

Registration

Name (First, Last) _____ Gender: Male Female

Birth Date: _____ Social Security #: _____

Address: _____

Preferred methods for communication: Phone Text Email Patient Portal

Best Number to reach you: _____ Email Address: _____

Can we leave a message on machine or with whoever answers? (Circle Yes or No)

Alternate Phone number : _____

Can we leave a message on machine or with whoever answers? (Circle Yes or No)

Marital Status: Single Married Widowed Separated Divorced

Race: (Check one) ___Caucasian ___African American ___Hispanic ___Asian ___Pacific Islander
___ American Indian/Alaskan Native

Ethnicity: (Check one) ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Decline

Insurance Information (Present Insurance Card(s) to Receptionist)

Primary Insurance _____

Subscriber Information:

Last Name _____ First Name _____ MI: _____

Date of Birth _____ Age _____ SS# _____ Sex (M/F) _____

Address _____ City/State _____ Zip _____

Home Telephone () _____ Work Telephone () _____

Secondary Insurance _____ Policy/ID # _____

Subscriber Information:

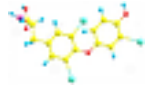
Last Name _____ First Name _____ MI: _____

Date of Birth _____ Age _____ SS# _____ Sex (M/F) _____

Address _____ City/State _____ Zip _____

Home Telephone () _____ Work Telephone () _____

Medical History



1. Which of the following are you being seen for today?

- Diabetes _____Type 1 _____Type 2
- Hyperthyroidism (overactive thyroid condition)
- Hypothyroidism (underactive thyroid condition)
- Goiter
- Thyroid Nodules
- Thyroid Cancer
- Osteoporosis
- High Calcium
- Pituitary Disorder
- Adrenal Disorder
- Menstrual problems
- Other (please explain):

2. Please list any past surgeries:

3. Please list any medications/vitamins: _____check if list is attached separately

4. Please select and identify any blood-related family members have any of the following conditions:

- Diabetes _____
- High Blood Pressure _____
- High Cholesterol _____
- Heart Disease _____
- Hyperthyroidism _____
- Hypothyroidism _____
- Osteoporosis _____
- Cancer
- If so, what type? _____

Office Policies



103 Parker Road, Suite B, West Long Branch, NJ 07764. Phone: (732) 222-0307, Fax: (732) 222-0394

Thank you for choosing "Prime Endocrinology" for your Endocrine care. Our office aims to provide you excellent medical care and customer service. We have implemented policies that will assist us to achieve our goals that we would like to bring to your attention:

1-New patients please arrive 15 minutes before your appointment time. You must have a valid insurance card and current identification at the time of the first visit.

2- Insurance co-pays are due at the time of service: Patients who do not pay their co-pay are billed a \$15.00 service charge in addition to their co-pay. If you have an outstanding balance at the time of your appointment, payment will be expected. We accept cash, checks, and all major credit cards for your convenience. There is a \$25.00 service charge for a returned check. Insurances are billed as a courtesy and the patient has financial responsibility for payment in full for services rendered.

3- Insurance coverage: We recommend that you check with your insurance company whether we are listed under the network and what's your expected payment. As we are a specialist office, if your insurance company requires referral/authorization from your primary care physician, be sure that you have obtained a valid referral or authorization prior to your appointment. If you do not have a valid referral or authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

4- Appointment and Cancellation policy: We recommend arrival 15 minutes prior to the visit. Late arrivals will be seen only upon the discretion of the provider. We request the courtesy of an **advanced notification of 24 business hours**. If you fail to notify us of your inability to keep your appointment, a "no-show" for your appointment time will be noted in your chart. After two consecutive no-shows, you may be considered for discharge from the practice. All patients who fail to present for their visits or cancel within 24 hours of their appointment will be subject for a fee. The fee will be waived if they reschedule within 24 hours after the missed visit. The charge is \$50.00 for the first visit and \$25.00 for a follow-up visit.

5- Prescription refills: New prescriptions and prescription changes are available to you during your visit. Refill requests should be made to your pharmacy. Please do not wait until you are out of medication to request a refill and allow 72 hours for prescription refills.

