Hayes Endocrine & Diabetes Center

New Patient Intake Form

Last Name: _____ **First Name:** _____ **M.I.** _____

Birth Date:_____ **Sex:** _____ **Marital Status: (circle one) Married Single Divorced Widowed**

Social Security #: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **E-Mail Address:** _____

Emergency Contact: _____

Emergency Contact Phone #: _____

Referring Physician: _____ **Referring Physician Phone #:** _____

Responsible Party (if under 18 years old): _____

Relationship to Patient: _____ **Phone #:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer's Name: _____

Employer's Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Insurance Co.: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ **Social Security #:** _____

Relationship to Patient: _____

Insured Policy #: _____ **Group #:** _____

Secondary Insurance Co.:_____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ **Social Security #:** _____

Hayes Endocrine & Diabetes Center

Andrea L. Hayes, M.D.

501 28th Avenue North

Nashville, Tennessee 37209

Phone: 615.320.1620 Fax: 615.327.0643

Policies and Procedures for New and Existing Patients

Sign and date this form prior to your visit

1. Upon arrival at **each** visit, you will be asked for your current insurance card and your prescription card. It is necessary for us to make a copy of both cards for our records. Please be aware that if insurance information that you provide us is either invalid or expired, you will be responsible for the entire cost of the visit.
2. If you are required to pay a co-pay, we will collect it prior to each visit. If you are unable to pay your co-pay, your appointment will need to be rescheduled.
3. If your account has a balance that is past due, it will be collected upon arrival at our office or your appointment will be rescheduled after payment has been made. Please be aware that you might not have received a statement in the mail for past due balances between visits. This is due to the lag time that some insurance companies require to respond to our claims submissions.
4. Please note that if your insurance has a deductible that applies to office visits and your deductible has not yet been met, you will be required to provide payment for services at the time of the visit.
5. All routine prescription refills should be requested at the time of your visit. That is, if you know you will need a refill of a routine medication before your next visit, it is your responsibility to request a refill while you are in our office.
6. If you need a prescription refilled at a time other than at your appointment, we will take care of that request within a 48 hour time period. ***Please understand that leaving one message is all that is necessary to get your refill request taken care of. Please do not wait until you have one pill left or you are out of insulin to call and request a refill as we cannot guarantee that we will get to your request the same day.***
7. Please note that after hours phone calls to our office should be for emergencies only. Please take care of routine matters such as appointment changes, routine refills and routine questions during normal business hours.
8. If your prescription coverage plan requires you to use a mail order pharmacy, it is your responsibility to notify either a medical assistant or the healthcare provider so that your prescriptions can be written to accommodate the requirements of that plan. Furthermore, it is your responsibility to mail your prescriptions to the appropriate pharmacy.
9. We prefer to use our patient portal for routine communication with you. If you have provided us with our email address, you will be sent a link to sign up for our portal at your visit. You must establish a username and password within 48 hours of receiving this email. Then you may use the portal for communication with our office. Your lab results will be provided to you through this portal. You may also receive messages from our office staff and you may communicate back with us in

this manner. Using the portal is the most efficient way of maintaining communication with our office.

10. If you do not have an email address or do not wish to use our portal, we will communicate with you by phone. Routine lab results will not be communicated by phone. These will be discussed with you at your next office visit. If your lab results require a change in medication or an issue that demands immediate attention, you will be notified by phone. If you do not have an email address and wish to receive routine lab results between visits, please bring a self-addressed stamped envelope to your visit.
11. Please be courteous of our schedule and show up on time for your appointments. New patients should arrive 30 minutes prior to scheduled appointment. If you show up late for your appointment, you will be worked into our schedule as time allows. If you will not be able to keep your appointment, please notify our office either through our portal or by phone so that we can cancel or reschedule your appointment.
12. Please bring a list of all current medications or the actual medications to each office visit. This includes medical supplements or any over the counter medications that you may be taking.
13. If you are a new patient referred by your primary care physician or another doctor, please make sure that your physician has forwarded your outside records that may pertain to the visit. Alternatively, it is best to actually bring a hard copy of the records with you to the visit. This will allow us to treat you in the most efficient way possible.
14. Please be aware that we will provide samples, if we have them available, at your office visit. Samples are provided for new medication starts. We are unable to routinely provide samples between office visits. If your insurance does not cover a certain medication that you are taking, please let our office staff know so that we may consider alternative medications for your treatment.

Signature: _____Date: _____

(Patient or Guardian)

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FINANCIAL POLICY SUMMARY

In an effort to avoid any delays in the services you receive, please be aware of the following:

- You are responsible for knowing your benefits including co-payments or co-insurance levels, requirements for referrals to a specialist, and any benefit exclusions. Your insurance company's customer service department can help answer any questions related to coverage for you or your family. The number for your insurance company's customer service department can be located on the back of your insurance card.
- You are responsible for bringing your current, valid insurance card to each visit.
- **All co-payments are due before services are rendered.** We accept cash, checks, MasterCard, Visa, and American Express.
- **Patients who have a deductible that applies to office visits will be responsible for the cost of the visit at the time of service.** The cost of the visit will be determined based upon your insurance's reimbursement for the service rendered.
- There will be a $75.00 service charge for all returned checks.
- The responsibility for payment of services lies with the person seeking treatment or the person seeking treatment for a minor.
- Any optional services offered in our office that are not covered by insurance must be paid at the time of service.
- All patients having insurance requiring a referral will be required to present that referral or confirm we have received that referral before services will be provided. If your referral is not in our office upon arrival you will be asked to reschedule the appointment.
- If you are seen without a valid referral you will be responsible for any balance due on that visit.
- Hayes Endocrine & Diabetes Center providers may discontinue care for any patient due to non-payment.
- Any patient's account that cannot be collected by our office may be turned over to an outside collection agency. In addition, you will be responsible for any court cost and/or attorney fees incurred by the agency collecting your account.

