ACE ENDOCRINOLOGY ASSOCIATES PC

NEW PATIENT REGISTRATION FORM

Last Name _____ First Name _____ MI: _____

Date of Birth _____ Gender: M □ F □ Social Security # _____

For Minors Parent/Guardian Name: _____

Address: _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Preferred methods for communication: □ Phone □ Text □ Email

Can we leave a message on machine or with whoever answers? (Circle Yes or No)

Home Yes / No Work Yes / No Cell Yes / No

DO NOT CALL: □ Home □ Work □ Cell

Please indicate your preferred Pharmacy below:

Local Pharmacy Name: _____ City and Zip Code: _____

MaIl- Order Pharmacy Name: _____

Insurance Information (Present Insurance Card(s) to Receptionist)

Primary Insurance _____

Subscriber Information: Last Name _____ First Name _____MI: __

Date of Birth _____ Age _____ SS# _____ Sex (M/F) _____

Address _____ City/State _____ Zip _____

Home Telephone _____ Cell Phone _____ Work _____

Secondary Insurance _____ Policy/ID # _____

Subscriber Information: Last Name _____ First Name _____MI: __

Date of Birth _____ Age _____ SS# _____ Sex (M/F) _____

Address _____ City/State _____ Zip _____

Home Telephone _____ Cell Phone _____ Work _____

Authorization to Access Electronic Prescription Records

- ✓ I authorize ACE Endocrinology Associates PC and its affiliated providers to view my external prescription history via electronic prescribing services.
- ✓ I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable.
- ✓ I understand that my prescription history will become part of my ACE Endocrinology Associates PC medical record.

❖ **Release and Assignment of Benefits**

- ✓ I directly assign all health insurance benefits, to which I am entitled, by Aetna, Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the providers in ACE Endocrinology Associates PC for services rendered on my behalf.
- ✓ I understand that I am financially responsible for all charges, whether I am insured at the time of service, including deductibles, co-insurance, copayments and benefits services that are out of network, denied and/or not covered by my health insurance plan.
- ✓ I authorize ACE Endocrinology Associates PC or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross, or any other insurance carriers or their authorized agents any information needed for this or a related claim.

❖ Consents

- ✓ I, the undersigned, voluntarily consent to and authorize ACE Endocrinology Associates PC through its physicians, employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my ACE Endocrinology Associates PC physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products.
- ✓ I acknowledge that no guarantees have been made to me about the results of any examination or treatment.
- ✓ I acknowledge that I have been advised of my right to an Advance Directive.
- ✓ I acknowledge receipt of ACE Endocrinology Associates PC Financial Agreement
- ✓ I agree to allow access to my electronic prescription records.
- ✓ I agree to the assignment of benefits as described above.
- ✓ I agree to treatment as described above.
- ✓ I acknowledge receipt of ACE Endocrinology Associates PC Electronic mail Agreement.
- ✓ I have read this form, my questions have bben answered, and I understand and agree to its content.

Patient/Representative's Signature: _____ Date: _____

If signed by Authorized Representative, Print Name: _____

Relationship to Patient/Authority to Sign: _____

ACE ENDOCRINOLOGY ASSOCIATES PC

FINANCIAL POLICY

Patient Name _____ Date of Birth: _____

We provide our patients with the best possible care and service, while keeping the cost to you from rising at unreasonable rates.

We ask for your help by understanding and cooperating with our **FINANCIAL POLICY.**

It is important for you to understand that health insurance coverage is an agreement between

you and your insurance company.

AND

Your doctor's bill for services provided is an agreement between you and your doctor.

YOUR RESPONSIBILITY: Our Physicians participate with several insurance companies. It is your responsibility to call your insurance company to verify that the doctor you are seeing is participating.

- If we do not participate with your insurance company, we will expect full payment from you at the time of service. We will give you a bill at the end of the visit, which you can submit to your insurance comapany and get reimbursed as per your contract with your insurance. If you do not have valid insurance information, do not provide your social security number and we cannot confirm coverage, we will consider you a self-pay and ask for full payment at time of service.
- All co-payments or payments for non-covered service are the patient's responsibility and will be collected by our staff at time of service.
- If you have not met your deductible for the year, then you will be required to pay for the services at the time of the visit. If there is any overpayment, we will refund the overpayment after insurance EOB is received.

SPECIALIST OFFICES & REFERRALS: If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization in Navinet prior to your appointment. Please allow five (3) business days for non-emergency services prior to seeing that specialist or facility. If you do not have a valid referral/authorization, you may be asked to reschedule. You are responsible for payment of your account regardless of referral status. If your insurance company requires referrals for services at a Specialist office, if you go to the Specialist office without a referral, you will be responsible for the entire bill.

