

Endocrine & Thyroid Center

7141 Colleyville Blvd., Colleyville, TX 76034. (817) 410-9993 (phone), (817) 410-9963 (fax)

PLEASE SIGN AT THE BOTTOM. ALL REQUIRED (*) FIELDS MUST BE FILLED OUT IN DETAIL. THANKS!

PATIENT INFORMATION

*LAST NAME: _____ *FIRST NAME: _____ MI: _____

*STREET ADDRESS: _____ *CITY/STATE: _____ *ZIP CODE: _____

*CELL PHONE: _____ *HOME PHONE: _____

*EMAIL: _____

SEX: Male Female *MARITAL STATUS: Single Married Divorced Other

*BIRTH DATE: _____ SOCIAL SECURITY #: _____ TX DRIVER'S LICENSE #: _____

REFERRING PHYSICIAN: _____ PHONE: _____

EMERGENCY CONTACT #1: _____ RELATIONSHIP: _____ PHONE: _____

EMERGENCY CONTACT #2: _____ RELATIONSHIP: _____ PHONE: _____

MEANINGFUL USE DATA

PREFERRED LANGUAGE: English Other: _____ ETHNICITY: Non-Hispanic Hispanic

RACE: _____

If you prefer not to answer these questions, please initial here. DECLINED TO ANSWER: _____

POLICY HOLDER INFORMATION

*INSURED LAST NAME: _____ *FIRST NAME: _____ MI: _____

STREET ADDRESS: _____ CITY/STATE: _____ ZIP CODE: _____

*INSURANCE NAME _____ MEMBER ID # _____ GROUP # _____

SEX: Male Female *MARITAL STATUS: Single Married Divorced Other

*BIRTH DATE: _____ SOCIAL SECURITY #: _____

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, & RELEASE OF INFORMATION TO INSURANCE COMPANY

- By my initials _____ and my signature below, I consent to treatment necessary for the care of the patient indicated on this form. I understand this facility may employ physician extenders.
- By my initials _____ and my signature below, I hereby authorize payment of medical benefits directly to the attending physician for services rendered. Authorization is hereby granted to use this form on ALL my insurance submissions. Authorization is hereby granted to release information as may be necessary to process and complete my claim. I understand I am financially responsible for this account. I permit a copy of this authorization to be used in place of the original.
- FOR MEDICARE PATIENTS ONLY** - By my initials _____ and my signature below, I hereby authorize payment of Medicare benefits directly to the attending physician for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

*PATIENT'S OR GUARANTOR'S SIGNATURE: _____ DATE: _____

Endocrine & Thyroid Center

7141 Colleyville Blvd., Colleyville, TX 76034. (817) 410-9993 (phone), (817) 410-9963 (fax)

PATIENT NAME: _____

The reason for seeing the doctor, in your own words: _____

How long has this been going on? _____

Other Medical Problems: _____

Surgeries: _____

Preferred Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____

Medications: _____

Drug Allergies: _____

Medical Problems that Run in the Family: _____

Occupation: _____

CIRCLE APPROPRIATE ANSWER: Smoke - Yes No Drink - Yes No Drugs - Yes No

REVIEW OF SYSTEMS: Please circle all that apply and specify length of time.

	HOW LONG?		HOW LONG?
Anxiety/Depression	_____	Leg swelling	_____
Weight Change	_____	Sleep problems	_____
Fatigue	_____	Facial/body hair	_____
Too hot or cold	_____	Acne	_____
Dry or Oily skin	_____	Loss of sensation	_____
Blurred or Dbl Vision	_____	Hair Loss	_____
Difficulty swallowing	_____	Earaches	_____
Chest pain/Palpitations	_____	Thyroid trouble	_____
Shortness of breath	_____	Exposure to radiation	_____
Cough	_____	Wheezing	_____
Nausea/Vomiting	_____	Hepatitis/jaundice	_____
Diarrhea/Constipation	_____	Bladder infections	_____
Abdominal Pain	_____	Kidney stones	_____
Freq/nightly urination	_____	Urine loss	_____
Bone/muscle problems	_____	Burning with urination	_____
Joint problems	_____	Seizures	_____

MEN:
Difficulty with erections _____ Narrow urinary stream _____

WOMEN:
Vaginal dryness _____ Irregular periods _____
Painful intercourse _____ Pain with menses _____

