



New Patient Registration Form

Today's Date:		PCP:		
Patient Registration				
Last Name:		First:	Middle	Preferred: Sex:
Date of Birth:		Social Security:		Marital Status:
Race: <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Mixed <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Decline				
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Decline				
Address:				
Primary Phone:			Secondary Number:	
Email:				
Preferred method of contact: <input type="checkbox"/> Primary Phone <input type="checkbox"/> Secondary <input type="checkbox"/> Email (We will not rent or sell this info-we value your privacy)		<input type="checkbox"/> Ok to leave detailed message <input type="checkbox"/> Leave callback message only <input type="checkbox"/> Do not leave message		Please note: *In order for email communication to occur, please accept the disclosure below: I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication. <input type="checkbox"/> YES <input type="checkbox"/> NO
Emergency Contact Information				
Emergency Contact:		Phone:	Relationship:	
Employer Information				
Employer Name:		Occupation:	Phone:	
Responsible Party (If other than patient)				
Name:		DOB:	SSN#	
Address:			Phone:	
Medical Insurance Information				
Policy Name:				
Contract #:		Group #:		
Subscriber Name:		DOB:	SSN#	
Relationship to Patient:				

Consent for Treatment

Patient Consent for Treatment

1. I understand that this is a cash/credit pay service. Endo NP will not file anything with my insurance.
2. I voluntarily consent to all health care treatment and diagnostic procedures provided by Endo NP and its associated providers, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Endo NP.
3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment, and health care operations consistent with the Endo NP Notice of Privacy Practices.
4. I authorize payment of medical benefits to Endo NP practitioners or their designee for services rendered.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice, Financial Policy Notice, and the Release of Information.

X _____
Patient or Authorized Person's Signature

Date

Patients Being Seen for Diabetes

I am aware that it is my responsibility to provide documentation of blood sugar readings to EndoNP. I understand that missing appointments may result in a lapse of insulin pump/CGM supplies in accordance with my insurance policy.

X _____
Patient or Authorized Person's Signature

Date

Patient Medical History

Name:		DOB:	
Major Illness (Please check all that apply)			
Hypertension: <input type="checkbox"/> N/A <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Notes:			
Diabetes: <input type="checkbox"/> N/A <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Notes:			
Cancer: <input type="checkbox"/> N/A <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Notes:			
Other: <input type="checkbox"/> N/A <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Notes:			
Surgeries (All surgeries and approximate dates)			
<input type="checkbox"/> No Surgeries			
Family History			
Mother: <input type="checkbox"/> N/A <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Other:			
Father: <input type="checkbox"/> N/A <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Other:			
Brother: <input type="checkbox"/> N/A <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Other:			
Sister: <input type="checkbox"/> N/A <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Other:			
Grandmother (P): <input type="checkbox"/> N/A <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Other:			
Grandfather (P): <input type="checkbox"/> N/A <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Other:			
Grandmother (M): <input type="checkbox"/> N/A <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Other:			
Grandfather (M): <input type="checkbox"/> N/A <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Other:			
Social History			
Drink Alcohol: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past		How much/often:	
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past		How much/often:	
Substance Abuse: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past		Which substance(s):	

Authorization for Release of Health Information

Today's Date: _____

Patient Name:	DOB:
<i>Endo NP is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.</i>	
Entity to Receive Information	Information to be released
<input type="checkbox"/> Voicemail	<input type="checkbox"/> Results of testing <input type="checkbox"/> Financial <input type="checkbox"/> Medical (including appointment reminders) <input type="checkbox"/> All my health information
<input type="checkbox"/> Email (If different than email provided on registration form): _____	<input type="checkbox"/> Results of testing <input type="checkbox"/> Financial <input type="checkbox"/> Medical (including appointment reminders) <input type="checkbox"/> All my health information
<input type="checkbox"/> Text	<input type="checkbox"/> Results of testing <input type="checkbox"/> Financial <input type="checkbox"/> Medical (including appointment reminders) <input type="checkbox"/> All my health information
<input type="checkbox"/> Family / Friend Name: _____ Phone: _____ Name: _____ Phone: _____	<input type="checkbox"/> Results of testing <input type="checkbox"/> Financial <input type="checkbox"/> Medical (including appointment reminders) <input type="checkbox"/> All my health information
<input type="checkbox"/> Other (Doctors, Lawyers, etc):	<input type="checkbox"/> Results of testing <input type="checkbox"/> Financial <input type="checkbox"/> Medical (including appointment reminders) <input type="checkbox"/> All my health information

