

## WELCOME

Welcome to Denver Endocrinology, Diabetes & Thyroid Center (DEDTC). We appreciate the opportunity to participate in your healthcare.

We provide specialized care in the areas of diabetes, thyroid disease, osteoporosis and bone disorders, cholesterol management, adrenal gland disorders, pituitary disorders, polycystic ovary syndrome (PCOS), male testicular dysfunction, and 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.

1. Please confirm that your referring physician has sent a request for consultation and all related medical records.

*Your referring physician may send us your medical records or you may bring them to your first visit. Important related medical records may include: relevant labs, pathology reports, x-ray studies, ultrasound reports, thyroid scans, bone density reports, surgical reports, current medications, etc.*

2. Bring your insurance card.
3. Bring a form of co-payment with you. We accept cash, check, and major credit cards.
4. If your insurance requires, please be prepared to apply payment towards your deductible.
5. Please bring the names or the bottles of your current prescriptions.
6. If you have diabetes and check your blood sugars, please bring your glucometer.
7. Please complete and bring the required forms.

**Denver Endocrinology, Diabetes & Thyroid Center, P.C.**

601 E Hampden Ave, Suite 560

Englewood, CO 80113

Phone: 303-321-2644 Fax: 303-321-2446

Website: [www.denverendocenter.com](http://www.denverendocenter.com)

**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 Denver Endocrinology, Diabetes & Thyroid Center regarding why a written acknowledgement was not obtained:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Legal Name \_\_\_\_\_  
Last First Middle  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Address \_\_\_\_\_  
Street or PO Box City State Zip  
Date of Birth \_\_\_\_\_  
Marital Status \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## Emergency Contact

(non-family member, outside of your home)

Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

## SPOUSE/GUARDIAN

Legal Name \_\_\_\_\_  
Last First Middle  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Address \_\_\_\_\_  
Street or PO Box City State Zip  
Date of Birth \_\_\_\_\_  
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  
Insured address \_\_\_\_\_  
Insured date of birth: \_\_\_\_\_

Secondary Health Insurance:

Insurance Company \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Policy or ID Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Insured Name \_\_\_\_\_ Relationship to insured \_\_\_ Self \_\_\_ Spouse \_\_\_ Child  
Insured address \_\_\_\_\_  
Insured date of birth: \_\_\_\_\_

## PREFERRED PHARMACY INFORMATION

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 Denver Endocrinology, Diabetes & Thyroid Center, P.C. I furthermore authorize payment of medical benefits to Denver Endocrinology, Diabetes & Thyroid Center, P.C. 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 responsible party for patient

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

Version Date: Aug 2010

## Online Communications Informed Consent

Patient Name \_\_\_\_\_

We have given our patients the option to communicate with us and view certain demographic material as well as lab results via our Patient Web Portal. You can access your Patient Portal online through our website and we will provide you instructions on how to access this. If you would like to be able to use this feature, please read through the following form and sign at the bottom.

### *Instructions for Using Online communications*

You agree to take steps to keep your online communications to and from our office confidential including:

- Do not store messages on your employer-provided computer; otherwise personal information could be accessible or owned by your employer
- Use screen savers or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private.
- Do not allow other individuals or other third party access to your computer(s) upon which you store medical communications. Standard email lacks security and privacy features and may expose medical communications to employers or other unintended third parties.
- Withdrawal of this Informed Consent must be done by written online communication or in writing to our office.

Use good communications etiquette:

- Confirm that your name and other personal information in the message is correct.
- Review the message before sending it to make sure that it is clear and that all relevant information is included.
- Update your contact information on the network as soon as it changes.

### *Conditions of Using Online Communications*

- Our office will save copies of any online communications in your electronic medical record. This means that appropriate members of our staff will have access to these communications as part of our medical records keeping, treatment and billing.
- You should print or store (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you.
- Our office will not forward online communications with you to third parties except as authorized or required by law.
- You agree to follow the recommended procedures to ensure your identity is protected in order to communicate with you and you acknowledge that failure to comply with these procedures may terminate our online communications.
- Online communications will be used for limited purposes only. It cannot be used for emergencies or time-sensitive matters. It should be used with caution. It should not be used to communicate highly sensitive medical information or information that requires immediate attention. If there is other information that you don't want transmitted via online communications, you must inform us.
- We will make every attempt to respond within 2-3 business days. However, there may be times when this is not feasible and you understand and agree to accept variations in response times and use other forms of communications with our office if online responses are not satisfactory to you. Please note that online communications should never be used for emergency communications or urgent requests. These should occur via telephone or using existing emergency communication tools.
- While our office will take reasonable precautions to protect your information, we are not liable for improper disclosure of confidential information unless it was caused by our intentional misconduct.
- Follow-up is your responsibility. You are responsible for scheduling any necessary appointments and for determining if an unanswered online communication was not received.

- You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. We are not responsible for breaches of confidentiality caused by you or an independent third party.
- We will not engage in any illegal online communication, including illegally practicing medicine across state lines.