6- Lab copies: Most of the time, your labs will be available to be seen through the patient portal online. Paper copies of your labs can be requested during your visit as well.

7- Medical records: If another practitioner is requesting your records, they can be sent electronically or faxed to the requesting provider at no charge after you sign a medical release. Otherwise, to obtain a copy of medical records a fee of \$ 25.00 and may take up to two weeks. The records can be picked up at the office. Upon request they may be mailed Certified/Return Receipt for an additional cost of the mailing fee.

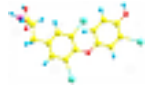
8- Online Communication: As a courtesy to our patients, we respond to your requests online through the patient portal. We recommend that the online communication be brief and limited to simple questions and answers. Please allow 24 - 48 hours for a response from our office. For urgent matters, we recommend that you call our office.

9. After-hour phone calls: We are happy to answer the phone during our regular business hours, which is Monday to Friday, 8:00 am till 5:00 pm and we are closed for lunch between 12:00 pm and 1:00 pm. If you call our office after 5:00 pm or over the weekend, we advise that you leave a message and we will respond to you the next business day. If you have a matter that requires urgent medical attention, we advise that you visit the nearest Emergency Room.

I read the office policies for Prime Endocrinology and I agree to all of them

Name _____ Signature _____

Cancellation and No Show Policy



We understand that situations arise in which you must cancel your appointment. It is therefore requested that you notify us of your cancellation more than 24 hours ahead of time. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification are subject to a **\$ 50.00 cancellation fee.**

Patients who don't show up to their appointments without a call to cancel an office appointment will be considered a **NO-SHOW**. Patients who have (2) or more **NO-SHOWS** in a 12-month period may be dismissed from the practice. Patients may also be subject to a **\$ 50.00 fee** for office appointment NO-SHOW.

The cancellation and the **NO SHOW** fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Prime Endocrinology believes that good physician / patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to our office staff.

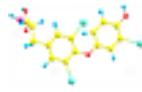
Please sign that you have read, understand and agree to this cancellation and no show policy.

Patient Name (please print)

Date of Birth

Signature of patient or patient representative

Date



Electronic Mail Consent Form

Before allowing electronic mail (“email”) communications with Prime Endocrinology, LLC please read and agree to the following information regarding the risks and conditions of email use:

The Risks of Using Electronic Mail

We offer patients and other individuals the opportunity to communicate by email. However, transmitting patient information by email has a number of risks that should be considered. These include, and are not limited to, the following risks:

- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Email senders can easily misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email may exist even after sender or recipients have deleted their copy.
- Employers and on-line services have a right to archive and inspect emails transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used as evidence in court.

Conditions for the Use of Electronic Mail

We will use reasonable and appropriate means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by our intentional misconduct. Thus, individuals must consent to the use of email for information. Consent to the use of email includes agreement with the following conditions:

1. All emails to or from patients concerning diagnosis or treatment may be printed out and made part of patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
2. We may forward emails internally to the practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. We will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
3. Although we will endeavor to read and respond promptly to an email, we cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, patients should NOT use email for medical emergencies or other time-sensitive matters.
4. If the individual's email requires or invites a response, and the individual has not received a response within a reasonable time period, it is the individual's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
5. Individuals should not use email for communication regarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse



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6. Individuals are responsible for informing us of any types of information that they desire not to be sent by email, in addition to those out in the above paragraph.
7. The individual is responsible for protecting his/her password or other means of access to email. We are not liable for breaches of confidentiality caused by the individual or any third party.
8. We will not engage in email communication that is unlawful, such as unlawfully practicing medicine across state lines.
9. It is the individual's responsibility to follow up and/or schedule an appointment if warranted.

Communicating by email

To communicate by email, patients and other individuals shall:

1. Limit or avoid the use of his/her employer's computer.
2. Inform us of changes in his/her email address.
3. If the sender is a patient of ours, to put the patient's name in the body of the email.
4. Review the email to make sure that it is clear and that all relevant information is provided before sending.
5. Take precautions to preserve the confidentiality of email, such as using screen savers and safeguarding his/her computer password.
6. Withdraw consent only by email or written communication to the practice.

