CPG Endocrinology

Patient Information				
Patient name	DOB	Age	Gender – Circle one Male Female	Today's Date
Address	Home phone		Cell phone	
City/State/Zip	SS#		Marital Status - Circle one S M D W	
Emergency Contact	Relationship		Phone # (H) (C)	

Patient Employment Information		
Employer	Contact name	Work number
Address	City/State/Zip	

Guarantor Insurance Information			
Primary Insurance	Employer	Secondary Insurance	Employer
Policy #	Group #	Policy #	Group #
Insured Name		Insured Name	
Address		Address	
City/State/Zip		City/State/Zip	
Insured DOB	Insured SS#	Insured DOB	Insured SS#

Guarantor Employment Information		
Employer	Contact name	Work number
Address	City/State/Zip	

Additional Information	
Parent/Guardian Name	Day Phone

Referral Information
How did you hear about us?

Consent for Healthcare and Release of Medical Information

I voluntarily consent to treatment at this facility by its physicians and staff. No guarantees have been made to me about the results of treatments or examination by staff at this practice. I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations. I have read this form and had the opportunity to ask questions.

Financial Responsibility and Assignment of Insurance Benefits

I authorize **CPG Endocrinology** to bill my insurance company using the information I have provided to this office for payment to their **MEDICAL FACILITY**. I assign payment for the unpaid charges for certain physician services to **CPG Endocrinology**. I understand I am responsible for any health insurance deductible and co-insurance payments. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any medical or any other information about me to be released to the Social Security Administration or its intermediaries or carriers and any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Signature of Patient or Authorized Person: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. I am aware that the Notice may be changed at any time and that I may request a copy of the revised notice by contacting the Office Manager.

Signature of Patient or Authorized Person: _____ **Date:** _____

FOR STAFF USE ONLY

☐ Patient refused to sign
☐ Patient refused to sign after receiving the Notice. Explanation provided that signature only documents that the Notice was received.
☐ Unable to provide NPP due to an emergency situation and the patient was not able to sign
☐ Patient refused copy of NPP but understands a copy is available upon request.

Signature of: _____ **Date:** _____

Conway Physicians Group
Endocrinology

Endocrinology Initial Consultation

Name: _____ Date: _____

Referring / Primary Care Physician: _____

Pharmacy: _____ Location: _____

Retail: ☐ Yes ☐ No Mail Order: ☐ Yes ☐ No

What is the reason for your visit?

Do you have any of the following medical conditions?

CONDITION	YES	NO
Diabetes		
High Blood Pressure		
Heart Disease		
Heart Attack		
Heart Failure		
High Cholesterol		
Stroke		
Sleep Apnea		
Asthma		
Thyroid Problems		
Kidney Stones		
Fractures		
Hepatitis		
Liver Problems		
Kidney Problems		

List medications you are allergic to and how you react to the medication.

MEDICATION	ALLERGIC REACTION

TURN PAGE OVER ⟶

Family History

Who in your family currently has, or has had in the past, any of the following problems?
(Please check the relative; if not known or adopted, please do not answer)

CONDITION	Mother	Father	Grandparent	Brother	Sister	Son	Daughter	Other
Diabetes								
High Blood Pressure								
Heart Disease								
High Cholesterol								
Cancer (Pancreas, Thyroid, Breast, Colon, Lung, Prostate, Skin, Other)								
Thyroid Disease								
Osteoporosis								
Hip Fracture								
Kidney Stones								
Rheumatoid Arthritis								
Lupus								

Alcohol use: ☐ Never ☐ Occasionally ☐ Daily

Cigarettes: ☐ Never ☐ Yes _____packs per day; _____packs per week; how many years have you smoked _____ years; if you smoked in the past and quit, what year did you quit? _____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Drug Use: ☐ Never ☐ Current ☐ Past

Current or prior occupation: _____

Do you have children? ☐ Yes Number _____ Ages _____

Who lives at home with you?_____

List any PRESCRIPTION and OTC medications you currently take (or attach list):

Have you had any of the following surgeries? If yes, please indicate the year of the surgery.

