Peconic Endocrinology

Barbara Gredysa, MD

Name:_____ **Date of Birth:**_____ **Date:**_____

Email:_____

Address: _____

Home Phone:_____ **Cell Phone:**_____ **SS#**_____

Do we have permission to download your medication list from your pharmacy? Yes No

If not, please list your current medications:

1._____ **dose/freq** _____ **2.**_____ **dose /freq**_____

3. _____ **dose/freq** _____ **4.**_____**dose/freq** _____

5. _____ **dose/freq** _____ **6.** _____ **dose/freq** _____

Pharmacy: _____ City _____ Phone: _____

List Allergies _____

If no allergies circle none NONE

Past Medical History: circle all that apply:

Diabetes	Overweight/Underweight	Liver Disease
Coronary Artery Disease	Hypertension	Glaucoma
Heart Disease	Thyroid Disorder	Blood Clot
Osteoprosis/Osteopina	COPD	Seizure
Cancer _____ type	Emphysema	Asthma
Vascular Disease	Parathyroid Disease	Pituitary Disorder
Adrenal Disorder	Other: Explain _____	

Family History:

Cancer _____	Mother	Father	Sibling
Heart Disease	Mother	Father	Sibling
Diabetes	Mother	Father	Sibling
Thyroid Disease	Mother	Father	Sibling
High Cholesterol	Mother	Father	Sibling
Hypertension	Mother	Father	Sibling
Stroke	Mother	Father	Sibling
Hormonal Disorders	Mother	Father	Sibling
Coronary Artery Disease	Mother	Father	Sibling

Other, please specify: _____

Have you ever had a bone density study performed? Yes No When/Where_____

Past Surgical History: Please list with date.

_____

_____

Social History

Do you drink alcohol? **Yes No** How often? **Daily Weekly Monthly Occasionally**

Do you use any drugs? **Yes No** What kind and how often?_____

Smoking History:

Do you smoke? **Yes No** Current Smoker Non Smoker Former Smoker

Former Smoker – When did you quit smoking?_____

***Race** White Asian Black Hispanic

***Ethnicity**: Latino Not Latino ***Primary Language** _____

Primary Physician:_____ Phone: _____

Referring Physician:_____ Phone: _____

Primary Insurance

Policy #:_____

Who is the policy under? Self Spouse Parent Other

Policyholder Name:_____ Policyholder Date of Birth: _____

Secondary Insurance

Policy #:_____

Who is the policy under? Self Spouse Parent Other

Policyholder Name:_____ Policyholder Date of Birth: _____

Emergency Contact_____ **Phone Number**_____

Relationship _____

Employer _____ Position _____

Employer Address_____

Employer Phone # _____

Signature _____ **Date _____**

Peconic Endocrinology 2020 Financial Policy

At Peconic Endocrinology, we believe in providing the best medical care possible. In order for us to provide you with the highest quality medical care, we must insure that we are able to meet the expenses necessary to operate this facility. Due to the wide variety of insurance plans and the changes in the healthcare system, we have implemented the following policies effective June 2020.

Patient responsibility We require that you pay any and all portions not covered by your insurance due to deductible, co-payments, coinsurance and cost share. As a courtesy to you, we will call your insurance company to verify Basic benefits. However, your insurance policy is a contract between you and your insurance company. Due to the wide variety of insurance plans and increasing in-network deductibles we will estimate a patient's cost share but the final amount will be determined by your insurance company.

Cancellations Policy Any appointment not cancelled within 48 hours will be subject to a $50.00 cancellation Fee.

Referrals-Any visit that requires an insurance plan referral from a primary care physician will be the responsibility of the patient to request from their primary providers. Any denial from your insurance for lack of referral will be your financial responsibility. _____ **Initial**

Labs All labs and testing ordered by Peconic Endocrinology **Must** be done altleast 7 days prior to your appointment. Failure to do so will result in your appointment being rescheduled. It may also result in a LATE cancellation fee. ___ initial

Credit Card Authorization Form

A secure method of payment for the portion of services that your insurance applies to patient responsibility. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been processed by your insurance carrier. Once the insurance has determined what your financial responsibility is, we will run your credit card and mail you a copy of the receipt and explanation of benefits. In the event that your insurance is not valid at the time of service, you will be charged as a self-pay patient.

Credit Card Information
Card Type: ☐ MasterCard ☐VISA ☐ Discover ☐ AMEX □Other _____
Cardholder Name (as shown on card): _____
Card Number Last 4 digits _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Peconic Endocrinology to charge my credit card above for Insurance Copays, Deductibles and Coinsurances that my Insurance deems patient responsibility for all medical services performed.

By signing below, I acknowledge that I have read and agree to the terms above.

Print Name: _____Signature: _____Date: _____

Peconic Endocrinology, P.C. - Privacy Practices Summary

This notice summarizes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully and take a written copy as well if you need to.

Our responsibilities

We are required to:

- Maintain the privacy of your personal health information
- Provide you with this notice of our legal obligations and privacy practices with respect the information we collect and maintain about you
- Abide by the terms of our Privacy Practice Notice

Your rights

As a patient you have several rights regarding your personal medical information, including the following:

- The right to request that we do not use or disclose your medical information in certain ways.
- The right to request to receive communication in an alternative manner
- The right to inspect and obtain a copy of your health information
- The right to request an amendment to your health information
- The right to an accounting of certain disclosures of your health information

We reserve the right to change our privacy practices and make the new provisions effective for all personal health information we maintain. Should we make material changes, we will post it in a clear and prominent location and make the revised notice available to you upon request.

I acknowledge that I have read and understand the Notice of Privacy Practices for Peconic Endocrinology. I also understand that I can contact the office @ 631.740-9273 with any questions that I may have

On Contact Privacy :

Our office may call about appointments, billing matters, or to leave a message to contact the office. We will not leave personal medical information such as test results or diagnoses or prognoses in a message. In the event that you are not available when we call, please indicate how we may leave a message for you:

1. Peconic Endocrinology may leave a message for me on my answering machine or voice mail at the phone number I have provided. **Yes** **No**

2. Peconic Endocrinology may leave a message with anyone who answers the phone at the number I have provided. **Yes** **No**

AUTHORIZATION TO RELEASE INFORMATION

I authorize Peconic Endocrinology to release all medical information to my Primary and/or Referring Physician. Please list any other person(s) authorized to receive your medical information

NAME_____ RELATIONSHIP _____

NAME_____ RELATIONSHIP _____

Signature _____ Date _____