Endocrinology, Diabetes & Metabolism Consultants
St. Anthony's Medical Building, Suite 160 B, 10004 Kennerly Road, Saint Louis, MO 63128
www.DrThampy.YourMD.Com **Tel 314-842-1588; Fax 314-543-5298; 24 Hour Cell 314-973-9573**

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information in the recruitment and/or conduction of clinical research studies in which you may qualify as a subject and subsequently benefit thereof. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information in the following situations without your authorization. Those situations include: as Required By Law, Public Health Issues as required by law, Communicable Diseases; Health Oversight Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purposes to treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:_____

Signature:_____Date:_____

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DEMOGRAPHIC INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: _____

Mailing Address: _____

City/State/ Zip Code: _____

Home Phone: _____
Cell Phone: _____
Work Phone: _____

Email Address: _____

Marital Status: _____

Social Security Number: _____

OK to enable Web Patient Portal?
(Get labs, records, Visit Summaries; send messages to nurses/staff)
Email address required
☐ Yes
☐ No

Appointment Reminder preference: (select one)
☐ Phone call
☐ Morning (9am) ☐ Afternoon (3pm) ☐ Evening (6pm)
☐ SMS Text message
☐ Email

Race: White____ Black ____ Hispanic____ Other: _____ Ethnicity:_____

Occupation: _____

Employer Name_____

Language: English___ Spanish____ Bosnian____ Other _____ ↑

EMERGENCY CONTACT INFORMATION
Emergency Contact Name: _____
Phone Number: _____
Relationship to Patient: _____

OK to discuss Medical Info with Emergency Contact?
☐ Yes ☐ No

Primary Care Physician (PCP): _____
Phone: _____

GUARANTOR/RESPONSIBLE PARTY
Name_____
Guarantor Address: _____

PRIMARY INSURANCE INFORMATION
Insurance: _____
Insured's Name: _____
Insured's Date of Birth: _____
Subscriber Number: _____
Group Number: _____
Insured's relationship to patient: _____
Copay: _____

SECONDARY INSURANCE INFORMATION
Insurance: _____
Insured's Name: _____
Insured's Date of Birth: _____
Subscriber Number: _____
Group Number: _____
Insured's relationship to patient: _____

PHARMACY INFORMATION
Pharmacy Name/Location: _____
Pharmacy Number: _____

I attest that the above information is correct and have read and understand the policies of Endocrinology, Diabetes & Metabolism, Consultants, P.C., and accept my responsibility as stated in those policies

_____ **DATE** _____

Patient Signature *(18 and under requires signature of Parent/Guardian)*

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Patient History Form

Patient Name:_____ Date of Birth:_____/_____/_____

Referring Physician:_____ Date of Visit:_____/_____/_____

Patient Medical History

Diabetes…… ☐No ☐Yes
High blood pressure... ☐No ☐Yes
Stroke ……... ☐No ☐Yes
Heart disease……. ☐No ☐Yes
Cancer ……... ☐No ☐Yes
Arthritis/Gout …….. ☐No ☐Yes
Kidney stones ……☐No ☐Yes
Thyroid problems….. ☐No ☐Yes
Convulsions……☐No ☐Yes
Bleeding tendency…. ☐No ☐Yes
Venereal disease…… ☐No ☐Yes
Hereditary defects….. ☐No ☐Yes
Acute infections…… ☐No ☐Yes
_____ ☐No ☐Yes

Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Previous Hospitalizations/Surgeries/ Serious Injuries	When

Family History

Disorder	Yes	No	Family Members
Diabetes	___	___	_____
Heart Disease	___	___	_____
Cancer	___	___	_____
Stroke	___	___	_____
Thyroid Disease	___	___	_____
High Blood Pressure	___	___	_____

Patient Social History

Occupation:_____
Marital Status ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed
Use of alcohol ☐Never ☐Rarely ☐Moderate ☐Daily
Use of tobacco ☐Never ☐Previously, but quit ☐Current packs/day ____
Use of drugs ☐Never ☐Yes, type/frequency_____

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Patient Name:_____ Date of Birth:_____/_____/_____

Constitutional Symptoms

Good general health lately	☐No	☐Yes
Recent change in weight	☐No	☐Yes
Fever	☐No	☐Yes
Fatigue	☐No	☐Yes
Headaches	☐No	☐Yes

Eyes

Eye disease or injury	☐No	☐Yes
Blurred or double vision	☐No	☐Yes
Glaucoma	☐No	☐Yes

Ear/Nose/Throat/Mouth

Hearing loss or ringing	☐No	☐Yes
Earaches or drainage	☐No	☐Yes
Chronic sinus problems	☐No	☐Yes
Nose bleeds	☐No	☐Yes
Mouth sores	☐No	☐Yes
Bleeding gums	☐No	☐Yes
Bad breath or bad taste	☐No	☐Yes
Sore throat or voice change	☐No	☐Yes
Swollen glands in neck	☐No	☐Yes