SURGERY	YEAR
Appendix Removal	
Back Surgery	
Heart Bypass	
Heart Stent	
Cataract Surgery	
Gallbladder Removal	
Hip Surgery	
Tonsil Removal	
Knee Surgery	
Neck Surgery	
Thyroid	
Pancreas	
Pituitary	
Tubes Tied	
Hysterectomy	
Ovary removal	
Other _____	

Have you had any tests recently done by your referring doctor? ☐ Yes ☐ No

Have you had any recent blood tests done? ☐ Yes ☐ No

Females Only:

Did you have diabetes with pregnancy? ☐ Yes ☐ No

Menopause? ☐ Yes ☐ No If yes, what year? _____

Regular periods? ☐ Yes ☐ No Last menstrual cycle: _____

TURN PAGE OVER ⟶

DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE CIRCLE)

GENERAL
Appetite Loss (don't want to eat)
Appetite increase
Fatigue / no energy
Weight gain
Weight loss

SKIN
Rash
Dry Skin
Hair loss
Leg swelling
Excessive sweating

EYES/NOSE/THROAT
Blurred vision
Loss of vision
Dental problems
Dry mouth
Hoarseness

NECK
Neck mass (feel something in neck)
Neck pain
Neck swelling (feels bigger)

RESPIRATORY
Cough
Shortness of breath
Difficulty breathing at rest
Snoring
Sleep Apnea

HEART
Chest pain
Palpitations (skipping beats)
Difficulty breathing during activity

STOMACH
Stomach pain
Difficulty swallowing liquids or solids
Nausea
Vomiting
Constipation
Diarrhea

GENITOURINARY
Decreased erections
Decreased sex drive
Urinating more (day or night)
Urinary tract infections
Yeast infections
Problems with menstrual cycle

MUSCULOSKETAL
Joint pain
Joint swelling
Muscle aches
Muscle weakness

NEUROLOGICAL
Dizziness
Seizures
Tremors
Numbness
Tingling

PSYCHIATRIC
Anxiety
Depression
Trouble sleeping
Trouble concentrating
Mood swings
Irritable

ENDOCRINE
Excessive thirst
Low blood sugar
Sensitive to heat
Sensitive to cold

HEMATOLOGIC
Anemia (low blood)
Easy bruising
Swollen glands

New Patient Diabetes Questionnaire

1. At what age were you diagnosed with diabetes?
2. How many years have you had diabetes?
3. If on insulin, when did you first start taking it?
4. What is your main trouble with diabetes (circle all that apply)?

   High blood sugar Low blood sugar Remembering to take medication

5. Do you check your blood sugar?

   ☐ Yes How many times per day? _____ How many times per week? _____

   ☐ No

6. Circle the names of pills you are taking or have taken before diabetes.

   Glipizide (Glucotrol) Glyburide Glimepiride (Amaryl)

   Metformin / Glucophage Prandin / Starlix Actos / Actos+Met

   Avandia / Avandamet Januvia / Janumet Onglyza / Kombiglyze

   Other _____

7. Circle the insulin you are currently using or have used before.

   Humulin R Humulin N Humulin 70/30 Novolin R

   Novolin N Novolin 70/30 Humalog Mix 75/25

   Novolog Mix 70/30 Novolog Lantus Humalog

   Levemir Apidra Victoza Byetta

8. Have you ever seen a Certified Diabetes Educator/Nutritionist/Dietitian?

   ☐ Yes When were you last seen?_____ ☐ No

10. Do you follow a "diabetic diet"?

11. What beverages do you drink (circle all that apply)? How much? (ex. 2 cans of Coke per day)

    Water _____ Milk _____ Regular soda _____ Diet Soda _____

    Sweet Tea _____Unsweet Tea _____ Coffee _____ Other _____

12. Do you exercise? ☐ Yes # of hours daily _____ weekly_____ ☐ NO

CPG Endocrinology

Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____

CPG Endocrinology 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.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays ❑ Other _____
❑ Give information to employer ❑ Give information to school	❑ Appointment absentee information
❑ Spouse	❑ Family billing information ❑ Financial ❑ Medical as follows: _____
❑ Parent (provide name)_____	❑ Family Billing Information ❑ Financial ❑ Medical as follows: _____
❑ Other (provide name) _____ _____	❑ Financial ❑ Medical as follows _____
❑ Support Group (provide name)_____	❑ Demographic Information

Rights of the Patient

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 by sending a written notification to CPG Endocrinology.

