

Capital Health - Endocrinology Specialists

2 Capital Way, Suite 290 Pennington, NJ 08534

1445 Whitehorse Mercerville Road, Suite 108 Hamilton, New Jersey 08619

609-303-4300 609-303-4301 Fax

Welcome to Capital Health - Endocrinology Specialists.

We are pleased you have chosen our practice.

Please take a moment to review the following information regarding your upcoming appointment and our practice's policies.

Your appoir	ntment is scheduled for:
Date:	Time:
	at our
HOPEWELL office 2 Capital Way, Suite 290 Pennington, NJ 08534	HAMILTON office 1445 Whitehorse Mercerville Road, Suite 108 Hamilton, New Jersey 08619

<u>New Patients</u> Please complete the attached paperwork and bring it to your appointment. Remember to bring your insurance card(s), a photo ID, copay and insurance referral (if required) to each appointment. Please also bring all current medications to your visit.

General Office Policies

Appointments We set aside adequate time to spend with you to address your needs. Please respect others and arrive on time for appointments. If you are more than 10 minutes late, your appointment may need to be rescheduled. Because of our growing practice, it may be difficult to reschedule you immediately. If you cancel, we will do our best to accommodate you as soon as possible.

<u>Cancellations and No Shows</u> If you need to cancel, please provide 24 hours' notice. Missed appointments and appointments cancelled with less than 24 hours' notice will be subject to a cancellation fee.

<u>Referrals</u> It is your responsibility to obtain a referral from your primary care physician if your insurance carrier requires one. Failure to do so will result in cancellation of your appointment.

<u>Refills</u> <u>Please allow 72 hours for completion of all prescription refill requests</u>. Please inform the medical assistant, nurse, or doctor if you need refills at the time of your visit and we will gladly provide you with a new prescription at that time. Refills not requested during your visit should be submitted electronically by your pharmacy.

<u>Pregnancy</u> Please notify the staff when scheduling your appointment if you are pregnant.

<u>Cell phone</u> In consideration of others, please refrain from using cell phones while in the office.

<u>After hours</u> The on-call physician will be notified by the answering service for all emergencies. Please do not contact the on call physician for prescription refills. If you are on insulin, your pharmacy will provide you with enough until the next business day when we can refill your prescription.

Please bring results of recent blood work and/or radiology reports, all medications, referrals and blood glucose logs (if you have diabetes) to each appointment. For follow up visits, please make sure all blood work and imaging studies are done at least one week prior to your appointment.

We appreciate your cooperation.



MISSED APPOINTMENT POLICY

It is the goal of Capital Health – Endocrinology Specialists to provide quality, individualized care in a timely manner. Late cancellations and missed appointments prevent us from utilizing all available appointments to achieve that goal.

Following is our missed appointment policy for your review. Adherence to this policy will ensure that we maintain the greatest accessibility for all patients.

CANCELLATION OF AN APPOINTMENT

If it becomes necessary to cancel a scheduled appointment, <u>we require that you call at least 24 hours in</u> <u>advance</u>. Appointments within the practice are in high demand, and your early cancellation will give another patient the opportunity to access timely medical evaluation in our office.

HOW TO CANCEL YOUR APPOINTMENT

To cancel appointments, please call 609-303-4300 or send a portal message to our office. We will be happy to assist you with rescheduling at that time also.

MISSED APPOINTMENT FEES

LATE CANCELLATION: A late cancellation is when a patient fails to cancel their scheduled appointment with the required 24-hour advance notice. Failure to cancel with appropriate notice will be recorded in your appointment history as a missed appointment.

NO SHOW: A "no show" is when a patient misses an appointment without cancelling as detailed above. Failure to be present at the time of a scheduled appointment will be recorded in your appointment history as a no-show.

- First missed/no show appointment: No charge
- Second and subsequent missed/no show appointments: \$25 fee billed to your account
- Third missed/no show appointment

Patient Name

Patient Date of Birth

Possible discharge from the practice

SIGNATURE

DATE

(OFFICE COPY)



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(PATIENT COPY)

Date: _____

Patient Name:	DOB:	
LIVING WILL:		
Do you have a Living Will and Durable Power of Attorney?	YES	NO
If <u>YES</u> , please furnish us with a copy for your medical chart or allow us to	o make a copy to attach t	to your chart.
If <u>NO</u> , would you like more information regarding this subject?	YES	NO

WHEN IT IS NECESSARY TO CONTACT YOU REGARDING TESTS RESULTS, PRESCRIPTION REFILLS, APPOINTMENT SCHEDULING, ETC. PLEASE INDICATE WHERE WE CAN LEAVE A MESSAGE:

() DO NOT LEAVE MESSAGE	() HOME #
() CELL #	() OTHER #

I GIVE MY CONSENT FOR MY MEDICAL INFORMATION TO BE SHARED AND DISCUSSED WITH THE FOLLOWING PERSON(S):

NAME	RELATIONSHIP	CONTACT NUMBER(S)