*Access to Online Communications*

The following pertains to access to and use of online communications:

- Online communication does not decrease or diminish any other ways in which you can communicate or see the providers in our office. It is an additional option and not a replacement. You are encouraged to contact our office via telephone, mail or in person, as always, if you have any questions or needs.
- We will decide which medical topics are appropriate for online communications and with whom we communicate with online.
- We may stop providing online communications with you or change our online services provided at any time without prior notification to you.

*Risks of Using Online Communication*

All medical communications carry some level of risk. While the likelihood of risks associated with the use of online communications, particularly in a secure environment, is substantially reduced, the risks are nonetheless real and very important to understand. It is very important that you consider these risks each time you plan to communicate with our office, and communicate in such a fashion as to mitigate the potential for any of these risks. These risks include, but are not limited to:

- Online communication may travel much further than you planned. It is easier for online communications to be forwarded, intercepted, or even changed without your knowledge.
- Online communication is easier to falsify than handwritten or signed hard copies. A dishonest person could attempt to impersonate you to try to get your medical records.
- It is harder to get rid of an online communication. Backup copies may exist on a computer or in cyberspace, even after both of us have deleted our copies.
- Online communication is not private simply because it relates to your own medical information. We use a secure network to avoid using standard email or email systems provided by employers. Employers and online services have a right to inspect and keep online communications transmitted through their system.
- Online communications are also admissible as evidence in court.
- Online communications may disrupt or damage your computer if a computer virus is attached.

*Patient Acknowledgement and Agreement*

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of online communications between my provider and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that my physician may impose to communicate with patients via online communication. I have had the chance to ask questions that I had and to receive answers. I have been proactive about asking questions related to this consent agreement. My questions have been answered and I understand and concur with the information provided in the answers.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

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Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

Primary Care Provider \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician(if not PCP) \_\_\_\_\_ Phone \_\_\_\_\_

Other Care Providers \_\_\_\_\_ Phone \_\_\_\_\_

Main Concern(s)/Reason for visit today \_\_\_\_\_

**ALLERGIES** (Include type of reaction to each allergy listed – include another page if needed)

**MEDICATIONS (Both prescription and over-the-counter including herbal, vitamins, etc)**

Please include another page if needed.

Name of medication and dosage

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_
- 7. \_\_\_\_\_ 8. \_\_\_\_\_

**HOSPITALIZATIONS/SURGERIES/PROCEDURES** (Please include exact date or at least year)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY** (List any health problems of your mother, father, siblings, children or grandparents only)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY** (Check all that apply)

- Smoker:  yes  no # of cigarettes per day \_\_\_\_\_
- Alcohol use:  yes  no # of drinks per day \_\_\_\_\_
- Exercise  yes  no # of days in a week \_\_\_\_\_
- Duration of exercise \_\_\_\_\_
- Type of exercise \_\_\_\_\_

**PERSONAL HISTORY** (Previous health problems)

- 1. \_\_\_\_\_ 4. \_\_\_\_\_ 7. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_

**REVIEW OF SYSTEMS** (Check current problems/symptoms you are experiencing now or in the past 1 month)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Wt gain ___lb          | <input type="checkbox"/> Chest pain                 | <input type="checkbox"/> Lightheadedness                    |
| <input type="checkbox"/> Wt loss ___lb          | <input type="checkbox"/> Pain with exercise         | <input type="checkbox"/> Dizziness with standing            |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Palpitations               | <input type="checkbox"/> Poor concentration                 |
| <input type="checkbox"/> Easy Bruising          | <input type="checkbox"/> Stomach pain               | <input type="checkbox"/> Memory Loss                        |
| <input type="checkbox"/> Excessive Sweating     | <input type="checkbox"/> Constipation               | <input type="checkbox"/> Frequent falls                     |
| <input type="checkbox"/> Brittle Nails          | <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Emotional swings                   |
| <input type="checkbox"/> Rash                   | <input type="checkbox"/> Difficulty swallowing      | <input type="checkbox"/> Numbness in hands                  |
| <input type="checkbox"/> Skin color changes     | <input type="checkbox"/> Nausea                     | <input type="checkbox"/> Numbness in feet                   |
| <input type="checkbox"/> Dry skin               | <input type="checkbox"/> Vomiting                   | <input type="checkbox"/> Burning in hands                   |
| <input type="checkbox"/> Darkening of skin      | <input type="checkbox"/> Pain with swallowing       | <input type="checkbox"/> Burning in feet                    |
| <input type="checkbox"/> Stretch marks          | <input type="checkbox"/> Loss of periods            | <input type="checkbox"/> Anxiety                            |
| <input type="checkbox"/> Peripheral Vision Loss | <input type="checkbox"/> Irregular periods          | <input type="checkbox"/> Depression                         |
| <input type="checkbox"/> Blurred Vision         | <input type="checkbox"/> Painful intercourse        | <input type="checkbox"/> Insomnia                           |
| <input type="checkbox"/> Bulging Eyes           | <input type="checkbox"/> Pain with urination        | <input type="checkbox"/> Acne                               |
| <input type="checkbox"/> Headache               | <input type="checkbox"/> Passage of stones in urine | <input type="checkbox"/> Decrease in appetite               |
| <input type="checkbox"/> Double Vision          | <input type="checkbox"/> Bone pain                  | <input type="checkbox"/> Increase in appetite               |
| <input type="checkbox"/> Hoarseness             | <input type="checkbox"/> Back pain                  | <input type="checkbox"/> Feeling full before finishing meal |
| <input type="checkbox"/> Snoring                | <input type="checkbox"/> Joint pain _____           | <input type="checkbox"/> Cold intolerance                   |
| <input type="checkbox"/> Inability to smell     | <input type="checkbox"/> Muscle cramps              | <input type="checkbox"/> Excessive thirst                   |
| <input type="checkbox"/> Change in dental bite  | <input type="checkbox"/> Muscle Weakness            | <input type="checkbox"/> Excessive urination                |
| <input type="checkbox"/> Change in head size    | <input type="checkbox"/> Pain in Hands              | <input type="checkbox"/> Heat intolerance                   |
| <input type="checkbox"/> Neck pain              | <input type="checkbox"/> Pain in Feet               | <input type="checkbox"/> Hot flashes                        |
| <input type="checkbox"/> Swollen glands         | <input type="checkbox"/> Unexplained bone fractures | <input type="checkbox"/> Flushing of skin                   |
| <input type="checkbox"/> Neck lump/swelling     | <input type="checkbox"/> Muscle Aches               | <input type="checkbox"/> Excessive facial/body hair         |
| <input type="checkbox"/> Difficulty breathing   | <input type="checkbox"/> Change in Hand/Foot size   | <input type="checkbox"/> Loss of hair                       |
| <input type="checkbox"/> Breast pain            | <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Decrease in height                 |
| <input type="checkbox"/> Nipple discharge       | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Decreased libido                   |
| <input type="checkbox"/> Breast enlargement     | <input type="checkbox"/> Weakness                   |   |

