PATIENT INFORMATION

PATIENT (Please Print) Date _____

Full Name _____ Occupation _____

Address _____ Employer _____

City, St, Zip _____ Work Address _____

Home Phone #_____ City, St, Zip

Cell Phone # _____ Work Phone #_____

Birthdate _____ Age_____ Sex _____ Race_____ E-mail Address _____

Patient's Social Security #_____ Marital Status M S W D

SPOUSE INFORMATION OR PERSON RESPONSIBLE FOR BILL

Name_____ Occupation _____

Address _____ Employer _____

City, St, Zip _____ How Long _____ Phone # _____

Home Phone #_____ Work Address _____

Social Security # _____ City, St, Zip _____

Birthdate _____

CONTACT IN CASE OF EMERGENCY_____

Relationship_____ Phone # _____

Referred by _____ Family Doctor _____

Your Chief Complaint_____

Date of Onset _____ Were you injured at work? _____

MEDICINE ALLERGIES: _____

INSURANCE INFORMATION - DO YOU HAVE HEALTH INSURANCE? _____

	PRIMARY	SECONDARY
Name of Health Insurance		
Claims Address:		
Insured's Name:		
Relationship:		
Policy Number:		
Group Number:		

AUTHORIZATION TO RELEASE INFORMATION FOR PAYMENT

I hereby authorize **Northeast Florida Endocrine & Diabetes Associates, P.A.** To release any medical or other information necessary to my insurance company to process claims for medical care, diagnostic testing and/or treatment provided to me by **Northeast Florida Endocrine & Diabetes Associates, P.A.**

DATE _____ SIGNATURE_____
(RESPONSIBLE PARTY IF MINOR)

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and assign **Northeast Florida Endocrine & Diabetes Associates, P.A.** All payments and/or insurance benefits for services rendered. I agree to complete any additional forms which may be required by my insurance plan for assignment of benefits. I understand that I am financially responsible for all amounts not covered by my insurance plan.

DATE _____ SIGNATURE_____
(RESPONSIBLE PARTY IF MINOR)

AUTHORIZATION FOR ASSIGNMENT OF MEDICARE BENEFITS

I hereby authorize and assign all payments of authorized medicare benefits for services rendered to patient, directly to **Northeast Florida Endocrine & Diabetes Associates, P.A.** I hereby authorize **Northeast Florida Endocrine & Diabetes Associates, P.A.** To release any medical information necessary to obtain payment. I understand that I am financially responsible for all amounts not covered by medicare for which I have signed an advance beneficiary notice (ABN).

DATE _____ SIGNATURE_____

Patient's Name:_____ Date of Birth:_____ Sex:_____
Address:_____ Phone#:_____
Insurance:_____ Referred by:_____ Phone#_____

Please list your reason/reasons for your visit:
1._____
2._____
3._____

MEDICATION ALLERGIES

_____
_____
_____

OTHER ALLERGIES

_____
_____
_____

MEDICATIONS: Prescription and non-prescription (including aspirin, vitamins, birth control, supplements, etc:_____
_____
_____
_____

PAST MEDICAL HISTORY

Please describe and give dates of any illnesses, injuries, hospitalizations, and surgeries:

_____
_____
_____
_____

SOCIAL HISTORY

Occupation:_____ Place of employment:_____
Level of Education:_____ Hobbies:_____
Have you ever used tobacco products regularly? Yes____No_____if yes, continue below:
Tobacco Product_____**#of years used?**_____**Amt each day**_____**Still use**_____
Circle the **beverage** you regularly consume and list the amount per WEEK:
Coffee/Tea_____Beer_____Wine_____Hard liquor_____ Soda_____

CURRENT HEALTH PRACTICES

Do you exercise regularly?_____Type of exercise and frequency:_____
How many meals do you eat per day?_____Snacks per day_____
How many meals do you eat out per week_____
If you are on a special diet, please explain:_____
When was your last EKG?_____Stress test_____
When was your last Eye Exam?_____

PERSONAL HISTORY

Do you have or have you ever had: Circle all that apply

HEENT:
Blurred vision/diplopia
Glaucoma/Cataracts
Sinus problems
Hearing problems
Hoarseness
Sore throat

