Office Use Only

MRN: ______________________

First Choice Endocrinology

PATIENT NAME:______________________________________ DOB:______________________ APPT DATE:______________________

PRIMARY CARE DR:___________________________________ FORMER ENDOCRINOLOGIST:___________________________________

PHARMACY NAME/LOCATION:____ PHARMACY NUMBER:__________________

CHIEF COMPLAINTS (Please check the box if you are experiencing any of these symptoms)

- ☐ Nausea
- ☐ Diarrhea
- ☐ Urinary Complaints
- ☐ Weight Loss ______ (amt)
- ☐ Weight Gain______ (amt)
- ☐ Fast Heart Beat/Fluttering
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Fracture Bones
- ☐ Thyroid Problems
- ☐ Pain or Pressure in Chest
- ☐ Dizziness or Fainting
- ☐ Frequent or Severe Headaches
- ☐ Seizures
- ☐ Blurry Vision
- ☐ Skin Problems/Rashes
- ☐ Sleep Problems
- ☐ Fertility Issues
- ☐ Sexual Problems
- ☐ Mood Changes
- ☐ Hair Loss/Hair Growth
- ☐ Snoring
- ☐ Cancer

When Was Your Last:

Flu Shot:_________ Pneumonia Shot_________________

If You're Diabetic, When Was Your Last:

Eye Exam:__________________ Foot Exam:____________

SOCIAL HISTORY

Marital Status: ☐ S ☐ M ☐ W ☐ D # of Children: ________ Tobacco Use: ☐ No ☐ Yes_______ Pack Per Day ______ Years

Alcohol Use: ☐ Social ☐ Heavy ☐ None Employment: ☐ None ☐ Full-Time ☐ Part-Time ☐ Retired Where:_______________

PAST MEDICAL HISTORY: Diagnosis and year you were diagnosed (*Example-"Hypothyroidism" Diagnosed in "1997")

Diagnosis	Year	Diagnosis	Year

PAST SURGICAL HISTORY

Surgery	Year	Surgery	Year

FAMILY HISTORY: Please check & list which 1st **degree relative (mom/dad, sibling, child)** was diagnosed with the disease.

- ☐ Diabetes:____
- ☐ Obesity:____
- ☐ Thyroid Disease:__________________________________
- ☐ High Cholesterol: _________________________________
- ☐ Auto Immune Disease:_____________________________
- ☐ Early Heart Disease:______________________________
- ☐ Cancer (What kind? Who?): _________________________
- ☐ Other: ____

ALLERGIES: If you are allergic to any medication, please list below and explain your reaction to it.

____

MEDICATIONS: Please list **ALL** medications you're taking here or provide us with a list. Make sure to include the dose and what you take the medication for. Also please list all over-the counter (OTC) medications, vitamins and supplements.

MEDICATION	DOSE	INDICATION	MEDICATION	DOSE	INDICATION

Signature of Patient: ____ Date: ________________________

Physician Reviewed: ____ Date: ________________________

Health Care Status Authorization

I, ____(name of patient) hereby give authorization to First Choice Endocrinology for the release of information concerning the status of my health care, including results of laboratory and radiology tests and to discuss my plan of treatment with:

____

Name of Authorized Individual

____

Relationship to Patient

I understand that I may revoke this authorization at any time.

____

Patient Signature

____

Witness

____

Date

Authorization for use of Answering Machines

I, ____(name of patient), authorize First Choice Endocrinology to provide detailed information to me via my home and/or work answering machine or cell phone voice mail concerning appointment, referral and test information. I understand that I may revoke this authorization at any time.

____

Patient (Parent) Signature

____

Date

Patient Registration & Insurance Information

Please present insurance card and photo ID for us to copy.

