Carolina Endocrine Associates, LLC

Patient Registration

If you have traveled out of the country in the past 30 days, please inform our staff!

Referred by: _____ **Family doctor:** _____

Patient Name: _____ Today's Date: _____

Home Address: _____ Race: White/Black or African American/Hispanic/Asian/Other

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Marital Status: Single Married Divorced Widowed

Social Security Number: _____ Date of Birth: _____ Age: _____ Gender: M F

Employer/Parent or Guardian Employer: _____ Work Phone: _____

Spouse Name (Parent/Guardian Name if Minor): _____ Phone: _____

Person to notify in case of emergency other than spouse: _____

Relationship: _____ Phone: _____

Primary Insurance Company:	
ID #:	Subscriber Name:
Subscriber SSN:	Subscriber DOB:
Relationship to Patient:	

Secondary Insurance Company:	
ID #:	Subscriber Name:
Subscriber SSN:	Subscriber DOB:
Relationship to Patient:	

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Carolina Endocrine Associates, LLC to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurances, and uncovered services that apply.

Patient's Signature: _____ **Today's Date:** _____

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Pharmacy Information:

Preferred Pharmacy: _____ Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Provider/Physician Information:

Primary Care Provider: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Other: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Other: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Authorization For Use Of Disclosure Of Protected Health Information:

I authorize my provider/physician and/or administration and clinical staff of Carolina Endocrine Associates, LLC to disclose general medical information and other protected health information to the following persons/entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name of Person or Entity: **Relationship:**

_____

_____

_____

_____

Patient or Patient Representative Signature: _____ **Today's Date:** _____

Patient Portal:

Our practice offers you the opportunity to use the power of the web to track all aspects of your health care through our office. The Patient Portal enables our patients to communicate with our practice easily, safely, and securely over the internet. Some features include: ability to view medical history, labs, statements, schedule appointments, communicate through e-messaging, and make payments online with a credit card.

Please make sure to provide us with your email address to access the portal online! **Initial Here:** _____

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Patient Name:_____

Please List Current Medications:

Name of Medication	Strength	Dosage

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Practice Policies

Quality of care for our patients is our top priority. Please take a few minutes to review our practice policies carefully and sign at the bottom of the form. Please do not hesitate to let us know if you have any questions.

New Patient Appointments:

- Any new patient who fails to attend or reschedules/cancels two consecutive appointments will not be rescheduled.

- Any new patient who fails to show or reschedules/cancels the initial visit with less than a 24 hour notice, will be subject to a fee of $50.

Return Patient Appointments:

- Any established patient who fails to attend or reschedules/cancels three appointments will not be rescheduled; rather, they will be discharged from the practice. A discharge letter will be mailed to the patient with a list of endocrinologists in the area for follow up care.

- Any established patient who fails to show or reschedules/cancels with less than a 24 hour notice, will be subject to a fee of $25.

Should you need to cancel or reschedule your appointment please contact our office as soon as possible, no later than 24 hours prior to your scheduled appointment in order to avoid a fee. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. In this case, please contact our practice as soon as possible.

Cellular Devices &Video/Audio Recording

Please silence your cellular devices while in the practice. If you need to answer or make a phone call, please step outside the practice to do so. Also, we ask that you do not video or audio record any conversions or persons while on practice premises.

I have read and understand the Practice Policies and agree to its terms.

Signature: _____ **Relationship to Patient:** _____

Printed Name: _____ **Today's Date:** _____

Carolina Endocrine Associates, LLC

Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please Review Carefully.

How we may use and disclose medical information about you. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

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, and other Practice personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

Who Will Follow This Notice. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as employees, staff and other Practice personnel.

Policy Regarding The Protection of Personal Information. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected health care information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

Notice Of Individual Rights

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request***. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice, or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact the Privacy Officer, (843) 863.0088, 2881 A Tricom Street, Charleston, SC 29406. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our privacy officer.

I acknowledge by signing below that this Notice of Privacy Practices and Notice of Individual Rights has been made available to me.

Patient or Patient's Personal Representative Signature _____ **Date** _____