GENERAL:
Recent weight change
Change of appetite
Increased thirst or urination
Always Hot/always cold
Rashes or skin problems
Night sweats/Hot flashes
Significant fatique
Chronic pain

CARDIOPULMONARY:
Chest pain
Frequent Cough
Edema
Heart Murmur
Palpitations
Shortness of breath
Shortness of breath upon exertion
Swelling of hands, feet, or ankles
Hypertension

ENDOCRINE:
Diabetes
Thyroid Disease
Head and Neck Radiation
Adrenal disease
Cold Intolerance
High cholesterol/triglycerides
Osteoporosis/osteopenia

FOR MEN ONLY
Impotence
Loss of sex drive

MUSCULO-SKELETAL
Neck pain
Back pain
Joint pain
Myalgia/cramps
Muscle weakness
Foot pain

GASTROINTESTINAL

Difficulty swallowing
Heartburn/gas
Diarrhea/constipation
Frequent nausea/vomiting
Abdominal pain
Ulcer
Hepatitis
Blood in bowel movement

NEUROLOGICAL:
Seizures/blackouts
Numbness/tingling/pain in feet, legs, hands
Headache
Depressed/anxiety

HEMATOLOGY
Anemia
Leukemia
Sickle cell
Lymph nodes
Abnormal bleeding

FOR WOMEN ONLY
Regular periods
Breast swelling
Menopause
Nipple discharge
Date of last pap_____
Last mammogram_____
Pregnancies ____How many_____

FAMILY HISTORY

INSTRUCTIONS: Please put a check mark by all that apply:

	Mother	Father	Brother	Sister	Grandparent	Other
Age(if living)						
Health(G)Good (B)Bad						
Cancer						
Tuberculosis						
Diabetes						
Heart disease						
High Blood Pressure						
Stroke						
Epilepsy						
Nervous Breakdown						
Asthma,Hives,hay fever						
Blood disease						
High cholesterol						
Thyroid disease						
Adrenal disease						
Pituitary disease						
Other health problems						
Age (at death)						
Cause of death						

****

FOR PHYSICIAN'S USE ONLY

SKIN:_____ HEART:_____

HAIR:_____ ABD:_____

HEENT:_____ SPINE:_____

FUNDI:_____ EXT:_____

NECK:_____ DP:_____

THYROID:_____ NEURO:_____

CAROTID:_____ STRENGTH:_____

BREAST:_____ SENSATION:_____

LUNGS:_____ DTR:_____

THE DIABETES DISTRESS SCREENING SCALE (DDS)

DIRECTIONS: Living with diabetes can sometimes be tough. There may be many problems and hassles concerning diabetes and they can vary greatly in severity. Problems may range from minor hassles to major life difficulties. Listed below are 2 potential problem areas that people with diabetes may experience. Consider the degree to which each of the 2 items may have distressed or bothered you DURING THE PAST MONTH and circle the appropriate number. Please note that we are asking you to indicate the degree to which each item may be bothering you in your life, NOT whether the item is merely true for you. If you feel that a particular item is not a bother or a problem for you, you would circle "1". If it is very bothersome to you, you might circle "6".

	Not a Problem	*A Slight Problem*	*A Moderate Problem*	*Somewhat Serious Problem*	*A Serious Problem*	*A Very Serious Problem*
1. Feeling overwhelmed by the demands of living with diabetes	1	2	3	4	5	6
2. Feeling that I am often failing with my diabetes routine	1	2	3	4	5	6

THE PATIENT HEALTH QUESTIONNAIRE-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	*Not At all*	*Several Days*	*More Than Half The Days*	*Nearly Every Day*
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Sum of Item 1 (___) + Item 2 (___) = ____

****

FOR PHYSICIAN'S USE ONLY:

DDS: Is either item ≥3? Yes ☐ No ☐
PHQ-2: Is sum of item scores ≥3? Yes ☐ No ☐
If Yes to either of above, consider Behavioral Health consult

CANCELLATION POLICY

NORTHEAST FLORIDA ENDOCRINE AND DIABETES ASSOCIATES, P.A.

