TEXAS DIABETES & ENDOCRINOLOGY, P.A.

6500 North Mopac*Bldg. 3, Ste. 200*Austin, TX 78731
5000 Davis Ln*Ste 200*Austin, TX 78749
110 Deer Ridge Dr*Round Rock, TX 78681
Phone: (512) 458–8400*Fax: (512) 458-8593

PATIENT DEMOGRAPHICS

Patient Name: ____ Date of Birth: __________________ Legal Gender: M or F

Address: ____City_____________________ State________ Zip______________

Marital Status (please circle) : Single / Married / Separated / Divorced / Widowed / Other ____________________________

Race (please circle): White / African American / Asian / American Indian / Other______________________________________

Ethnicity: __________________ Preferred Language: __________________ Email address: ____________________________

Social Security Number: ______________________________ Drivers License: ______________________ State: ___________

Employer Name: ____ Phone: __________________________________

Address: ____

Primary Insurance: __________________________________ Policy #: __________________________ Group #: ______________

Secondary Insurance: ______________________________ Policy #: __________________________ Group #: ______________

Pharmacy Benefits: _________________________ Policy #:________________________ RX Group#___________ RX Bin#________

Emergency Contact: _______________________________Phone: ________________________ Relation: _________________

Referring Physician: ____Phone: ______________________________________

Most convenient means of communication for appointments, lab results and general information:
Please note: if you provide an email address, we can communicate to you via our patient portal.

Home Phone: _________________________________ Cell Phone: __________________________________

Work Phone: _________________________________ Email address: _______________________________

Appointment reminders are sent through an automated service via Text Message. If this is not convenient, please let us know.
Preferred method for receiving appointment reminders: ☐ Email ☐ Home/Cell Phone

If you wish to not be reminded of any future appointments at all, please select this box: ☐ DO NOT CONTACT

****PLEASE INFORM OUR OFFICE OF ANY INSURANCE, PHONE NUMBER, OR ADDRESS CHANGES****

Signature: ____ Date: ____________________________

MINOR PATIENTS – please provide a parent or guardian's Name and Social Security Number

Parent/Guardian (print) ____

Parent/Guardian (signature) ____

SS#______________________________

Please be advised that our Privacy Policy is posted in our waiting room for you to review.
Should you have any questions concerning this policy, please inquire at the front desk.

Texas Diabetes & Endocrinology, P.A.

Patient Information

Due to the many changes in healthcare and our ability to comply with those changes and the growth in our practice, we have implemented the following policies and procedures for our office.

Appointments: We will make every effort to schedule an appointment within a reasonable time frame with one of our practitioners. We appreciate our patients and understand that your time is valuable. Our goal is to be as punctual as possible and to see you in a timely manner. We require a 24 hour notice to cancel your appointment. This allows us to give your appointment to another patient. There is a $50 charge for no show appointments and same day cancellations. If we are unable to confirm your appointment due to incorrect phone numbers, your appointment will be cancelled.

Non-Physician Practitioners: Texas Diabetes & Endocrinology utilizes physician assistants and advanced practice nurses to assist in the delivery of medical care. Physician assistants and advanced practice nurses are not doctors, however they can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. A physician assistant is a graduate of a certified training program and is licensed by the state medical board. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. Nurse practitioners and clinical nurse specialists are advanced practice nurses. Your signature below indicates your understanding that some services may be rendered by a physician assistant or advanced practice nurse.

