NEW PATIENT REGISTRATION

PLEASE COMPLETE ALL INFORMATION. PRINT AND SIGN WHERE REQUIRED

PATIENT INFORMATION

Last Name: _____ **Date of Birth**: _____
First Name: _____ **MI**: _____ **Assigned sex at birth**: □ Male □ Female
Maiden Name (if applicable): _____ □Unknown □Choose not to disclose
SSN: _____ **Gender Identity**:
(Providing your SSN is optional; however for patients with Medicare or Medicaid, may help determine eligibility for certain benefits)
□ Identifies as male
□ Identifies as female
Address: _____ □Transgender male (FTM)
_____ □ Transgender female (MTF)
City:_____ □ Gender non-conforming
State: _____ **Zip Code**: _____ □ Other, please specify: _____
Please put an (X) on your preferred contact # □ Choose not to disclose
Home: _____( ) **Pronouns**: □ she/her □ he/him □ they/them
Cell: _____( ) **Marital Status**: □ Single □ Married □ Divorced
Work: _____ **Ext**._____( ) □ Separated □ Widowed □ Partner
Email: _____ **Are you hispanic/latino?**: □Yes □No □Decline
Communication: □ Leave a detailed voicemail **Race**: □ White □ Black/African American □Asian
□ Leave message with a call back number only □Asian Indian □ Native Hawaiian/Pacific Islander
Preferred Language: _____ □American Indian/Alaskan Native
□ Other (fill-in) _____ □ Decline

PRIMARY INSURANCE	SECONDARY INSURANCE
Ins. Company: _____	Ins. Company: _____
Policy ID #: _____	Policy ID #: _____
Subscriber Information (if different from patient)	Subscriber Information (if different from patient)
First Name: _____	First Name: _____
Last Name: _____	Last Name: _____
Date of Birth: _____	Date of Birth: _____Sex
Address_____	Address: _____
_____	_____
City:_____	City:_____
State: _____Zip Code: _____	State: _____Zip Code: _____

EMERGENCY CONTACT

#1 Person/Entity Name:_____ Home Number: _____
Relationship to Patient:_____ Mobile Number: _____

□ DO NOT discuss health information **□ OK to discuss health information**

#2 Person/Entity Name:_____ Home Number: _____
Relationship to Patient:_____ Mobile Number: _____

□ DO NOT discuss health information **□ OK to discuss health information**

MEDICAL HISTORY

REASON FOR VISIT:

□ Diabetes ___1 ___2
□ Weight issues
□ Hypothyroidism
□ Hyperthyroidism
□ Goiter
□ Other _____

□ Thyroid nodules
□ Thyroid cancer
□ PCOS/hirsutism
□ Gestational diabetes
□ Irregular periods

□ Adrenal insufficiency
□ Adrenal adenoma
□ Parathyroid disease/hypercalcemia
□ Osteoporosis
□ Pituitary adenoma

ALLERGIES: _____

CURRENT MEDICATIONS/VITAMINS: □ check here if you have a separate list

NAME	DOSE	FREQUENCY

SURGICAL HISTORY (please include the year)**:**

LAST COLONOSCOPY (45+): _____

SMOKING HISTORY

Do you or have you ever smoked tobacco? ☐ Current ☐ Past ☐ Never
If you are a current/past smoker, how many years have/did you smoke tobacco? _____years
If past smoker, when did you quit? _____months or _____years
Do you or have you ever used any other forms of tobacco or nicotine? □ Yes □No
Do you use any illicit or recreational drugs? □ Yes □No

ADVANCE DIRECTIVE/LIVING WILL

Do you have a living will/advance directive? □ Yes □ No If yes, please provide a copy to the office.

FAMILY HISTORY:

Family Member	Medical Conditions
Mother	
Father	
Brother(s)	
Sister(s)	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

CARE TEAM:

NAME	SPECIALTY	PHONE	ADDRESS

For diabetics ONLY, please list your ophthalmologist and last visit date:

_____

_____

MAIL ORDER PHARMACY: _____

LOCAL PHARMACY NAME: _____
ADDRESS: _____
PHONE NUMBER: _____

Assignment of Benefits

I hereby assign and authorize direct payment of all medical benefits, including major medical benefits to Prime Endocrinology for services provided to me. 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.
I understand that "Prime Endocrinology" will bill my insurance for the visit as a courtesy. I am financially responsible for all charges not covered by my insurance. Any copayments, deductibles, coinsurance amounts, or non-covered services are my responsibility. Verification of insurance benefits is not a guarantee of payment.

Release of Billing Information

I authorize Prime Endocrinology to release medical information necessary to bill and receive payment for services provided to me. This may include diagnosis, treatment, and service information required by my insurance company or other payers. This authorization applies only to billing and payment purposes. I understand that I may revoke this authorization in writing at any time.