I understand that it is my responsibility to know and abide by the terms of my benefit coverage including but not limited to properly securing referrals for specialized care before making appointments. I also understand that I am responsible for full payment for services provided if I fail to supply the referral forms, when required.

_____

Signature of Patient/Guarantor **Date**

ACE ENDOCRINOLOGY ASSOCIATES PC OFFICE PAYMENT POLICY

PAYMENT FOR SERVICES PERFORMED:

- We check insurance eligibility and deductible before each visit.
- If you have a high dedictible plan, we collect the charges of the visit up-front and then send the bill to Insurance company, if there is any overpayment, we will refund you the difference.
- For Out of network insurances, we will collect the office visit up-front and provide you with a super-nill which can submit to your insurance company.
- We require to keep a credit card on file for No show fees or any co-payments/deductibles.
- Our office accepts Health Spending Account (HSA), Visa, MasterCard, Discover, American Express, as well as Cash, and Debit Cards for payment of services.
- We no longer accept personal checks due to too many returned checks in past.
- Any co-payments/deductibles required by an insurance company must be paid at the time of service.
- All payments are expected at the time of service. Should your account require the action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

RETURNED CHECK FEE IS $30

CHARGES TO ACCOUNT: You shall have the right to cancel our privilege to make charges against your account at any time. Future visits would then need to be paid in full at the time of service.

MISSED APPOINTMENT FEE: Patients who do not show up on time for an appointment or cancel with less than 24 hours' notice will be charged a $25 fee. This charge will not be reimbursed by your insurance. Patients with three missed appointments will be removed from the practice.

FORMS FEE: There is a charge for the completion of forms. The fee for this service is $10 per page of form and will not be paid by your insurance company. The forms will be completed within five (5) business days.

TRANSFERRING OF RECORDS: If you require a copy of your records, you must sign a record release form. We can fax the records to other physician office involved in your care, for free of charge. If you need a paper copy, then there is a search feee of $10 and then the fee will be $1/page to a maximum of $100. Please note we cannot email the records as it is HIPAA violation. You will be asked to pick up the records from the office. Please allow at least 3 business days to get the records ready. If you want them to be mailed, then there will be extra charge for the maliling service with tracking number.

You are authorizing us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

AGREEMENT: I have read and fully understand the Office Payment Policy set forth by ACE Endocrinology Associates PC, and I agree to the terms of this policy. I also understand and agree that ACE Endocrinology Associates PC may amend the terms of this Financial Policy at any time without prior notification to the patient.

EFFECTIVE DATE: Once you have signed this Agreement, you agree to all the terms and conditions contained herein, and the Agreement will be in full force and effect.

Signature of Patient/Guarantor : _____ Date: _____

ACE Endocrinology Associates PC

Past Medical History Form

Patient Name: _____ Date of Birth: _____ Age: _____

Race: _____ Ethnicity: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Phone #: _____ Fax #: _____

Specialists: _____

Reason for visit: _____

Past Medical History:

□ Diabetes mellitus Type 2	□ Diabetes mellitus Type 1	□ LADA/ Gestational diabetes
□ Hypothyroidism	□ Hyperthyroidism	□ Thyroid nodules/cancer
□ Pituitary Disease/ adenoma	□ Adrenal fatigue/insufficiency	□ Adrenal adenoma
□ High Blood Pressure	□ High Cholesterol	□ Coronary artery disease
□ Chronic kidney disease	□ Anxiety/ Depression	□ Osteoporosis
□ PCOS/Hirsutism	□ Menopause	□ Parathyroid disease
□ Obesity	□ Anxiety/Depression	□ _____
□ _____	□ _____	□ _____

Past Surgical History:

Type of surgery Date: Month and year

_____

_____

_____

_____

_____

ALLERGIES:

Medication/ Food Reaction:

_____

_____

ACE Endocrinology Associates PC

Past Medical History Form

Patient Name: _____ Date of Birth: _____ Age: _____

Personal History: Education: _____ Occupation: _____

Gender: □ Male □ Female □ Transgender: _____ Sexual Orentation: □ Straight □ Gay/ Lesbian / Bisexual

Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced □ Living with partner male/female

Smoking history: □ Never Smoked □ Past Smoker □ Current smoker – Cigarettes / pipe / cigars/ marijuana

Drug History: □ Never □ In Past □ Current: Heroin, Coccaine, Marijuana, Other: _____

Alcohol History: Yes / No; If yes, Type of alcohol: _____ Frequency: _____

Diet: _____

Exercise: _____

Family History: Age, Medical Conditions

Mother: _____
Father: _____
Brother: _____
Sister: _____
Daughter: _____
Son: _____
Cousins: _____
_____

Obstetric History (women only):

Age at menarche (first menstrual period) _____

Date of last period: _____ Periods are regular? □ Yes □ No

Total Number of pregnancies: _____ Number of miscarriages: _____ Number of Medical Terminations: _____

Children, age, sex: _____

Have you used estrogen, progesterone products, oral contraceptives, IUD or any other hormones in past? □ Yes □ No

If yes, give more details: _____

Age of Menopause: _____

Have you used any hormonre replacement therapy? _____
_____
_____
_____

ACE Endocrinology Associates PC

Past Medical History Form

Patient Name: _____ Date of Birth: _____ Age: _____

Current Prescription Medications:

Name of the medication Dose Instructions

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you use or have you used any over-the-counter vitamins or supplements not listed above?