Lab Reporting and Review: Lab testing is a necessary tool in the treatment of chronic conditions. It is important that you get your lab tests done and keep your follow up appointments to discuss your plan of care. If lab testing is done between visits, results will be reported within two weeks through our patient portal or via mail. You may be contacted via phone by a nurse with instructions. Please allow two weeks before contacting our office to allow time for lab processing, review, and mailing of results. If you would like for us to review and interpret labs done elsewhere, please get copies of the labs and bring them with you to the appointment. **PLEASE NOTE: CLINICAL PATHOLOGY LABORATORIES (CPL) IS OUR DESIGNATED LAB. IF YOU USE A DIFFERENT LAB, PLEASE NOTIFY YOUR PROVIDER AT YOUR VISIT. WE ARE NOT RESPONSIBLE FOR OBTAINING LABS DONE AT OTHER OFFICES.**

Medication Refills: We provide 30 and/or 90 day prescriptions and refills are done at the time of your appointment. We send prescriptions electronically, so if you are using a mail order company please notify them when you would like your prescriptions filled and shipped. If you need a refill between visits, please do not contact our office. Contact your pharmacy and they will send a refill request on your behalf. Please allow 48 hours for processing of these refills.

Nurse Call Backs: To better serve your needs, nurses are available via phone from 8:30a.m. – 12:00p.m. and 1:30p.m. – 4:30p.m. If the nurses are unavailable, please leave a voicemail message. Voicemail is checked in the morning and after lunch. Messages left in the morning will be returned the same day. Messages left after 4:30p.m. will be returned the following business day. If you have an urgent request, please speak directly with the receptionist and do not leave a message.

Letters & Forms: If you request that we generate a letter on your behalf, your account will be charged $25.00. The fee is due when the letter is requested. This is not a covered insurance benefit and will be billed directly to the patient. Should you misplace any forms generated by this office there will be a $10.00 charge for replacing them. This is not an insurance benefit and is due at the time of the request. This includes lost prescriptions, lab requisitions, and physician orders for testing.

Contacting You: Texas Diabetes & Endocrinology and any of our affiliates or vendors, such as collection agencies, may contact you by telephone or text message using any phone number you have provided to us, or any other phone number associated with your account, including wireless or mobile phone numbers. We may use any method to contact you at these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. You must notify us if you have given up ownership or control of any such phone numbers.

Signature: ____ Date: ______________________

Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our Office Manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Full payment is due at the time of service for self-pay patients unless other arrangements have been made in advance. For your convenience we accept Discover, Mastercard, Visa, Personal Checks and Cash.

Your Insurance:

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement on your behalf. You will only be responsible for any "out of pocket" expenses at the time of service including: copays, coinsurances, and deductibles.
- If you have insurance coverage with a plan for which we do not have a prior agreement, payment is due at the time of service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the office. Any balance due is your responsibility and is due at the time of service. A credit card can be placed on file for you out of convenience, just ask a receptionist.
- If you have Medicaid or obtain Medicaid at any time during your care, you understand TD&E is accepting you as a private pay patient and that you are responsible for payment of any and all services rendered at time of service. TD&E will not file a claim to Medicaid for the services that are provided to you. Your signature below indicates your understanding and agreement with this policy.

Minor Patients:

- For all services rendered to minor patients, the accompanying adult or the parent/guardian with custody is responsible for payment.

Other Fees:

- If you have a balance on your account, you will receive a total of two statements. Should your account become more than 60 days past due, your account may be sent to a collections agency. A collections fee of 30% of your total balance will be added to your account. Please note: If you have an appointment scheduled, the total balance will be due upon check-in. If you are unable to pay the full amount, a payment arrangement can be made with a credit card on file. Failure to resolve your account will result in your appointment(s) being canceled.
- In certain circumstances, your provider may charge for telephone services that include more extensive medical discussions. This charge will be billed to you directly.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

______________________________________ **DOB: ____________________**

Printed Name of the Patient

______________________________________ Date ____________________

Signature of Patient or Responsible party if a Minor

Assignment of Benefits Form

Financial Responsibility:

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Texas Diabetes & Endocrinology, P.A. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information:

I hereby authorize Texas Diabetes & Endocrinology, P.A. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Texas Diabetes & Endocrinology, P.A. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_______________________________________   _________________________

Patient/Responsible Party Signature   Date

Auto Pay Withdrawal Authorization

I, ____________________________, hereby authorize Texas Diabetes & Endocrinology, P.A. to debit my credit card for any amount that is in my responsibility. Texas Diabetes & Endocrinology, P.A. will file my claim to my insurance on my behalf (if applicable- please see Private Pay Agreement). Once the patient responsibility portion has been determined, Texas Diabetes & Endocrinology, P.A. will charge my credit card on file for the amount due and email me a receipt of payment. I understand that I may still be able to dispute said charge at any point up to 90 days from the date of service. I also may request that if the amount due exceeds a certain limit that I be called prior to deducting payment from my card.