HIPAA Privacy and Release of Information Authorization

I hereby authorize Prime Endocrinology and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.
I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.
I understand that I have a right to revoke this authorization by providing written notice. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.
I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

Patient or Legal Representative Name: _____

Patient or Legal Representative Signature: _____ Date: _____

Office Policies & Consents

Thank you for choosing Prime Endocrinology LLC for your endocrine care. Our office aims to provide you with excellent medical care and customer service. We would like to bring to your attention:

1. 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. 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 keep their appointment 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 directly to your pharmacy. Please do not wait until you are out of medication to request a refill and allow 1 business day for prescription refills.

6. Lab copies: In most cases, labs will be available to be viewed 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, there is a fee of $1 per page to a maximum of $100 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 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, 8:30 am till 4:30 pm and we are closed for lunch between 12:00 pm and 1:00 pm. If you call our office after 4:30 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.

10. I consent to my provider using a medical scribe human or machine, in person or remotely, to assist with documenting my visit. I understand the scribe's role is limited to documentation and my information remains protected under privacy laws.

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

12. I give permission for Prime Endocrinology to release information and/or discuss my medical condition including my protected health information with the person (s)/ entities listed per my request under emergency contacts.

13. I authorize Prime Endocrinology LLC to use Surescripts Inc, a prescription system that allows Prescriptions and related information to be exchanged between my providers and the pharmacy.

I acknowledge the above.

Patient Signature: _____

Authorization for Release of Medical Records

- Patient Full Name: _____
- Date of Birth: _____
- Address: _____
- Mobile Phone: _____

I authorize any physician, healthcare provider, hospital, clinic, laboratory, imaging center, pharmacy, behavioral health provider, or other healthcare facility that has provided care to me to release my protected health information to:

Receiving Practice: Prime Endocrinology LLC
Address: 103 Parker Rd, Suite B, West Long Branch, NJ 07764
Phone: 732-222-0307, Fax: 732-222-0394

Disclosure may occur via secure electronic transmission, fax, mail, health information exchange (HIE), or other standard healthcare communication methods. The purpose of this disclosure is continuity of care. This authorization applies to all past and future records created during the valid authorization period. I understand 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 and infectious diseases, AIDS and HIV information as applicable.

Information Authorized for Release

☐ Complete Medical Record
☐ Office Visit Notes
☐ Consultation Reports
☐ Laboratory / Pathology Results
☐ Imaging Reports
☐ Hospital Records
☐ Operative Reports
☐ Emergency Department Records
☐ Medication Lists
☐ Immunization Records

This authorization remains valid until revoked in writing by the patient or legal representative. Revocation must be submitted in writing to Prime Endocrinology LLC. Revocation does not apply to information already disclosed in reliance on this authorization. Information disclosed may be subject to redisclosure and may no longer be protected under federal or state privacy laws.

Patient / Legal Representative Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____/ _____/ _____



Prime Endocrinology

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). Pursuant to the Privacy Rules established by the Health Insurance Portability and Accountability Act of 1996, Prime Endocrinology, LLC is legally required to protect the privacy of your health information. This information, commonly referred to as "protected health information," or "PHI", includes information that can be used to identify you and that we have created or received about your past, present, or future health condition, the provision of healthcare to you, or the payment for this healthcare. We are required to provide you with this notice about our privacy practices. This Notice applies to all services that are provided to you at each of our facilities. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the previously obtained PHI. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in our reception area. You can also request a copy of this notice from our office as noted below at any time and can view a copy of this notice on our website at http://www.primeendocrinology.com.

USES AND DISCLOSURES TO YOUR PROTECTED HEALTH INFORMATION. We use and disclose health information for many different reasons. For some of these uses and disclosures we need your specific authorization. Below, we describe the different categories of uses and disclosures.

I. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclose your PHI without your authorization for the following reasons:

1. For treatment. We may disclose your PHI to hospitals, physicians, nurses, and other healthcare personnel in order to provide, coordinate or manage your healthcare or any related services, except where the PHI is related to HIV/AIDS, genetic testing, or federally-funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law.
2. To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. This means that we may disclose your PHI information to your health plan to obtain payment for the healthcare services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. We may also contact your health plan regarding future treatment or services you may be provided with in order to obtain approval or to find out whether your health plan will pay for the treatment or services.
3. For healthcare operations. We may disclose your PHI, as necessary, to operate this organization. This means we may use your PHI in order to evaluate the quality of healthcare services that you received or to evaluate the performance of the healthcare professionals who provided healthcare services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us. We may also use and disclose your PHI in order to provide you with reminders of appointments with our physicians, and/or to provide information about treatment alternatives or other healthcare services that may benefit you.
4. When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. We may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.
5. For public health activities. We may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
6. For health oversight activities. We may disclose PHI to assist the government, such as Medicare or Medicaid, or other health oversight agencies with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.
7. To coroners, funeral directors, and for organ donation. We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants. We may also provide PHI to coroners, medical examiners, and funeral directors in order for them to carry out their duties as permitted or required by law.