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed because of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

X _____

Signature of Patient or Representative

Date



Notice of Privacy Practices: EndoNP

(Please Read and Sign)

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.

Patient Health Information (PHI) Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing, and insurance information. We are committed to protect the privacy of your PHI.

How we use your patient health information (PHI) This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies to assist with qualifications of benefits, or collection agencies.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients, or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results,

to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission:

We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

Military Activity and National Security:

When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services. In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

Individual Rights: You have certain rights regarding your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance

Notice of Privacy Practices Continued

provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12-month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency, we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

Our Legal Duty

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice on our website at www.EndoNP.com. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Practice Manager listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

**EndoNP Attn:
Dennis Jeffrey
522 W Finnie Flat Rd
Ste E157
Camp Verde, AZ 86322**

Patient Acknowledgment

My signature verifies that I have been provided a copy of EndoNP "Notice of Privacy Practices" to review. I understand that if I would like a copy of this Notice, EndoNP will provide me with a copy of this

X _____ Patient's printed name	_____ DOB	_____ Signature
X _____ Patients Representative Printed Name	_____ Representative Signature	_____ Relationship to Patient

Policies and Disclosures

(Please Sign and Date)

The Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Policy and Disclosure stating our requirements for services provided to patients.

Self-Pay Policy

- Patients are responsible for the payment of all services provided by EndoNP.
- As a self-pay patient, you will be required to pay for the office visit before services are rendered.
- In addition, any remaining balance on your account will be collected at discharge.
- Some insurance companies may allow for reimbursement of receipts; however, this depends on your insurance company's policy and reimbursement is not guaranteed by EndoNP.
- In special cases, we may need your help in contacting your insurance company.

Overdue and Credit Balances

- All over-due patient balances will be sent to collections if there has been no attempt to repay debt within 90 days from bill origination.
- All accounts sent to collections will be charged a \$25 collection fee in addition to the account balance.

Late and No-Show Policy

Appointments must be canceled 24 hours prior to the scheduled appointment time, or you will be subject to a fee of \$35 at the discretion of EndoNP. Appointment times are limited and if you are unable to make it to your appointment, someone else needed that time. Please be respectful of the needs of all patients in the practice and provide adequate notice. We understand that 24-hour notice is not always possible. In those situations, please give as much notice as possible. Repeat no-shows or late cancellations will result in dismissal from the practice at the discretion of EndoNP.

Telemedicine Policy

By receiving care at EndoNP, you are providing consent to receive services via telemedicine. This method of patient care is done exclusively in real-time audio or audio/video. You will not see the healthcare provider in-person. Visits are confidential and will not be recorded under any circumstances.

Prescription and Refills Policy

Please contact your pharmacy and ask them to fax us your refill request for medications first before calling EndoNP to request refills. Please allow 3 business days for EndoNP to respond to refill requests. If your pharmacy has not received a response from our office after 3 business days, please call our office to inquire. In situations of urgent requests for refills (patient does not have enough medication to last up to 3 business days) please call our office after requesting your pharmacy to send us an urgent request. This will help us to ensure our patients are not without their medications. Prescriptions for controlled substances are provided only at the discretion of the healthcare provider and are subject to any applicable state laws.

Paperwork Policy

A separate appointment must be scheduled for any paperwork that needs to be completed by the healthcare provider.

To help in these policies, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service.

To provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the provider. Please discuss any account information with the clinic manager or receptionist.

X _____
Responsible Party's Signature

Date

Your cooperation is greatly appreciated. Thank you for choosing EndoNP!