 24 hours notice is not received prior to a missed appointment. Insurance will not pay for this charge.

We reserve the right to end the physician-patient relationship in the case of a missed initial or multiple follow-up appointments.

FINANCIAL POLICY

As a courtesy to its patients, Virginia Endocrinology will file insurance claims upon the receipt of a current insurance card. If coverage is denied, you will be billed and payment in full is due upon the receipt of the bill. You will also be responsible for all co-payments (co-pays) at the time of the visit, as well as deductibles and balances due following insurance payments.

It is your responsibility, with the help of Virginia Endocrinology, to ensure that all referrals and authorizations are obtained prior to receiving medical care. If the referral/authorization is not obtained and your claim is denied, you will be responsible for the balance.

In the event that your account, following insurance payments and the normal billing cycle of Virginia Endocrinology, is not paid in full within thirty days from the date of service, you will be responsible for any additional special handling fees should your account fall into past due status.

Past due amounts that are **greater than 90 days overdue are subject to being turned over to a collection agency**. You are strongly encouraged to pay all past due amounts promptly or set up a payment plan with us.

There is a **$25.00 charge for returned checks**. If two (2) checks are returned, you will no longer be able to write checks in our office. Payments must then be made either by cash, credit card, money order, or certified check.

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INSURANCE AUTHORIZATION

You authorize any holder of medical or other information about you to be released to the insurance payor or other secondary insurance, as listed in your file, any information needed for the insurance claim(s). You permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to you or to Virginia Endocrinology, who accepts assignment.

SIGN IN THE SPACE BELOW		
Patient Name (printed):		
Patient Signature:	x	**Date Signed:**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices (NOPP) provides information about how we may use and disclose personal health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have reviewed a copy of the Virginia Endocrinology Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Virginia Endocrinology if I do not understand any information contained in the Notice of Privacy Practices.

Patient's Printed Name	
Patient's Signature	x
(if applicable) Patient's Personal Representative & Relationship	
(if applicable) Patient's Personal Representative's Signature	
Date	

The following section is for use by Virginia Endocrinology personnel if unable to obtain a written acknowledgement of receipt of the NOPP from the patient.

I have made a good faith effort to obtain a written acknowledgement of receipt of the Virginia Endocrinology & Osteoporosis Center's Notice of Privacy Practices from the above named patient, but was unable to for the following reason(s):

- ☐ Language Barrier
- ☐ Patient Cannot Read
- ☐ Patient Objects
- ☐ Read Later and Return
- ☐ Unable to Sign
- ☐ Other:

Employee Name and Date: _____

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Notice of Privacy Practices (Keep for your records)

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. If you have any questions, please contact our privacy office at the address or phone number at the bottom of this notice.

Who will follow this notice?

Virginia Endocrinology provides health care to our patients in partnership with other health care professionals. The information privacy practices in this notice will be followed by:

• Any healthcare professionals who treat you at any of our locations.

• All employees, medical staff, trainees, students, or volunteers of the entities listed above.

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by any of the separate facilities and providers described above. We are required by law to:

• Keep medical information about you private;

• Give you this notice of our legal duties and privacy practices with respect to medical information about you;

• Follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you:

• We may use and disclose medical information about you without your prior authorization for treatment (such as sending medical information about you to another healthcare provider or specialist as part of a referral) (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment (such as sending billing information to your insurance company or Medicare); and to support our healthcare operations (such as comparing patient data to improve treatment methods or for professional education purposes) (Note: only limited psychiatric or HIV information may be disclosed for billing purposes without your authorization). If you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures other than emergencies).

• Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you.

• We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you, without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal process.

• Under certain circumstances, we may use and disclose health information about you for research purposes, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protections.

• If admitted as an inpatient, unless you tell us otherwise, we will list in the patient directory your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation, and may release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to clergy members, even if they do not ask for you by name.

• We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information:

• In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Right to Access and or Amend Your Records:

• In most cases, you have the right to look at or get a paper or electronic copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

• If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:

• You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions.

• To request this list of disclosures, indicate the relevant period, which must be after February 1, 2005. You must submit your request in writing to the Privacy Office listed below.
• You will be notified within 30 days in the event of a breach of the privacy or security of a your protected health information.

Right to Request Restrictions:

• You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. Furthermore, if treatment is paid fully out of pocket, you may restrict disclosure of this information to your insurer. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. We will inform you of our decision on your request. All written requests or appeals should be submitted to the Privacy Office listed below.

Requests for Confidential Communications:

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Right to request a paper copy of this Notice:

You may receive a paper copy of this Notice from us upon request.

Changes to this Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas. You can receive a copy of the current notice at any time. The effective date is listed at the end. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:
• If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact the Privacy Office listed below.
• If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Privacy Office
Virginia Endocrinology
2384 Colony Crossing Place
Midlothian, Virginia 23112
(804) 423-3636