Acknowledgment and Agreement

I acknowledge that I have read and fully understood this consent form. I understand the risks associated with the communication of email between Prime Endocrinology and me, and consent to the conditions outlines herein. In addition, I agree to the instructions for communicating by email outlined herein, as well as any other instructions that Prime Endocrinology may impose to communicate using email.

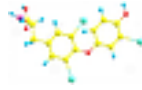
Patient Signature _____

Patient Name _____

Date _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME _____



Prime Endocrinology

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D.O.B: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

TELEPHONE: Home: _____ Cell: _____

I hereby authorize

Phone: _____ Fax: _____

To disclose my health information to Prime Endocrinology LLC,

Dr. Sudha Ganne, MD at 103 Parker Road Suite B, West Long Branch NJ 07764

Phone: 732-222-0307 Fax: 732-222-0394

The information to be disclosed to and used by the above is for the following purpose:

This authorization is limited to the following dates of treatment:

FROM _____ TO _____

Information to be disclosed:

- | | | |
|--|--|---|
| <input type="checkbox"/> COMPLETE RECORD | <input type="checkbox"/> CLINIC RECORDS | <input type="checkbox"/> REHAB. RECORDS |
| <input type="checkbox"/> EMERGENCY ROOM RECORD | <input type="checkbox"/> CONSULTATIONS | <input type="checkbox"/> PATHOLOGY |
| <input type="checkbox"/> OPERATIVE REPORT | <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> BILLING INFO. |
| <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> LAB, X-RAYS & TESTS | <input type="checkbox"/> OTHER _____ |

I understand that the information to be disclosed includes my identity, diagnosis and treatment including Alcohol, Drugs, Genetic testing, Behavioral or Mental Health Services, Reproductive Rights, Sexually Transmitted & Infectious Diseases, AIDS and HIV information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Dr.Sudha Ganne of Prime Endocrinology LLC. I understand that this revocation will not apply to the extent of any actions that the practice has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or Condition:

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

If I have questions about disclosure of my health information, I can contact Dr.Sudha Ganne of Prime Endocrinology LLC at 103 Parker Road Suite B, West Long Branch NJ 07764 Phone: 732-222-0307

PATIENT SIGNATURE: _____ DATE: _____

LEGAL REPRESENTATIVE:

Name: _____ RELATION: _____ DATE: _____

Please read carefully, initial next to each statement and sign the form.

Consents



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1. _____ I have read and **received a copy** of this practice's Notice of Privacy Practices and the office policies.

Consent to release medical information

2. _____ I give **consent to release medical information** to the following parties: Third party payors covering the medical services, other health care professionals, institutions involved in my care, the proponent of any legally sufficient subpoena, or in response to a court order, employees and agents of the practice, pharmacies and other parties as otherwise required by law.

Consent to use SureScripts

3. _____ I authorize **"Prime Endocrinology"** use SureScripts, Inc. a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy.

Assignment of Benefits

4. _____ I hereby **assign all medical benefits**, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), to issue payment check(s) directly to "Prime Endocrinology" for the medical services rendered to myself.

Consent to treat

5. _____ I give permission for Prime Endocrinology to give me medical treatment. I understand that I have the right to discuss all medical treatments with my provider and to refuse any procedure or treatment.

Financial Policy

6. _____ I understand that "Prime Endocrinology" will bill my insurance for the visit as a courtesy. I am still responsible to pay all expenses in case the insurance does not submit the payment on time.

Releasing medical information to friends and family

7. _____ I hereby **give authorization to release information** and/or discuss my medical condition including my protected health information with the person(s)/entities listed below:

Person/entity name: _____ Mobile Phone: _____
Relationship to Patient _____ Home Phone: _____

This authorization can be revoked at any time upon my request in writing.

Patient's Signature: _____ Date: _____

Print Full Name : _____