_________________________________ _________________________

Signature of Patient or Responsible Party Date

_____________________________ _________________________

Email Address Phone Number

Credit Card Information

I understand that this authorization will take into effect until I cancel it in writing. I agree to notify Texas Diabetes & Endocrinology, P.A. in writing of any changes in my account information or termination of this authorization. I certify that I am an authorized user of this account.

Card Type: **We do NOT accept AMEX or Care Credit.*

☐ VISA ☐ MasterCard ☐ Discover

Cardholder Name (as it appears on card): ____

Expiration Date (mm/yy): _______________

Cardholder ZIP Code (from credit card billing address): ______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received Texas Diabetes & Endocrinology's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice.

______________________________	______________________________
Patient Name	**Date of Birth**
______________________________	______________________________
Patient's Signature	**Date**
______________________________	______________________________
Personal Representative/Guardian Name	**Relationship to Patient**
______________________________	______________________________
Personal Representative/Guardian Signature	**Date**

Please list names, relationships, and contact numbers of all persons TDE is authorized to release medical information to.

______________________	______________________	______________________
Name	**Relationship**	**Contact Number**
______________________	______________________	______________________
Name	**Relationship**	**Contact Number**
______________________	______________________	______________________
Name	**Relationship**	**Contact Number**

FOR OFFICE USE:

If the signed acknowledgement could not be obtained from the patient or representative, the reason(s) must be documented.

1. Please explain why the patient did not sign an acknowledgement form:
   - [ ] Patient Refused to Sign
   - [ ] Patient Communication Barrier
   - [ ] Emergency Situation
   - [ ] Other: ____________________

2. Completed by:

______________________	______________________	______________________
Employee Signature	Title	Date

HEALTH SUMMARY REPORT

Texas Diabetes and Endocrinology, P.A.

Patient Name: ___________________________________ Date of Birth: ___________________

Referring Physician: _______________________________ Phone: ________________________

Primary Doctor: __________________________________ Phone: ________________________

OB/GYN: _______________________________________ Phone: ________________________

Pharmacy: ______________________________________ Phone: ________________________

Past Medical History: **Date:**

____

____

Past Surgeries: **Date:**

____

____

Medication List: **Dosage:**

____

____

____

Drug Allergies:

____

Family Medical History (not patient): **CHECK ALL THAT APPLY**
(Father, Mother, Sibling, Children, Aunt, Uncle, Grandparent; please specify)

	Diabetes	Relationship:		Heart Attack	Relationship:		Other
	Thyroid	Relationship:		Stroke	Relationship:		
	Osteoporosis	Relationship:		High Blood Pressure	Relationship:		
	Cancer	Relationship:		Cholesterol	Relationship:		

Social History:

Occupation: ____

Marital Status: Married Single Divorced Widow Partner Children: # _________

Affirmed Gender (if different than legal gender): ____________ Preferred Pronoun: ______________

Tobacco Use: Y N Frequency: ____________ Previous Smoker? Y N How long? _________

Alcohol Use: Y N Frequency: ____________ Drug Use: Y N Frequency: ____________

Complete ONLY if you are a Diabetic:

1. Recent flu shot? Y or N When? ____________
2. Pneumonia vaccine? Y or N When? ____________
3. Hep B Series? Y or N When? ____________
4. Shingles vaccine? Y or N When? ____________

5. Last eye exam? _______________

6. Last foot exam? _______________

7. Last dental cleaning? ___________

Office Use Only :
Height _____ft_____in Weight:__________ BP:___________ Pulse:______________