Date ____ Physician________________________________

Person Responsible for Bill

Guarantor Name ____
Address ____
City, State, ZIP ____
Home Phone # ____________________________ Work Phone # _______________________
Relation to Patient ____

Patient Information

Name ____
Address ____
City, State, ZIP ____
Home Phone # ____________________________ Work Phone # _______________________
Cell Phone # ______________________________ Email ____________________________
Date of Birth _____________________ Sex _______________ Marital Status ______________
Race: ☐ Black, African American ☐ Asian ☐ White ☐ American Indian, Alaska Native
☐ Native Hawaiian, Other Pacific Islander ☐ Unknown ☐ Declined
Ethnicity: ☐ Hispanic or Latino ☐ Not-Hispanic or Latino ☐ Unknown ☐ Declined
Primary Language _______________________________________
Social Security Number ___________________________________
(If a minor): Mother's Name ____________________________Home Phone #_____________
Father's Name ____________________________ Home Phone #_____________

Emergency Contact Information

Contact Name ____
Relationship to Patient ____
Address ____
City, State, ZIP ____
Home Phone # ___________________________ Work Phone # _______________________

Primary Insurance Name

Insurance Name ______________________________ Policy #__________________________
Group #____
Subscriber Name ____
Patient Relation to Subscriber ____
Social Security Number _________________________
Employer ______________________________________ Work Phone # __________________

Secondary Insurance Name

Insurance Name ____
Group #_________________________________ Policy #___________________________________
Subscriber Name ____
Patient Relation to Subscriber ______________________________ Date of Birth____________
Social Security Number____________________________________
Employer____ Work Phone #________________

Referred by ____

Authorizations and Acknowledgments

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

All new patients will be asked to provide patient information prior to being seen by the physician. We also may ask to make a copy of any type of picture identification to remain a permanent part of your chart.

Insurance Information

-If you are covered by Medicare, Tricare or any of our managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit. **Methods of Payment: Cash, Check, Visa, Mastercard and Discover.**
-All self-pay patients are expected to pay for services in full at the time services are rendered.
-We will file with all insurance plans for our professional fees for any hospital admissions
-In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately, payment responsibility rests with the patient.
-Please advise the office personnel of any changes in your insurance or mailing address.
-Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs incurred for that purpose.

Worker's Compensation

Worker's Compensation patients will be seen only after the proper authorization and paperwork has been received.

Unaccompanied Minors

The parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an accompanied minor must be on file.

Authorization for Treatment and Payment

I consent to examination, diagnosis and general medical care and treatment to be performed by office personnel, including physicians, physician assistants, nurses and assistants.

I hereby authorize First Choice Endocrinology to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorized any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the above information is currently correct.

_______________________________________ _______________________________
Responsible Party Signature Date

_______________________________________ _______________________________
Patient's Name (Please Print) Date of Birth

Notice of Privacy Practices

I acknowledge receipt of a copy of the First Choice Endocrinology Notice of Privacy Practices either at this time or previously. By accepting services at First Choice Endocrinology, I authorize First Choice Endocrinology to use and disclose information from and release copies of my (the patient's) medical records in accordance with First Choice Endocrinology's policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers.

___________________________ _______________________________
Patient or Parent (Guardian) Date

Wasim Deeb, M.D.
Lindsay Choate, PA-C
Endocrinology, Diabetes and Metabolism

First Choice Endocrinology
Address
Jacksonville, FL
Phone: 904-990-0555
Fax:
www.firstchoiceendo.com

First Choice Endocrinology Office Policies

Appointments and Consultations: To schedule an appointment with First Choice Endocrinology, please call the office at 904-990-0555. Our staff's primary goal is your utmost satisfaction, which includes accommodating your schedule as efficiently as possible, and we make every attempt to meet requests for specific dates and times. With our scheduling practice, we strive to keep waiting times to a minimum.

If you are more than 15 minutes late for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible but cannot compromise on the quality and timely care provided to our other patients.

Cancellation Policy: If you are unable to maintain your scheduled appointment, we kindly ask that you provide us with at least 48 hours' notice. This courtesy on your part will allow another patient to accept your appointment time. No shows/Cancellations less than 24 hours can result in a $50.00 fee that must be paid before another appointment can be rescheduled. Please note that any confirmation including, voice messages on our voicemail system of a missed appointment within 24 hours is sufficient.
More than 3 cancellations/no-shows can result in dismissal from the practice.