Cardiovascular

Heart trouble	☐No	☐Yes
Chest pain	☐No	☐Yes
Palpitation	☐No	☐Yes
Shortness of breath with exertion	☐No	☐Yes
Swelling of feet/ankles	☐No	☐Yes

Respiratory

Chronic or frequent coughs	☐No	☐Yes
Spitting up blood	☐No	☐Yes
Shortness of breath	☐No	☐Yes
Asthma or wheezing	☐No	☐Yes

Gastrointestinal

Loss of appetite	☐No	☐Yes
Change in bowel movements	☐No	☐Yes
Nausea or vomiting	☐No	☐Yes
Frequent diarrhea	☐No	☐Yes
Constipation	☐No	☐Yes
Rectal bleeding or blood in stool	☐No	☐Yes
Abdominal pain or heartburn	☐No	☐Yes
Peptic ulcer	☐No	☐Yes
Reflux disease	☐No	☐Yes

Musculoskeletal

Joint pain	☐No	☐Yes
Joint stiffness or swelling	☐No	☐Yes
Weakness of muscles or joints	☐No	☐Yes
Muscle cramps/pain	☐No	☐Yes
Backpain	☐No	☐Yes
Cold extremities	☐No	☐Yes

Genitourinary

Frequent urination	☐No	☐Yes
Burning or painful urination	☐No	☐Yes
Blood in urine	☐No	☐Yes
Kidney stones	☐No	☐Yes
Sexual difficulty	☐No	☐Yes
Male-testicle pain or mass	☐No	☐Yes

Genitourinary (Female)

Female-pain with periods	☐No	☐Yes
Female-irregular periods	☐No	☐Yes
Female-vaginal discharge	☐No	☐Yes

Female-# of pregnancies____ # of miscarriages_____
Female-date of last pap smear_____/_____/_____
Female-age of menarche_____
Female-age of first pregnancy_____/_____/_____
Female-last menstrual period_____/_____/_____

Integumentary (Skin, Breast)

Rash or itching	☐No	☐Yes
Change in skin color	☐No	☐Yes
Change in hair or nails	☐No	☐Yes
Varicose veins	☐No	☐Yes
Breast pain	☐No	☐Yes
Breast lump	☐No	☐Yes
Breast discharge	☐No	☐Yes

Neurological

Frequent or recurring headaches	☐No	☐Yes
Light headed or dizzy	☐No	☐Yes
Convulsions or seizures	☐No	☐Yes
Numbness or tingling sensation	☐No	☐Yes
Tremors	☐No	☐Yes
Paralysis	☐No	☐Yes
Stroke	☐No	☐Yes
Head injury	☐No	☐Yes

Psychiatric

Depression	☐No	☐Yes
Insomnia	☐No	☐Yes
Nervousness	☐No	☐Yes
Memory loss or confusion	☐No	☐Yes

Endocrine

Glandular or hormone problem	☐No	☐Yes
Thyroid disease	☐No	☐Yes
Diabetes	☐No	☐Yes
Excessive thirst or urination	☐No	☐Yes
Heat or cold intolerance	☐No	☐Yes
Skin becoming drier	☐No	☐Yes
Change in ring, hat or glove size	☐No	☐Yes

Hematologic/Lymphatic

Slow to heal after cuts	☐No	☐Yes
Bleeding or bruising tendency	☐No	☐Yes
Anemia	☐No	☐Yes
Swollen glands	☐No	☐Yes

Allergic/Immunologic

History of skin reaction or adverse reaction to:

Penicillin or other antibiotics	☐No	☐Yes
Morphine, Demerol or other narcotics	☐No	☐Yes
Aspirin or other pain medications	☐No	☐Yes
Tetanus antitoxin or other serums	☐No	☐Yes

Allergy to other medications:_____

Known food allergy:_____

Additional Comments:_____

_____

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Thyroid Disease
Patient Thyroid History (Addendum)

Patient Name:_____ Date of Birth:_____/_____/_____

Have you lost or gained weight in the past 6 months?	Yes/No (Lost____; Gained____)
Do you have difficulty swallowing?	Yes/No
Do you have difficulty breathing?	Yes/No
Do you currently have neck pain?	Yes/No
Did you have neck pain during the past 6 months?	Yes/No
Have you ever had radiation treatment or exposure to radiation?	Yes/No
Have you ever taken Tapazole (Methimazole) or Propylthiouracil?	Yes/No
Have you ever taken Synthroid, Levoxyl or Armor Desiccated Thyroid?	Yes/No
Have you had thyroid surgery?	Yes/No
Have you ever had radioactive iodine treatment?	Yes/No
Have you had CT scan or cardiac cath or IV contrast dye recently?	Yes/No
Have you ever taken Amiodarone or Lithium?	Yes/No

Comments?