TRI CITY ENDOCRINOLOGY

Tri City Endocrinology
New Patient form

Today's Date:_____

Last Name:_____First:_____M. I:_____D.O.B:_____Sex: _____

Address:_____City:_____State: _____ Zip Code: _____

Email:_____Marital Status: _____ Advance ***Directive:*** Yes or No

SSN:_____Home number:_____Cell number: _____

Occupation:_____Employer:_____Employer number: _____

Reason for Visit: _____

Name of Primary Care Physician:_____Phone#: _____

Name of Referring Physician:_____Phone#: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____ Group#: _____

Card Holder:_____D.O. B:_____Phone#: _____

Relationship to cardholder:_____Employer:_____Occupation: _____

Address (if different):_____

Secondary Insurance: _____ ID#: _____Group#: _____

Card Holder: _____DOB: _____Phone# _____

Relationship to cardholder:_____Employer:_____Occupation:_____

Address (if different):_____SSN:_____

EMERGENCY CONTACT

Name:_____Relationship to patient:_____Phone#:_____

NOTE: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the office staff/biller of Tri City Endocrinology or insurance company to release any information required to process my claim

Signature of patient/guardian:_____Date:_____

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As a patient or guardian for a patient receiving services from Dr. Manal Alhakim, MD, I understand that I am responsible to cancel appointments within appropriate time frames. I do hereby agree to the following:

1.) I will cancel a scheduled appointment at least 24 hours before the appointment.

2.) I agree to pay a **$50 No Show Fee** for a scheduled appointment and confirmed appointment.

3.) Allowances will be made for failing to keep my appointments due to unavoidable or reasonably.

4.) My provider may terminate my services if I do not cancel or fail to attend three scheduled appointments

5.) Should my provider terminate my services, they will send me a letter. This letter will explain a 30-day grace period that will be given to enable me to secure alternative services and will also allow prescription refills when medically appropriate for 30 days from the date of the termination of service letter.

Patient Signature:_____Date:_____

PRESCRIPTION REFILL POLICY

Prescription refill request must be made **7-10 days before running out of medication,** also please allow up to 72 hours for the refill to be processed. Refills will only be approved if your follow- up visits have been kept per your physician's recommendation. Prescriptions will only be handled during business hours.

Patient Signature:_____Date:_____

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Notice of Privacy Practices

Patient Name: _____ DOB: _____

I have the option to receive or decline *(circle one)* this practices **Notice of Privacy Practices** written in plain language. The notice providers in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices' legal duties with respect to my protected health information. This practice reserves the right to change the term of its Notice of Privacy Practices and to make new provisions effective for all protected health information that is that it maintains. I understand that I can obtain this practice's Notice of Privacy Practices on request.

I participate in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals.
Participants in this arrangement work together to improve the quality and efficiently of the delivery of healthcare to their patients. As a participant in this arrangement, we may share you PHI with other members of this arrangement for purpose of treatment, payment or the health care operations of this organized health care arrangement.

Signature_____Date:_____

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I am a patient of Tri City Endocrinology.

I would like to request that this individual:_____

Phone Number: _____

Relationship to individual:_____

Be given access to my medical records and/or medical conditions, allowing the staff or physician to discuss my care and any medical changes.

Patient Signature:_____Date:_____

Please note: All medical records are kept confidential; no information will be transmitted by phone, fax, or mail without written/verbal consent from the patient

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Authorization of Medical records

Patient Name: _____ DOB: _____

The above authorizes:

Medical provider: _____

Phone: _____ Fax: _____

Purpose of release:

_____ Appointment/ Continuation of care other: _____

Medical records:

Specific records: _____ Date: _____

Radiology Reports: _____ Date: _____

Other: _____ Date: _____

_____ _____

Patient Signature **Date**

PLEASE NO CD'S. THANK YOU!!!

To Release medical records information concerning the above mention patient to **Manal Alhakim, MD**
This consent will expire in 90days after the signed date below. I have given my consent freely, voluntarily and without coercion, I may revoke this authorization at any time providing I notify them in writing to that effect. I understand that any release which wasn't made prior to revocation in compliance with this authorization shall not constitute a breach of my rights to confidentially. I understand subject to re- disclosure by the recipient and no longer protected by the privacy act.

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Medication List

Patient Name: _____ DOB: _____

Pharmacy /Mail Order	Pharmacy Phone #	Cross Streets	
Name of Medication	Dosage (mg}	Times Taken **(AM-PM)**	Pill/Injection
Name of Insulin	# of units per day	Times Taken **(AM-PM)**	Pen or Vials
Name of BS Meter	Name of Test Strips	Name of Lancets	# of times you test daily
Name of Insulin Pump			

Drug Allergies: _____