**CONDITIONS OF TREATMENT**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Today's Date \_\_\_\_\_

1. **Insurance Verification and/or Pre-Authorization** - Many insurance companies require pre-authorization for various procedures. Denver Endocrinology, Diabetes & Thyroid Center, PC 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.

2. **Assignment of Insurance Benefits** - I hereby authorize my insurance company to pay Denver Endocrinology, Diabetes & Thyroid Center, PC 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.

3. **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.

4. **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.

5. **Authorization for disclosure of Information for Purpose of Service Reimbursement** - I hereby authorize Denver Endocrinology, Diabetes & Thyroid Center, PC 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 Denver Endocrinology, Diabetes & Thyroid Center, PC 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.

6. **Financial Agreement** - I understand that in consideration of the services rendered, I am obligated to pay Denver Endocrinology, Diabetes, & Thyroid Center, PC 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.

7. **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 \_\_\_\_\_

### CO-PAY AND DEDUCTABLE 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 primary care provider, your family physician, or nurse practitioner 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. If you need to discuss a budget plan, please contact our billing department before your initial appointment and any time thereafter, if the need arises.

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

Patient \_\_\_\_\_

Signature Date \_\_\_\_\_

### **NO SHOW POLICY**

Our goal here at Denver Endocrinology, Diabetes & Thyroid Center, PC is to provide quality service to all of our clients in a timely manner. Failure to keep scheduled appointments is costly to both the clinic and you as a patient. This letter is to inform you of our policy concerning "No Shows".

Patients who are unable to keep their appointments are requested to give 24-hour notice prior to their appointments. We realize this is not always possible and the practice will consider each individual case. Providing such notice allows the clinic time to offer other persons the opportunity to see our providers, thus using the time more efficiently. If an established patient fails to provide notice, it will be necessary to charge 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 3 consecutive missed appointments, he/she will be considered dismissed from the practice, and a letter of dismissal will follow.

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

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

### PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**Preferred method of contact: (check all that apply):**

- Home Telephone:** \_\_\_\_\_
  - OK to leave message with detailed information
  - Leave message with call-back number only
- Cell Phone:** \_\_\_\_\_
  - OK to leave message with detailed information
  - Leave message with call-back number only
- Work Telephone:** \_\_\_\_\_
  - OK to leave message with detailed information
  - Leave message with call-back number only
- Other Phone:** \_\_\_\_\_
  - OK to leave message with detailed information
  - Leave message with call-back number only
- Online Communication via Patient Web Portal**
  - OK to send me messages on the website regarding my care
- Written Communication**
  - OK to mail to my home to my home address
  - OK to mail to my work/office address
  - OK to fax to this number \_\_\_\_\_
- Permission to discuss Protected Health Information with Friends/Family**
  - Name: \_\_\_\_\_ Phone number: \_\_\_\_\_
  - Name: \_\_\_\_\_ Phone number: \_\_\_\_\_
  - Name: \_\_\_\_\_ Phone number: \_\_\_\_\_
  - Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

**Of all the above methods of communication, please indicate which method(s) is/are best for you to be contacted regarding appointment reminders, lab results and any other communication:** \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Birth date \_\_\_\_\_