NORTHEAST FLORIDA ENDOCRINE AND DIABETES ASSOCIATES, P.A. PHYSICIANS WORK BY APPOINTMENT ONLY. BECAUSE OF THIS, WE HAVE HAD TO ADOPT A VERY STRICT "LATE CANCELLATION" AND "NO SHOW" POLICY FOR ALL OFFICE EXAMINATIONS.

CANCELLATIONS, LESS THAN 48 HOURS IN ADVANCE, MAY BE CHARGED A CANCELLATION/NO SHOW FEE OF $25.00. FAILURE TO PAY A CANCELLATION/ NO SHOW FEE WILL BE TREATED ACCORDING TO OUR POLICY ON UNPAID BALANCES.

APPOINTMENTS YOU SELECT ARE RESERVED ESPECIALLY FOR YOU. LATE CANCELLATIONS/NO SHOWS DENY OUR PATIENTS THE OPPORTUNITY TO SCHEDULE THEIR CARE ACCORDINGLY.

_____

PATIENT SIGNATURE

_____

DATE

NORTHEAST FLORIDA ENDOCRINE & DIABETES ASSOCIATES, P.A.

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and cooperation. The following is an explanation of our financial policy; please read carefully:

We will accept assignment and file your primary insurance if you are insured by one of the following companies: Medicare, Wellcare Medicare, Aetna, Avmed, AARP, Blue Cross Blue Shield of Florida, Cigna, Humana, Champus Tricare, United Healthcare, Beechstreet, First Health, Great West, Private Health Care System, PPO Next, Preferred Health Network, Southcare, Coventry, Health Options. If your insurance is not listed, please call your insurance company to verify that we participate with your insurance plan.

If you have insurance that is not listed above, we will file your claims as a courtesy. However, you will be responsible to provide proof that you have met your deductible upon check in.

If you are self-pay, please be prepared to pay in full at the time services are rendered unless prior arrangements have been made with our billing staff.

If you have a referral based HMO/PPO insurance, it is your responsibility to make sure you have a valid referral upon each visit, and that you pay your copay amount upon check-in.

We will file secondary insurance claims for Medicare patients only. All other patients will be responsible to file their own secondary insurance claims.

If your insurance plan sends you a check for payment of the services provided by Northeast Florida Endocrine & Diabetes Associates, P.A. (the "Practice"), the check belongs to the Practice and you must immediately deliver the check to the Practice for payment on your account.

We accept cash, checks, and credit cards. Any returned checks are subject to a $25.00 returned check fee. The amount of the check as well as the $25.00 fee will be assessed immediately.

In the event that you pay by credit card, the credit card must not have expired and not reached its available credit limit. The billing address for the credit card must match the address that appears on your monthly credit card bill or bank statement. You agree to pay such total amount charged in accordance with the agreement governing the use of such credit card.

Any patient account balances older than sixty (60) days are subject to collections procedures. Should your account be referred to a collection agency or attorney for collections, then you will pay all costs of collection, including a reasonable attorneys' fee.

We understand that temporary financial problems may affect timely payment of your account. If such problems arise, you must contact our billing staff to make payment arrangements.

Please understand that if your insurance policy does not cover any services performed in our office, you will be responsible for payment in full.

There is a charge of $25.00 for the completion of disability, FMLA, or leave of absence forms. You must complete the patient information sections of the form completely and sign the form prior to submission to the Practice. The Practice requires ten (10) business days from the date the form is received by the Practice for completion.

I have read and understand the above financial policies of Northeast Florida Endocrine & Diabetes Associates, P.A.

_____

Patient Name

_____ _____

Patient Signature Date

_____

Legal Representative Name (if applicable)

_____ _____

Legal Representative Signature Date

_____

Relationship to Patient

_____

Legal Representative's Authority to Act for Patient
(Power of Attorney), Healthcare Surrogate, etc.