Supplement Name Dose Instructions

_____

_____

_____

_____

_____

_____

Have you taken any steroids or cortisone (pills, injections, inhalers, creams) in the last year? Yes No

Please list type and dates of exposure:

_____

Have you ever used products/medications from a compounding pharmacy? Yes No

If yes, please explain:

_____

ACE Endocrinology Associates PC: Past Medical History Form

Patient Name: _____ Date of Birth: _____ Age: _____

Review Of Systems:

General, constitutional □ Fatigue □ Recent weight gain / weight loss □ Difficulty to lose weight □ Fever □ Chills □ Change in hat, ring, or glove size □ Increased sweating □ Night sweats □ Recurrent infections □ Hair loss/thinning □ Dizziness □ Breast enlargement/ lumps/ nipple discharge	**Gastrointestinal** □ Nausea □ Loss of appetite □ Vomiting □ Constipation □ Diarrhea □ Alternating diarrhea and constipation □ Heartburn □ Abdominal pain □ Difficulty swallowing food/ water □ Choking on food
Endocrine □ Excessive hunger □ Excessive thirst □ Cold intolerance □ Heat intolerance □ Dry skin □ High blood sugar □ Low blood sugar	**Neurological** □ Headaches □ Tingling and numbness in fingers or toes □ Weakness in hands / legs □ Confusion □ Memory loss □ Abnormal balance □ Seizure □ Syncope
Heart & Cardiovascular □ Chest pains □ Sudden heartbeat change □ Palpitations □ Swelling of feet/ankles/hands	**Respiratory** □ Shortness of breath □ Frequent cough □ Snoring □ Waking up in the middle of night, gasping for air
Eyes & Vision □ Blurry vision □ Double vision □ Loss of peripheral vision □ Budging of eyes □ Redness of eyes □ Difficulty closing eyes completely □ Increased tearing	**Genitourinary** □ Kidney stones □ Frequent urination □ Increased urination during night □ Urinary incontinence □ Difficulty obtaining or maintaining erections □ Vaginal dryness □ Vaginal discharge □ Irregular menstrual cycle □ Last menstrual period: _____
Musculoskeletal □ Joint pain □ Joint swelling □ Weakness of muscles/joints □ Muscle pain or cramps □ Back pain	**Skin** □ Dry skin □ Rash □ Itching □ Change in skin color

Signature of patient: _____ Date: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO ACE ENDOCRINOLOGY ASSOCIATES PC

PATIENT NAME: _____

D.O.B: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

TELEPHONE: Home: _____Cell: _____

I hereby authorize _____

Phone: _____ Fax: _____

To disclose my health information to ACE Endocrinology Associates PC:

- Dr. Smita Kargutkar, MD at 225 Highway 35 N Suite 102-B Red Bank NJ 07701 Phone: 732-413-8000 Fax: 732-400-6745

The information to be disclosed to and used by the above is for the following purpose: _____

This authorization is limited to the following dates of treatment:

FROM _____ TO _____

Information to be disclosed:

□ EMERGENCY ROOM RECORD	□ CONSULTATIONS	□ COMPLETE RECORD
□ HISTORY & PHYSICAL EXAM	□ PROGRESS NOTES	□ ABSTRACT
□ OPERATIVE REPORT	□ LAB, X-RAYS & TESTS	□ PATHOLOGY
□ DISCHARGE SUMMARY	□ NURSES' NOTES	□ BILLING INFO.
□ CLINIC RECORDS	□ REHAB. RECORDS	□ OTHER _____

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, AND email correspondence as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Smita Kargutkar of ACE Endocrinology Associates PC. I understand that this revocation will not apply to the extent of any actions that the practice has already acted in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or Condition: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

If I have questions about disclosure of my health information, I can contact Dr. Smita Kargutkar, MD of ACE Endocrinology Associates PC of at 225 Highway 35 N Suite 102-B Red Bank NJ 07701 Phone: 732-413-8000.

PATIENT SIGNATURE: _____ DATE: _____

LEGAL REPRESENTATIVE: Name: _____ RELATION: _____ DATE: _____