Endocrine & Thyroid Center

7141 Colleyville Blvd., Colleyville, TX 76034. (817) 410-9993 (phone), (817) 410-9963 (fax)

PRESCRIPTION POLICY

Medical Questions

- If you have any medical questions, please call the Provider that you saw at your last appointment.
 - Dr. Prost's assistant 817.410.9993 EXT 106
 - Dr. Roopa's assistant 817.410.9993 EXT 107
 - Dr. Burney's assistant 817.410.9993 EXT 117
 - PA Amanda's assistant 817.410.9993 EXT 105
 - NP Christine's assistant 817.410.9993 EXT 108

****NEW****

Medication Prior Authorization (PA): PAs are required by YOUR insurance company, not our office or any of our providers. These take time for our staff to complete so please allow seventy-two (72) hours for us to start the PA, and up to two (2) weeks for a determination from your insurance company. If the initial PA is denied, your provider will be made aware and another medication will be prescribed, please allow **seventy-two (72) hours** for the new medication to be sent to your preferred pharmacy. Initials: _____

Advance Notification for Refills

- For local pharmacy prescriptions or refills, seventy-two (72) hour advance notice is required.
- For mail order prescriptions, seventy-two (72) hour advance notice is required. Initials: _____

Knowing Your Insurance Benefits for Prescriptions

- Due to individual insurance companies' requirements, please check with your insurance company prior to requesting prescriptions to ensure accuracy and maximize the amount the insurance company reimburses you.

Required for a Refill

- Please contact your pharmacy and have them fax a refill request to our office at (817) 410-9963. Your refill prescription will be authorized by our office within seventy-two (72) hours after the time we receive the fax from your pharmacy. Please do not call our office until after this time in order to not delay your prescription. Initials: _____

Required Information for Mail Order Prescriptions

- Failure to supply all required information will delay your prescriptions. Thank you for your cooperation with this matter.
- Please provide the following information:
 - Name of the mail order prescription company
 - Fax number of the mail order prescription company
 - Cardholder name
 - Cardholder identification #
 - For testing supplies, please also provide:
 - Glucometer model
 - Number of times tested per day
 - Continuous Monitor type
 - Insulin Pump Model

Initials: _____

ENDOCRINE & THYROID CENTER

7141 Colleyville Blvd., Colleyville, TX 76034. (817) 410-9993 (metro), (817) 410-9963 (fax)

FINANCIAL & OFFICE POLICIES

UPDATED JULY 25, 2025

Endocrine & Thyroid Center recognizes the need for a clear understanding between patient and physician regarding financial arrangements and standard office policies for your medical care. In order to provide you with the best and most efficient care, the following information is provided for you. If you have any questions, please let us know before signing below.

To ensure confidentiality and privacy, ANY TYPE OF ELECTRONIC RECORDING IS STRICTLY PROHIBITED AT ANY LOCATION WITHIN THESE OFFICES. No exceptions. Thank you for your understanding and compliance.