PATIENT SIGNATURE

DATE

SIGNING THIS FORM VERIFIES ALL INFORMATION IS CORRECT AND/OR HAS BEEN UPDATED

Capital Health - Endocrinology Specialists: New Patient History Form

Name:	DOB:
Address:	
	Advance Directive: Y N
Primary Care Physician:	Phone:
PCP Address:	
Ophthalmologist:	Phone:
Cardiologist:	Phone:
Podiatrist:	Phone:

Past Medical History - Do you have any history of:

			Month/Year	Description
Diabetes Mellitus	Yes	No		
Thyroid Disease	Yes	No		
Osteoporosis	Yes	No		
Heart Disease	Yes	No		
Lung Disease	Yes	No		
Stroke	Yes	No		
Kidney Problems	Yes	No		
Eye Problems	Yes	No		
Cancer	Yes	No		
High Blood Pressure	Yes	No		
Circulation Problems	Yes	No		
Other	Yes	No		

Current Medications (strength and dose EX: drug name 5mg once a day) Include all over the counter medications

1		6	
2			
3			
4			
5		10	
Allergies:			
Family History:			
<u>Family Member</u>	Current Age		<u>Health Status / Medical Problems</u>
Mother			
Father			
Brother(s)			
Sister(s)			
Children			
Surgical History - List all surg	geries you have had and date	of surgery:	
1		3	
2.		4.	



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Medication History & Medication Benefits Consent

I give permission for Capital Health to obtain my current Medications and Medication History from the Surescripts Pharmacy Clearinghouse.

I understand that this information will be stored in my Electronic Health Record and may be used in the normal course of my treatment at Capital Health.

Patient Signature: _____ Date: _____

Capital Health - Endocrinology Specialists

Patient Name:				DOB:	
Social History (circle one)	Single	Married	Divorced	Widowed	
Alcohol Use:	Tobacco	Use:		Occupation:	

Please answer the following:

Have you had (in the past year) or are you currently having any of the following:

	YES	NO	COMMENTS		YES	NO	COMMENTS
Weight Loss				Back Pain			
Weight Gain				Fracture			
Thirst				Joint Pain			
Fatigue				Swelling of			
Dizziness				Joint			
Recent Chemotherapy				 Leg Pain at Rest 			
Recent				 Leg Pain Walking 			
Radiation Headaches				Frequent Falls			
Blurry Vision				Rashes			
Difficulty				Dry Skin			
Swallowing				Change in			
Breathing Problems				Hand or Feet Size			
Cough				Difficulty			
Asthma				Sleeping Depression			
Memory Change				Irregular			
Balance				Period			
Problem				Libido			
Numbness				Change Breast			
Frequent				Discharge			
Urination				Kidney Stones			
Blood in Urine				Erectile			
Heartburn				Dysfunction			
Vomiting				Chest Pain			
Constipation				Leg Swelling			



Authorization for Patient Access/Release of Health Information

Patient Name:					Medical I	Record #:	
Date of Birth:			Phon	e #:			
Home Address:				City:	S	tate:	Zip:
Type of Request: I hereby request the f	ollowin	g:					
Access to review my original medical	record		🗌 Re	lease/Disclosure of m	ny health info	ormation, as request	ed below
Request my medical records from and	other fa	cility	Name o	f Facility:			
Description of Information to be Rele	eased:	(Check ALL that apply)					
Abstract* (defined below)		Entire Medical Record		History and Physica	I 🗆	Operative reports	
Immunization Record		E/R Record		Progress Notes		X-ray Reports	
Outpatient Records		Consultation Reports		EKG/EEG		Discharge Summar	у
Treatment Record		Labs		Other (specify):			
Date(s) or Service:	to be i r psych	eleased may include refe	rence to a	alcohol abuse, drug a	buse, AIDS/	HIV infection, sexua	lly
□ Myself (the patient or authorized rep.	resenta	tive)	To Orgar	ization/Individual:			
Organization:		Phone#:			Fax#:		
Street Address:	City	St	tate:	Zip:	🗌 Please m	ail 🛛 Please Fax	
				[🗆 Please p	repare for pick up	
Purpose of Release: I authorize Capital He	ealth En	docrinology Specialists to	release m	ny health information	for the follo	wing specific purpos	e:
Term/Expiration: I understand that by law, I do not have to or written revocation to Capital Health Inform will automatically expire twelve (12) or my health care and the payment for information is disclosed, it is no longo without my permission. Fees:	nation I nonthe my hea	Management Department s from the date listed be alth care will not be affe	at One (elow. T ected if I	Capital Way Pennii understand that I n I do not sign this fo	ngton, NJ (nay refuse orm. I unde	08534. This authors to sign this form a berstand that once the second se	prization and that his
Capital Health may charge a reasonable fe	e for re	trieval of medical records a	and prepa	aration of photocopie	es for purpos	es other than patien	t care.

Signature of Patient or Patient's Representative

Date

Relationship to Patient

Witness Signature