- I authorize Hayes Endocrine and Diabetes Center to bill my insurance for services rendered.

- My signature below attests to my understanding and agreement with the policies listed above.

Patient Name: _____ Date of Birth: _____

Guarantor/Responsible Party (if other than patient): _____

Signature of Responsible Party_____Date_____

Authorization to Reveal Medical and Billing Information

I authorize Hayes Endocrine and Diabetes Center and staff to reveal to the following individuals as needed, information regarding my protected health information and billing information. I understand that once with this information is disclosed to these individuals, Hayes Endocrine and Diabetes Center will not have responsibility over to whom these individuals reveal this information. I may revoke this authorization by giving written notice to Hayes Endocrine and Diabetes Center.

1. Name: _____ Relationship: _____

2. Name: _____ Relationship: _____

3. Name: _____ Relationship: _____

Signature: _____ **Date: _____**

Acknowledgement of Privacy Practices

I hereby acknowledge that I have read and understand the privacy practice provided to me by Hayes Endocrine and Diabetes Center. I understand that this notice will be in effect until further notice from Hayes Endocrine and Diabetes.

Signature: _____ Date: _____

Authorization to Obtain Outside Medical Records

Hayes Endocrine and Diabetes Center has my authorization to request my Protected Health Information from another physician, hospital or other personnel involved with my care in order to facilitate treatment.

Signature: _____ Date: _____

Please provide the names and phone numbers of physicians or institutions from whom you consent for us to obtain your outside medical records.

_____
_____
_____

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PHARMACY INFORMATION

Patient Name: _____ DOB: _____

Please fill out this form as completely as possible.

If you don't have the exact address, please give us the street name or zip code where the pharmacy is located.

Pharmacy Name: _____

Address: _____

City, State, ZIP: _____

Pharmacy Phone #:_____

Pharmacy Fax#: _____

We are requesting this information so that we can send your prescriptions electronically to your pharmacy.

Medical History Intake Form

Please answer these questions to make your wait time shorter. Please be aware that no one will see these answers other than our medical staff. Thank you!

Please provide a brief description of the reason for your visit today:

_____

_____

If referred by another physician, please list the name here.

_____

_____

Please list all drug allergies and the adverse event that the drug caused. Include date of reaction if possible.

_____
_____
_____
_____

Please list all medications that you are currently taking including both prescription drugs and over the counter medications. Include all doses and dosing instructions.

_____
_____
_____
_____

_____
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Please list all medical diagnoses that you have or have had in the past. Please include the date of the diagnosis if known. Please include any hospitalizations that you have had. You may attach a list if you prefer.

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Please list all surgeries that you have had and date if known

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_____

Please provide a list of all of your current medical providers including specialty

_____

_____

_____

_____

_____

_____

Social History

- **Do you now or have you ever had a Sexually Transmitted Disease (STD): Yes No**

If yes please list:

_____

_____

_____

- **Do you now or have you ever had a Mental Health Condition (Anxiety, Depression or sleeping disorders) Yes No**

If yes please list: _____

_____

- **Do you now or have you ever abused illegal substances (have you ever used illegal drugs) Yes No**

If so, please list: _____

- **Do you now or have you ever smoked: Yes No**

If you are a former smoker please list your quit date (or year): _____

If yes, how many packs do you smoke per day: _____

- **Do you drink alcohol: Yes No**

If so, how often: _____

- **Occupation (job): _____**

- **Marital Status: Married Single Separated Divorced Widowed**

  Number of Children: _____

- **Do you exercise: Yes No**

If so, how many days per week: _____ what type of exercise: _____

- **Do you follow a particular diet or meal plan? If yes, please explain?**

  _____
  _____
  _____
  _____

Family Medical History

Do your parents or siblings have or have they had any heart problems before the age of 50: Yes No

If so, who in the family and what kind of heart problem: _____

_____
_____

Do your parents or siblings have or have they had any form of Cancer: Yes No

If so, who in the family and what kind of Cancer:

_____
_____
_____

Do your parents, children or siblings have, or have they had thyroid disorders ,diabetes, or any other endocrine disorder? Yes No

If so, who in the family and what kind of problems: _____

_____
_____
_____
_____
_____

Please list below any other information that you would like for us to know that is pertinent to your health.

_____

_____

_____

Please fill out the attached form entitled the Review of Systems form (ROS form). Please fill in the circle completely to allow for our system to be able to decipher your responses. Please do not write in the margins or outside of the circles provided as this information will not be picked up by our system.

Thank you for taking the time to accurately and completely fill out our new patient intake information. This will greatly enable us to care for your medical needs.