8. For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.
9. Law Suits and disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery requests or other process by others involved in the dispute. We will only disclose information with assurance that efforts were made to inform you about the request or to obtain an order protecting the information requested.
10. Disaster Relief. When permitted by law, we may coordinate our uses and disclosures of protected health information with other organizations authorized by law or charter to assist in disaster relief efforts. For example, a disclosure to the Red Cross or a similar organization.
11. To Employers. In accordance with applicable law, we may disclose your PHI to your employer to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work related illness or injury. You will be notified of these disclosures by your employer or the hospital as required by applicable law.
12. To avoid harm. In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
13. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.
14. For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.B. Uses and Disclosures Where You to Have the Opportunity to object.
15. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your healthcare, unless you object in whole or in part.

II. All Other Uses and Disclosures Require Your Prior Written Authorization. Other than as stated herein, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

- Authorization for Marketing Communications. We will obtain your written authorization prior to using or disclosing your PHI for marketing purposes. However, we are permitted to provide you with marketing materials in a face-to-face encounter, without obtaining a marketing authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining a marketing authorization. In addition, as long as we are not paid to do so, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.
- Sale of PHI. We will disclose your PHI in a manner that constitutes a sale only upon receiving your prior authorization. Sale of PHI does not include a disclosure of PHI for: public health purposes; research; treatment and payment purposes; sale, transfer, merger or consolidation of all or part of our business and for related due diligence activities; the individual; disclosures required by law; any other purpose permitted by and in accordance with HIPAA.
- Fundraising Activities. We may use certain information (name, address, telephone number, dates of service, age and gender) to contact you for the purpose of various fundraising activities. You have the right to opt out of receiving such fundraising communications.
- Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by person not involved in your care would be permitted.
- Business Associates. We may engage certain persons to perform certain of our functions on our behalf and we may disclose certain health information to these persons. For example, we may share certain PHI with our billing company or computer consultant in order to facilitate our healthcare operations or payment for services provided in connection with your care. We will require our business associates to enter into an agreement to keep your PHI confidential and to abide by certain terms and conditions.

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI. You have the following rights with respect to your PHI:

- The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. Notwithstanding the foregoing, you have the right to ask us to restrict the disclosure of your PHI to your health plan for a service we provide to you where you have directly paid us (out of pocket, in full) for that service, in which case we are required to honor your request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

- The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.
- The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI, but we know who does, we will provide you with information on how to obtain it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will inform you, in writing, our reasons for the denial and explain your right to have the denial reviewed.
- If you request a copy of your information, we will charge you $1 per page or other reasonable fees for the costs of copying, mailing or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
- Note also that you have the right to access your PHI in an electronic format (to the extent we maintain the information in such a format) and to direct us to send the e-record directly to a third party. We may charge for the labor costs to transfer the information; and charge for the costs of electronic media if you request that we provide you with such media.
- The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or healthcare operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 14, 2003.
- We will respond within 60 days of receiving your written request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one (1) list during any 12-month period without charge, but if you make more than one request in the same year, we will charge you $10 for each additional request.
- To the extent that we maintain your PHI in electronic format, we will account all disclosures including those made for treatment, payment and healthcare operations. Should you request such an accounting of your electronic PHI, the list will include the disclosures made in the last three years.
- The Right to Receive Notice of a Breach of Unsecured PHI. You have the right to receive notification of a "breach" of your unsecured PHI.
- The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing to our Privacy Officer (See Section VII below). We will respond within 60 days of receiving your request in writing. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have completed it, and inform others that need to know about the change to your PHI.
- The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.
- MEDICATION HISTORY SERVICE. We may work with Surescripts who delivers medication history information when you have an office visit with us. Surescripts accesses the information securely from pharmacies and patient medication claims history from payers and pharmacy benefit managers. Our physicians obtain this information for treatment purposes, as prescribers who can access critically important information on their patient's current and past medications are better informed about potential medication issues with their patients and can use this information to improve safety and quality. If you would like to opt out of this service and would not like your medication history provided to us, please send an email or contact our Privacy Officer as instructed in Section VII below.
- HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES. If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VII below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.
- PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES: If you have any questions about this notice or any complaints about our privacy practices, please contact Dr. Sudha Ganne at 732-222-0307. Written correspondence to the office should be sent to Prime Endocrinology, L.L.C.