Capital Health Endocrinology Specialists

2 Capital Way, Suite 290
Pennington, NJ 08534

100 K Johnson Boulevard N.
Bordentown, NJ 08505

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.

New Patients 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.

Cancellations and No Shows 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.

Referrals 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.**

Refills *Please allow 72 hours for completion of all prescription refill requests*. 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.

Pregnancy Please notify the staff when scheduling your appointment if you are pregnant.

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

After hours 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.

Date: _____

Patient Name: _____ **DOB:** _____

LIVING WILL:

Do you have a Living Will and Durable Power of Attorney? YES NO

If YES, please furnish us with a copy for your medical chart or allow us to make a copy to attach to your chart.

If NO, 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: _____ Phone: _____
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._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Allergies: _____

Family History:

Family Member	Current Age	Health Status / Medical Problems
Mother	_____	_____
Father	_____	_____
Brother(s)	_____	_____
Sister(s)	_____	_____
Children	_____	_____

Surgical History - List all surgeries you have had and date of surgery:

1._____ 3._____
2._____ 4._____

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
Weight Loss			
Weight Gain			
Thirst			
Fatigue			
Dizziness			
Recent Chemotherapy			
Recent Radiation			
Headaches			
Blurry Vision			
Difficulty Swallowing			
Breathing Problems			
Cough			
Asthma			
Memory Change			
Balance Problem			
Numbness			
Frequent Urination			
Blood in Urine			
Heartburn			
Vomiting			
Constipation			

	YES	NO	COMMENTS
Back Pain			
Fracture			
Joint Pain			
Swelling of Joint			
Leg Pain at Rest			
Leg Pain Walking			
Frequent Falls			
Rashes			
Dry Skin			
Change in Hand or Feet Size			
Difficulty Sleeping			
Depression			
Irregular Period			
Libido Change			
Breast Discharge			
Kidney Stones			
Erectile Dysfunction			
Chest Pain			
Leg Swelling			

Capital Health

General & Financial Consent: Inpatient, Outpatient, Emergency Department

Financial Agreement: I agree whether I sign as a representative of the patient or as the patient, that in consideration of the services to be rendered to me, I obligate myself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. I intend to be legally bound, assume full responsibility for, and agree to pay Capital Health upon presentation of the bill, all expenses, and charges for such services and care. Should the account be referred to an attorney for collection, I shall reimburse Capital Health reasonable attorney's fees and collection expense.

Medicare Authorization for Information and Payment Request Release: I agree the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers or to the Professional Review Organization any information needed in order to process payment for this visit or a related Medicare claim. I request that payment or authorized benefits be made on my behalf, if I am a member of a Medicare Risk Contracting Health Maintenance Organization.

Release of Information: I assign benefits payable for hospital and physicians' services to the physician or provider furnishing the service and authorize such physician or provider to submit a claim containing information related to my treatment, to Medicare, Medicaid or other Insurance Carrier for payment. I understand that if under Medicare Program Guidelines, as necessary, Capital Health is required by various governmental agencies to review and release patient information. Capital Health also cooperates with various agencies by providing statistics and medical information for research purposes. I understand and agree that Capital Health is authorized to review and release such information.

I understand that these records will contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Any specimens taken from my body during my treatment may be retained, preserved, used for teaching purposes, or disposed by Capital Health.

Consent to Release Medical Records: I authorize the release of my medical records and information for the purpose of coordinating care and discharge planning and for the purpose of my follow-up care, this includes the designated Caregiver, if elected. I understand that the information disclosed may include Specially Protected Health Information such as records of psychiatric treatment, counseling or testing, substance abuse counseling or treatment, and or HIV, AIDS diagnosis, treatment, or testing. I may revoke this authorization as it relates to Specially Protected Health Information by providing written notice to Capital Health, Health Information Management Department.