Financial Policy: All fees and co-payments are due at time of service is rendered; we accept most major credit cards, checks and cash.
Returned checks will be charged a minimum of $25.00.
If you have questions regarding billing/making financial agreements, please contact __________________________________.

Past Due Accounts:
Delinquent accounts will be required to make payment at the time of service. If you are unable to make mutually agreeable payment arrangements, we will be glad to reschedule your appointment.

Insurance: As the healthcare environment continues to evolve, it is most prudent to call your insurance to determine whether we participate with your particular insurance carrier.
Please bring the following to your visits:

- Insurance card
- Effective Authorization from your primary care physician if your insurance requires one
- If there is no authorization on file you may be charged for the visit.
- Picture identification
- A list or medications you are currently taking (including nutritional supplements)

Medication Refills: To insure timely refill of your medications, please follow these steps:

- Let your provider know at each visit if there are any medications that need to be refilled
- If you are not at the clinic, please contact your pharmacy for medication refills. They will fax a request to our clinic with all appropriate information (name of medication, quantity, last fill date, etc).
- Medication refills are processed during regular office hours only.
- Your provider needs at least 48 hours advanced notice to fill your prescription. Please contact your pharmacy **BEFORE** you run out.

Prior Authorization: Insurance companies frequently deny payment for certain non-formulary prescriptions. We encourage that all patients check their prescription formulary to avoid a delay in treatment and the need for a prior authorization. An office visit may be required to address "prior authorization" concerns.

The physicians at First Choice Endocrinology **DO NOT fill out** ANY type of disability or FMLA forms/paperwork.

All testing results are discussed during a scheduled appointment. Test results are NOT discussed over the phone. Once testing is completed, it is the patient's responsibility to call and schedule a follow up visit with the physician. Once should NOT assume results are normal.

Contact Us
Monday-Friday 8:30 am- 4:30 pm
Phone: 904-990-0555
Fax:
After hours answering service:
Office Email: ____(for NON-Urgent Matters only)

PRINT NAME: _______________________________ SIGNATURE:_____________________________________ DATE:_______________

The signature reflects acknowledgment of review and understanding of First Choice Endocrinology Office Policies

Wasim Deeb M.D.
Lindsay Choate PA-C
Address
Jacksonville, FL
Phone: 904-990-0555
Fax:
www.firstchoiceendo.com

FINANCIAL POLICY-INFUSION/INJECTION THERAPY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or what exactly **IS your responsibility.**

Please verify with your insurance company that the Therapeutic Injection Therapy _________ is a covered service at this location.

INSURANCE INFORMATION

If you are covered by Medicare, Champus or any of the participating managed plans with First Choice Endocrinology, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit.

*All self-pay patients are expected to pay for services in full at the time that services are rendered.

*We will file with all insurance plans for our professional fees for any hospital admission.

*In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately, payment responsibility rests with the patient.

*Please advise the office personnel of any changes in our insurance or mailing address.

*Payment arrangements can be arranged with the Office Manager prior to services being rendered.

Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs incurred for that purpose.

I hereby authorize First Choice Endocrinology to bill my insurance company directly for these services. I understand that I am financially responsible for charges not covered by my insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the above information is currently correct.

PATIENT OR PARENT (GUARDIAN):____

There will be a $50 charge for no show or cancellation without a 24 hour notice. Your insurance company will NOT cover this charge.

*We thank you for understanding our financial policy. If you should have any questions or concerns, please feel free to ask. Please sign below to acknowledge your understanding of this policy.

RESPONSIBLE PARTY SIGNATURE: ____

Patient's Name (Please Print): ____ Date:________________________

Insurance Company: _________________________ Date Verified: __________________ Time: ______________

Coverage:___________________ (100%, 50%, etc) spoke with:_________________________ Initials: ___________

Appointment Dates: ____