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 as a result 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.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

_____

CONWAY PHYSICIANS GROUP

NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

This Notice describes how we may use and disclose your protected health information to provide treatment, obtain payment and conduct health care operations and for other purposes permitted or required by law. It also describes your rights concerning your protected health information. "Protected health information" is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to follow the practices described in this Notice. We may change the terms of this Notice at any time. The new Notice will be effective for all protected health information we maintain at that time including health information we created or received before we made the changes.

You may obtain a copy of our Notice of Privacy Practices at any time by calling our office or requesting one at your next appointment.

Uses and Disclosures of Health Information

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We may use and disclose your information to obtain payment for services we provided to you. For example we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided.

Healthcare Operations: We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment. We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Others Involved in Your Health Care: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree. If we determine it is in your best interest based on our professional judgement or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information.

We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care of your location, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involved in your health care.

Emergencies: In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

We must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule, Section 164.500 et.seq.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Additionally, we may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Military Activity and National Security: When the appropriate conditions apply, we may disclose, to military authorities, protected health information of individuals who are Armed Forces personnel. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: we may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Minors: We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Business Associates: We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. All of our business associates are obligated, under contract with us, to protect the privacy and security of your health information.

Data Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Your Rights

Your rights with respect to your protected health information and how you may exercise those rights are outlined below.

You have a right to obtain a copy and/or inspect your health information: Health information includes treatment records, billing records and any other records used by us to make decision about your treatment. You may obtain a form from our office to request access. A reasonable cost-based fee will be charged for expenses such as staff time, copies and postage. Contact us as indicated at the end of this Notice to obtain information about our fees or if you have any questions about your access.

Right to an Electronic Copy of Electronic Medical Records: If your Protected Health Information is maintained in an electronic format, you have the right to request than an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such format. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

You have a right to request a restriction on the use and disclosure of your protected health information: You may ask us not to use or disclose some part of your protected health information for the purposes of treatment, payment or operations. You may also request that we not disclose some part of your information to family and others who may be involved in your care or for notification purposes as otherwise described in this Notice. We are not required to agree to the restrictions but if we do, we are obligated to abide by the agreement except in cases of emergency. You may request a restriction by sending your request in writing to our Privacy Contact.

You have a right to request confidential communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your cell number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not request an explanation from you as to the basis for the request.

You may have the right to request an amendment to your protected health information. You may request that we amend protected health information about you. Your request must be in writing with an explanation as to why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures made by our Business Associates or us. It excludes disclosures for treatment, payment or healthcare operations as described in this Notice of Privacy Practices, to you, to family members or friends involved in your care, for notification purposes or as a result of an authorization signed by you. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 for up to the previous 6 years. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request an accounting more than once in a 12 month period, we will charge you a reasonable cost-based fee for responding to the additional request.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Out of Pocket Payments: If you paid out of pocket (or in other words, you have requested that we not bill your health plan) in full for a specific items or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

The Adult Consent Act & Disclosure of Health Information to Designated Individuals (S.117): "DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHEN?"

NO_____ **YES (WHEN)** _____

You may revoke or modify this specific authorization and the revocation or modification must be in writing.

This laws defines treatment as "the broad range of emergency, outpatient, intermediate, and inpatient services and care that may be extended to a patient to diagnose and treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin. Treatment includes, but is not limited to, psychiatric, psychological, substance abuse, and counseling services."

The provider who discloses this information in good faith in accordance with the designation, the provider will be immune from civil and clinical liability, and disciplinary sanctions. While we assume most hospitals already have forms which comply with this law, you are encouraged to review all of your information forms, and add this required language if needed. This law becomes effective January 1, 2014.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your Physician's office directly.

Changes to this Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our offices and on our website.

Questions and Complaints

If you have any questions, concerns or want more information about our privacy practices please contact us using the information below.
If you are concerned that we may have violated your privacy rights or you disagree with a decision we have made regarding your access to your health information or any other request you have made in the exercise of your rights, you may send your complaint to us using the information below. You may also submit a written complaint to the Secretary of Health and Human Services. Contact us for the address of the Department of Health and Human Services.
We support your right to the privacy of your health information and we will not retaliate against you in any way for filing a complaint.

Contact our administrative office:

Contact Office or Official Warren C. Ratley, MBA, FACMPE, President

Phone 843-234-5139 **Fax** 843-234-6822

Address 300 Singleton Ridge Road
P.O. Box 829
Conway, SC 29528-0829

This notice was published and becomes effective on September 1, 2015.