Texas Associates of Endocrinology and Diabetes, P.A.

Welcome to our practice!

- For your first visit, we require all important medical records and new patient paperwork BEFORE we schedule. **Your visit might be rescheduled if we do not have the records for your visit.**

- **Please bring all your medications and supplements or a detailed list to all your appointments.**

- **Diabetes patients:** Please bring your glucometer and glucose logbook to all visits. Without these, changes cannot be made, and you may be rescheduled.

- **Late arrivals of 15 mins or more** will be rescheduled to the next available appointment.

- **Missed appointments**: If an established patient reschedules or no-shows for 3 visits, we will be unable to schedule any future appointments. If a new patient reschedules or no-shows for 2 visits, we will be unable to schedule any future appointments. There will be a $50 no-show fee for same-day cancellations or missed appointments. **Please notify us 24 hours in advance if you need to cancel or reschedule your appointment.**

- **HMO insurance plans**: If a patient has an HMO plan, it is the patient's responsibility to ensure that there is an active authorization on file with us or request one from their PCP.

- We ask that every patient has a primary care physician (PCP). **General health questions should be addressed by your PCP.**

- Returning patients need to have labs performed at least 7 days prior to your appointment.

- We recommend signing up for Patient Portal. Ask us how you can set it up!

- **Prescription refills can take 48-72 hours to process after receiving the request.** Please plan accordingly. If you are overdue for labs and follow up, a one-time ONE-month refill will be sent. Please make sure labs and follow up are completed prior to the completion of the one-month refill.

- Our providers are unable to call patients or respond to multiple messages. Discussions outside of quick questions which can be answered by staff will require a scheduled appointment either telemedicine or in person to address all concerns at once.

- After hours calls and weekends are only for emergencies. Scheduling/ refill or other issues will only be addressed during business hours.

- Please note our staff is working hard and covering multiple tasks at any given time. We have a busy clinic. Any task can take up to 3 business days to complete. If it's urgent, you may need to schedule a same day appt if available.

- Please note that rude behavior of any kind is not acceptable and is grounds for dismissal from the practice. We value our employees. We value our patients. We expect mutually respectful communication. NO EXCEPTIONS.

4521 Medical Center Drive, STE 400 • McKinney, TX 75069 | P: 214-547-7557 • F: 469-631-7217 • texasendopa@gmail.com
600 E. Taylor Street, STE 3011 • Sherman, TX 75090 | P: 903-357-4579 • F: 903-792-8579 • taedsherman@gmail.com
www.texendocrine.com

Texas Associates of Endocrinology and Diabetes, P.A.

New Patient Registration Form

Last name: _____ First name: _____ Middle Initial: _____ Sex: • M • F

DOB: _____ Married Status: • Single • Married • Divorced • Widowed • Separated

Referred to our clinic by: _____

Address: _____

_____

Best Contact#: _____ Employer: _____ Work#: _____

SSN#: _____ Pharmacy name and address: _____

Email for portal access: _____

Guarantor/Insurance information:

- Check if same as patient

Person responsible for bill: _____ DOB: _____

Address (if different): _____

Phone#: _____ SSN: _____ Employer: _____

Do you have insurance? • Yes • No

Primary insurance: _____ Policy#: _____ Group#: _____

Subscriber name: _____ DOB: _____ SSN: _____

Relationship to subscriber: _____

Secondary insurance: _____ Policy#: _____ Group#: _____

Subscriber name: _____ DOB: _____ SSN: _____

Relationship to subscriber: _____

In case of emergency:

Name of local friend or relative: _____ Phone#: _____
(not living at same address)

Relationship to patient: _____

Texas Associates of Endocrinology and Diabetes, P.A.

HEALTH HISTORY QUESTIONNAIRE

SOCIAL

Occupation: [Retired] [Active] _____

Do you: (Please circle No or Yes and explain if yes)

Get Exercise	[No]	Yes] __Hours per week	Type of exercise: _____
Use illegal drugs	[No]	Yes] _____	
Use alcohol	[No]	Yes] Ounces per day: _____	
Use Tobacco	[No]	Yes] __Packs per day for	____years ____currently smoking

PAST MEDICAL

What medications are you currently taking (including supplements and vitamins)? Please list dose and frequency.

Medication name	Dose	Frequency	Medication name	Dose	Frequency
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Have you had previous surgeries? Please list any below:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **6.** _____

Problems for which you have seen a physician or have been treated for: (use back of page if necessary)

Diabetes	[No]	Yes]	Type_____	Year_____Treatment _____
Cancer	[No]	Yes]	Type_____	Year_____Treatment _____
Nodule/Tumor	[No]	Yes]	Location_____	Year_____Treatment _____
Cholesterol	[No]	Yes]	Date_____	Treatment _____
Stroke	[No]	Yes]	Year_____	Treatment _____
Blood Pressure	[No]	Yes]	Year_____	Medications _____
Heart Problem	[No]	Yes]	Year_____	Treatment _____
Kidney Disease	[No]	Yes]	Diabetic?_____	Year_____Treatment _____
Foot Infections	[No]	Yes]	Diabetic?_____	Year_____Treatment _____
Thyroid Disease	[No]	Yes]	Type_____	Year_____Treatment _____
Others	[No]	Yes]	_____	

Do you have any allergies/reactions? {please list reaction} _____

FAMILY

Do any of your blood relatives have or have had any of these diseases or do any other problems run in the family:

	Mother	Father	Paternal Grandfather	Sibling	Paternal Grandmother	Maternal grandmother	Maternal grandfather	
Cancer								Location:_____
Osteoporosis								Location:_____
Heart Problem								
Kidney Disease								
Thyroid Problems								Type:_____
High Blood Pressure								
Stroke								
Diabetes								Type:_____

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PATIENT PREFERENCE FOR COMMUNICATION OF HEALTH INFORMATION

WHO TO CONTACT

I hereby give permission to Texas Associates of Endocrinology & Diabetes to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name		Relationship	
Name		Relationship	
Name		Relationship	
Name		Relationship	

⎦I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition(s).