Consent for Blood Test: In the event a physician, hospital employee, worker, student, or other person is accidentally stuck with a needle or otherwise directly exposed to my blood or body fluids in connection with my treatment at Capital Health or during the discharge process, I consent to having my blood drawn and tested for Human Immunodeficiency Virus (HIV, the virus that causes Acquired Immune Deficiency Syndrome, AIDS), Hepatitis B virus, and Hepatitis C virus. Such testing will allow any necessary treatment of the physician, hospital employee, worker, student, or other person to begin without delay. I further understand that if such testing is required I will receive appropriate counseling. The results of the test will be released only to those involved with the medical treatment of the exposed physician, hospital employee, worker, student, or other person as required by law or as agreed to by me.

Information about Doctors at Capital Health: Some physicians and other health care providers who participate in your care, including but not limited to, for example, surgeons, radiologists, anesthesiologists, pathologists, pediatricians, and consultants are private practitioners and not employees or agents of Capital Health. Physicians who practice at Capital Health must meet certain educational and experience requirements; however, Capital Health is not responsible for specific care provided to you by that physician. If you wish to change your physician, ask to speak with a nurse manager.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Contact by Telephone, Cellular, and/or Electronic Communications: By signing this form you consent to the terms in this section. Capital Health conducts patient care quality reviews to ensure the continued highest quality of services. Patients may participate or be invited to participate in the surveys through the use of text messaging, phone call, automatic telephone dialing system, artificial, prerecorded voice messaging, or electronic mail. These communications may come from Capital Health or a third party vendor to the phone number or email address that the patients have provided. Patients are not required to provide a phone number or email address as a condition of receiving treatment and/or other healthcare service from Capital Health. Should you choose to opt out of receiving contact from Capital Health or its third party vendor, you understand that it is your responsibility to contact Capital Health Patient Experience Department at 1-609-394-6336 (RMC) or 1-609-303-4280 (Hopewell) with this information. Message and data rates may apply.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Treatment: I consent to be treated by/admitted to Capital Health under the care of my physician, and their associates, partners, assistants, and designees. I consent to any hospital care, which encompasses routine laboratory, diagnostic, or medical/surgical treatment advisable during treatment and or hospitalization. I agree to allow medical students, interns, and residents, under the supervision and direction of a physician to observe my treatment and review my medical record. I understand that no guarantees have been made to me about the outcome of this care. I acknowledge that Capital Health has the authority to dispose of specimens taken for laboratory and pathology examinations.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Interoperability – Admission, Discharge and Transfer Notifications

In accordance with the Interoperability and Patient Access final rule (CMS-9115-F) Capital Health is required to make Conditions of Participation (CoPs) for hospitals. CoPs require Capital Health sends electronic patient event notifications of patient's Admission, Discharge, and/or Transfer to another healthcare facility, or to another community provider or practitioner. Government regulations require Capital Health to notify your primary care physician, referring physician, or other community provider in the event that you are admitted, discharged, or transferred to another facility.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Acknowledgement of Privacy Notice: I acknowledge receipt of Capital Health Notice of Privacy Policy:

☐ **By checking this box, I confirm that I have received the Capital Health Notice of Privacy Practices. The act of checking this box shall have the same effect as signing my name.**

By signing below, I agree to be subject to all of the terms in this General and Financial Consent. I agree that any checked boxes shall have the effect of my written signature.

X _____ Relationship to Patient: _____ Date: _____Time: _____
(Signature of patient or patient representative)

Witness: _____ Date: _____ Time: _____

Patient Name: _____ DOB: _____ Date: _____

Living Will:

Do you have a Living Will and Durable Power of Attorney? **YES** **NO**

If **YES**, please furnish us with a copy for your medical chart or allow us to make a copy to attach to your chart. Thank you.

If **NO**, would you like more information regarding this subject? **YES** **NO**

I. When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., Please indicate where we can leave a message:

CIRCLE YES OR NO

HOME NUMBER ~ YES / NO _____

CELL NUMBER ~ YES / NO _____

II. I AUTHORIZE THE FOLLWING INDIVIDUALS TO RECEIVE INFORMATION PERTAINING TO MY MEDICAL CARE.

NAME	RELATIONSHIP	CONTACT NUMBERS

I agree _____ to the above. Date Signed: _____
(Patient Signature)

Signing this form verifies all information is correct and /or has been updated.

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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: _____

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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, we require that you call *at least* 24 hours in advance. 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 Possible discharge from the practice