NORTHEAST FLORIDA ENDOCRINE & DIABETES ASSOCIATION, P.A.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Northeast Florida Endocrine & Diabetes Association, P.A. ("NEFEDA"), we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule effective March 26, 2013. It applies to all PHI as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit NEFEDA; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your health information.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of NEFEDA, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. You have the right to inspect and/or request a paper copy of your medical record. If the NEFEDA office where you receive services maintains an electronic medical record ("EMR"), you have the right to access your health record in a machine readable electronic format. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity. NEFEDA may charge you a reasonable, cost-based fee for the labor and supplies associated with copying or transmitting the electronic PHI.
- Amend your health record which you believe is not correct or complete. NEFEDA is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for NEFEDA; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by NEFEDA, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.
- Obtain a written accounting of certain non-routine disclosures of your PHI. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and health care operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years prior to the date of your request. If the NEFEDA office where you receive services maintains your medical records in an EMR system, you may request that the accounting include disclosures for treatment, payment and health care operations for the three (3) years prior to the date of such request. You must submit your request in writing to the Privacy Officer. The first list you request within a 12-month period is free of charge, but NEFEDA may charge you for additional lists within the same 12-month period. NEFEDA will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- Communications of your health information by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).
- Place a restriction to certain uses and disclosures of your information. In most cases NEFEDA is not required to agree to these additional restrictions, but if NEFEDA does, NEFEDA will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). NEFEDA must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Obtain a copy of your health care information in paper or a machine readable electronic format.

Our Responsibilities

NEFEDA is required to:

- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or

disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your health information without your written authorization, except as described in this Notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the NEFEDA Privacy Officer at:

Northeast Florida Endocrine &
Diabetes Association, P.A.
915 W. Monroe Street, Suite 200
Jacksonville, Florida 32204
Telephone: (904) 384-2240
www.nefeda.com

If you believe your privacy rights have been violated, you can file a written complaint with NEFEDA's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, NEFEDA operates an EMR. This is an electronic system that keeps health information about you. NEFEDA may also provide a subsequent healthcare provider with health information about you (e.g., copies of various reports) that should assist him or her in treating you in the future. NEFEDA may also disclose health information about you to, and obtain your health information from, electronic health information networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

NEFEDA may use a prescription hub which provides electronic access to your medication history. This will assist NEFEDA health care providers in understanding what other medications may have been prescribed for you by other providers.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to provide services on our behalf and disclose your health information to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail, in person, or by encrypted e-mail, in reference to any items that assist NEFEDA in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist NEFEDA in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam room, it is considered implied consent that a disclosure of your PHI is acceptable.

Open treatment areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

To Avert a Serious Threat to Health or Safety: We may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. NEFEDA may use a single compound authorization to combine conditioned and unconditioned authorizations for research (e.g. participation in research studies, creation or maintenance of a research database or repository), provided the authorization: (i) clearly differentiates between the conditioned (provision of research related treatment is conditioned on the provision of a written

authorization) and unconditioned research components; and (ii) provides the individual with an opportunity to opt in to the unconditioned research activities.

Coroners, Medical Examiners and Funeral Director: In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Fund Raising: We may contact you as part of a fund-raising effort. We may also disclose certain elements of your PHI, such as your name, address, phone number and dates you received treatment or services at NEFEDA, to a business associate or a foundation related to NEFEDA so that they may contact you to raise money for NEFEDA. If you do not wish to receive further fundraising communications, you should follow the instructions written on each communication that informs you how to be removed from any fundraising lists. You will not receive any fundraising communications from us after we receive your request to opt out, unless we have already prepared a communication prior to receiving notice of your election to opt out.

Sale of your PHI: NEFEDA may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.

Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability..

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

As Required by Law: We may use or disclose your health information if we are required by law to do so.

Acknowledgment of Receipt of Notice

I acknowledge that I have had the opportunity to review a copy of NEFEDA's Notice of Privacy Practices ("Notice"). I understand that I am responsible to read this Notice and notify NEFEDA, in writing, of any request for restrictions in the use or disclosure of my PHI. I understand NEFEDA has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at: www.nefeda.com. NEFEDA will provide me with a copy of its most recent Notice upon my request.

Please sign and return a copy of this Notice to NEFEDA.

Patient Name: _____
DOB: _____
Patient Signature: _____

Name(s) of others authorized to discuss or request medical information:

_____
_____
_____
_____

Revised September 23, 2013.