ITEMS FOR WHICH YOU ARE FINANCIALLY RESPONSIBLE

1. **Co-payments, deductibles, and co-insurances** are due at the time of service. For your convenience, we accept VISA, Mastercard, American Express & Discover. As a courtesy, we will file your insurance if we are in-network. We have made prior arrangements to accept an assignment of benefits. You are responsible for any balance after insurance processes your claim. Payment is due upon receipt of a statement from our office. NO CASH PAYMENTS
 - a. **Terms of Your Insurance** – It is your responsibility to understand if your insurance carrier is in-network and the terms and conditions of your insurance benefits. When speaking with your insurance carrier, please specify that you want benefits for an office visit with a specialist. In the event that your insurance carrier is out-of-network, you will be responsible for the complete charge.
 - b. **No Insurance or Out-of-Network Patients** – We also offer a **PROMPT PAY DISCOUNT** for those patients with no insurance or out-of-network coverage. Arrangements must be made prior to your visit by working with the office manager.
 - c. **Returned Checks** - There will be a \$50 charge for returned checks and must be paid before additional appointments will be scheduled. The returned check may be sent to a collection agency and/or the District Attorney's office.
2. **Insurance Referral Authorization:** It is **YOUR** responsibility to obtain all referral authorizations from your primary care physician prior to your appointment. If you do not, you are responsible for the complete charge for your office visit.
3. **Collection Agency:** By signing below, I authorize Endocrine & Thyroid Center, its assignees, and third-party collection agents to use any contact information I have provided to communicate regarding my account. I understand and agree that any of these entities may contact me by manual dialing or by using an automatic telephone dialing system, and they may use an artificial or pre-recorded voice. I understand that these calls may be to my home phone, business phone, cellular phone, or other wireless device, and I consent to such calls regardless of whether I incur charges as a result. I also agree to receive text messages on my cellular device and e-mails sent to any e-mail address I may provide. I understand that any consent provided hereunder may be revoked by me at any time, by informing Endocrine & Thyroid Center, its assignees, and/or third-party collection agents of such revocation of consent.
4. **Patient Balances Older Than 90 Days:** Any account with a patient balance older than 90 days will be charged a 10% finance charge.
5. **Disputed charges/billings:** Any charges/billings that you feel are incorrect or that you request an adjustment be made, must be requested within 90 days of the date of service.
6. **Medical Care by Phone or Through Portal Messages:** Caring for your medical needs may sometimes necessitate a phone call or through messages directly through the patient portal. In some instances, there is a charge of \$25 - \$75 for prolonged or excessive phone calls/messages. The amount is determined by the length of the call(s)/message(s) & is considered non-covered by insurance and is your responsibility.
7. **Canceling or Rescheduling an Appointment:** If you need to cancel or reschedule your appointment, **you must notify our office at least twenty-four (24) hours in advance of your scheduled appointment**. Failure to do so will result in a \$50 fee for the first no show, \$75 for the second, and \$100 for subsequent missed appointments there after. After the **third** missed appointment you may be considered as a non-compliant patient and be discharged from the practice. This fee is considered non-covered by insurance and you are responsible for this charge. If you no-show your new patient appointment you will be rescheduled for the next available, not worked into the schedule and the fees above will apply. If you no-show 2 new patient appointments you will be referred back to your referring provider.
8. **Late Arrival Policy:** If you are 10 minutes or more late for your appointment, you may be asked to reschedule.
9. **Medical Records:** Our office is authorized to release medical records to the insurance of the insured for purposes including, but not limited to the following: 1) payment of claims, 2) utilization management, 3) quality assurance, and 4) claim audits.
 - a. **Medical Records sent directly to another physician office** – There is no charge to send one copy of your medical records to another physician office once a year.
 - i. **Additional copies** - If additional copies need to be sent to additional physician offices, **THERE IS A \$25 CHARGE** for the first twenty (20) pages with an additional \$0.50/page charge for each additional page.

- ii. **7-10 Business Days** – It will take 7-10 business days to process your request.
- b. **Medical Records sent directly to you** – There is a \$25 charge for the first twenty (20) pages of your medical records with an additional \$0.50/page charge for each additional page.
- c. **Surgery Clearance, Custom Letters, Miscellaneous Forms:** Any forms, FMLA, etc. please allow seven to ten (7-10) business days to complete and be returned to you. There is a fee of \$25-\$50 for all forms and you must be compliant with your follow-ups to not see the provider prior to forms being filled out. If you have missed or cancelled your follow-ups and are not current on those an additional appointment will be required and can delay the paperwork being completed.

OFFICE POLICIES

1. **Valid Identification:** Per the FACTA regulations, you are required to provide a valid form of identification. This includes: 1) a Texas or other state-issued driver's license, 2) Texas or other state-issued identification card, or 3) government-issued passport. Failure to provide valid identification on the initial visit will result in rescheduling your appointment.
2. **Proof of Insurance at Every Visit:** All patients will be required to show proof of insurance at every visit.
3. **Insurance Changes or New Insurance Card Received:** If there are any changes in your insurance, **you are required to call our**
4. **office and give the detailed changes of your insurance at least forty-eight (48) hours prior to your appointment.** Otherwise, you will have to reschedule your appointment. We apologize for any inconvenience.
5. **Medication Prior Authorization (PA):** PAs are required by YOUR insurance company, not our office or any of our providers. These takes time for our staff to complete so please allow seventy-two (72) hours for us to start the PA, and up to two (2) weeks for a determination from your insurance company. If the initial PA is denied, your provider will be made aware and another medication will be prescribed, please allow 72 hours for the new medication to be sent to your preferred pharmacy.
6. **To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within these offices.** Thank you for your understanding and compliance.

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, & RELEASE OF INFORMATION TO INSURANCE COMPANY

- By my signature below, I consent to treatment necessary for the care of the patient indicated on this form. I understand this facility may employ physician extenders.
- By my signature below, I hereby authorize payment of medical benefits directly to the attending physician for services rendered. Authorization is hereby granted to use this form on ALL my insurance submissions. Authorization is hereby granted to release information as may be necessary to process and complete my claim. I understand I am financially responsible for this account. I permit a copy of this authorization to be used in place of the original.
- FOR MEDICARE PATIENTS ONLY** - By my signature below, I hereby authorize payment of Medicare benefits directly to the attending physician for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature below requests that payment be made and authorizes the release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

By my signature below, I, _____, understand all of the policies above and agree to be bound by its terms.

Patient Signature

Date