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Texas Associates of Endocrinology and Diabetes, P.A.

Authorization for Release of Medical Records

Type or print:
I hereby authorize Texas Associates of Endocrinology and Diabetes (Dr. Muhammad Siddiqui) to release health records information on:

Name of Patient_____DOB_____

Address_____

Contact Phone #_____City/State/Zip_____

For Healthcare Covering the Period(s) from date_____to date _____

• May include other healthcare facility or healthcare providers' records? ☒Yes ☒ No

The purpose of this disclosure is for:

☐ **Continuance of Patient's medical care** ☒ **Attorney Review** ☒ **Insurance purposes**

☐ Other_____

Information to be disclosed may include:

☐ Copy of all health records to **include** HIV testing/results, mental health and/or alcohol or drug abuse records

☐ Copy of all health records to **exclude** HIV testing/results, mental health and/or alcohol or drug abuse records

☐ Specific records: **Progress Notes_____Laboratory Tests_____Radiology Reports _____ Other_____**

I understand that the information released as a result of this Authorization for Release of Protected Health Information (PHI) may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying of my medical records if it is to be used for other than continuance of healthcare with another provider.

I understand that this Authorization may be revoked in writing at any time. I understand that revocation will apply only to releases of information made after the date of my revocation.

Unless otherwise indicated, this authorization will expire twelve months (12) from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of this Authorization by Texas Associates of Endocrinology & Diabetes upon request.

I understand and agree that my medical record will be maintained in a paper or electronic medical record (EMR) format and that records may be transmitted electronically via fax, E-mail, Internet, or data transfer system.

I understand that Texas Associates of Endocrinology & Diabetes cannot require me to sign this Authorization as a condition to providing services to me. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact my physician or Texas Associates of Endocrinology & Diabetes' Privacy Officer.

TO:

(This section will be filled out in case your records need to be sent to another physician. Please only sign and date.)

Physician name: _____

Address: _____

Phone:_____Fax: _____

Signature of Patient_____ Date _____

_____

(Relationship or status if signed by anyone other than patient, parent or legal guardian, personal representative, etc.)

Texas Associates of Endocrinology and Diabetes, P.A.

Authorization to Request Medical Records

_____

Patient's Name and Date of Birth

_____

Patient's Signature and Date

_____

Information Requested

_____

Reason for Request

I request that mine or my child's complete records or specific information as listed above be released to:

Texas Associates of Endocrinology and Diabetes, P.A. (Select location below)

4521 Medical Center Drive, STE 400
McKinney, TX 75069
P: 214-547-7557
F: 469-631-7217

600 E. Taylor Street, STE 3011
Sherman, TX 75090
P: 903-357-4579
F: 903-792-8579

(This section will be filled out in case your records need to be requested from another physician and/or facility. Please do not fill out.)

_____

Physician or Practice Name

_____

Address

_____

Phone Number and Fax Number

By signing this form, I authorize you to request confidential health information about me or my child. I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to the facility receiving the revocation.

If the requestor or receiver is not a health care plan or healthcare provider, the released information may no longer be protected by federal privacy regulations or may be redisclosed.

I have read and authorize the disclosure of the protected health information as stated. I may receive a copy of this form after I have signed it.

I have read and understand the following consent notices provided by TAED:

1. Office policies
2. Medical care and treatment
3. Financial responsibility
4. Telemedicine services
5. Patient portal
6. Electronic Prescriptions and use of electronic connectivity between payers, physicians and pharmacists.

_____ _____

Name Date

(This consent is valid for 1 year (365 days) from the date signed. It can be revoked at any time with your written request.)

If you have a Personal Representative /Guardian who has been given authority to act on your behalf, please provide us with that name and contact information.

_____ _____

Personal Representative Date

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Texas Associates of Endocrinology & Diabetes originates records and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health information may be used or disclosed by Texas Associates of Endocrinology & Diabetes for treatment, payment, and health care operations. For example, my health information serves as:

- A basis for planning my care and treatment;
- A means of communication among other health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;

I acknowledge that I have been provided with Texas Associates of Endocrinology & Diabetes' Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Texas Associates of Endocrinology & Diabetes reserves the right to change its Notice of Privacy Practices at any time and that I will be provided a copy of the revised Notice of Privacy Practices.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that Texas Associates of Endocrinology & Diabetes is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

I understand that I may revoke this consent in writing, except to the extent that Texas Associates of Endocrinology & Diabetes has already acted in reliance thereon.

By signing this form, I consent to Texas Associates of Endocrinology & Diabetes' use and disclosure of my health information for treatment, payment, and health care operations.

□ I request the following restrictions to the use or disclosure of my health information:

_____

_____

⌋ Restrictions accepted □ Restrictions denied

Patient Name: _____

Signature of patient/guardian:_____

Date: _____