Southern Endocrinology Associates P.A
Patient Information

Today's Date: _____/_____/_____ Reason for Appointment: Diabetes Thyroid Other: _____

Primary Care Physician _____ Referred by: _____

Patient Name: _____ Gender: F M
(Last) (First) (MI)

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____/_____/_____ Marital Status: S M D W Social Security # _____-_____-_____

Home Number: (_____)-_____-_____ Cell Number: (_____)-_____-_____

Work Number: (_____)-_____-_____ EXT: _____

Driver License #: _____ Ethnicity: _____ Language: _____

Email: _____ Would you like to receive email notifications? Y N

Employer Name: _____ Employer Phone#: _____

Occupation: _____

Primary Insurance: _____ Insurance ID# _____

Secondary Insurance: _____ Insurance ID# _____

Name of Insured: _____ DOB: ____/____/_____ SSN: _____-_____-_____

Emergency Contact: _____ Phone #: (_____)-_____-_____ Relationship: _____

Pharmacy: _____ Street: _____

City: _____ State: _____ Phone #: (_____)-_____-_____

*****I authorize Southern Endocrinology & Associates to leave detailed information regarding labs or test results at the following phone number*****

Phone #:(_____)-_____-_____ Initials: _____

Assignment of benefits
I authorize payment of benefits to this provider for professional services rendered.

Signed: _____ Date___/___/___

Release of Information
I authorize the release of any medical information necessary to process this claim.

Signed: _____ Date: ___/___/___

Southern Endocrinology & Diabetes Associates PA

Statement of financial obligation

All payments are expected at the time of service.

This office is contracted with many different insurance plans, we will be happy to file your insurance claims, however, you will be expected to pay your co-payment, deductible, and/or co-insurance at each visit. We accept cash, check or master/ visa card.

Statement of benefits obligation

All patients are expected to provide our office with current insurance information and to understand their benefits.

For the convenience of our patients our provider participates in a variety of managed care plans. Our office also acts as an advocate for our patients with their managed care plans. This may include completing pre-certifications, eligibility verifications or similar paper work on behalf of the patient. Ultimately, the patient is responsible for understanding their benefits and providing our office with current information so that we can handle this paperwork on their behalf in a timely manner.

Referral from primary care physician

If you are required by your insurance to have a referral from the primary care physician to see us this must be done prior to the appointment. Otherwise you will be directly responsible for the service rendered.

Our mission as a practice is to provide for the health and wellbeing of our patients. Your health insurance is a contract between you and your health insurance company. You are financially responsible for any non-covered services.

I hereby authorize Southern Endocrinology Associates P.A Sumana Gangi, M.D and Sreedevi Guttikonda, M.D. to apply for benefits on my behalf for covered services rendered by her order. I request that payment by my insurance company be made directly to Dr. Gangi/ Southern Endocrinology Associates P.A. or by the party who accepts assignment. I certify that all information I have reported with regards to my insurance information is correct. I also authorize the use of this signature on all of my insurance submission.

_____ _____

Patient Signature / responsible party Date

Southern Endocrinology & Diabetes Associates PA

Consent for use and disclosure of health information

I hereby permit Southern Endocrinology Associates to release and furnish all medical and financial date related to my care that may be necessary now or in the future for purposes of treatment, payment or health care operations to assist with, and in, or facilitate the collection of data purposes of utilization to review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance company, **HMO's** and **PPO's**, managed care organizations, **IRA's, Medicare/Medicaid.** Or other governmental or third party payers, or organization contracting with any of the above entries to perform such functions.

The notice of privacy practices issued by Southern Endocrinology Associates provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of our access to **THE NOTICE OF PRIVACY PRACTICES** and understand that I have the right to review the notice prior to signing this consent. If this consent is revised in the future, I may obtain a revised copy from the office.

I have the right to request at the office to restrict uses and disclosure of my health information. However, this office is not required to agree to a requested restriction. I have the right to revoke this consent in writing to the extent this office has previously taken action in reliance on this consent. My treatment by this office is conditional upon signing this consent.

_____ _____

Patient Signature / Guardian Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Southern Endocrinology & Diabetes Associates PA

Our Practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all our patients.

In return, we ask that patients make every effort not to change reserved medical appointments and give us time to cancel or reschedule if necessary. A **$25.00 charge** will be applied for **no show** or **canceled** appointments **without a 24-hour advanced notification**.

Thank you for your cooperation in this matter

Sincerely,

Your medical staff.

Patient Signature: _____ Date: _____

Sumana Gangi, MD Gary Noworatzky, PA-C Kimberly Haire, FNP
Shalini Paturi, MD Sreedevi Guttikonda, MD Sindhu Igala, MD
Youssef Hassan, MD

Southern Endocrinology
Ensuring you a Healthy Life

Authorization for Release and or Disclosure of Patient Health & Medical Information

Patient: _____ DOB: _____

I hereby authorize: _____

_____

Address City State

_____ _____

Phone Fax

To Disclose to: Southern Endocrinology & Diabetes Associates PA

PH: 972-682-5700 Fax: 972-682-5703

My individually identifiable health information as described below, may include information concerning communicable diseases such as Humans Immunodeficiency Virus (HIV) and Acquired Immune Deficiency (AIDS) mental illness (except for psychotherapy notes) Chemical or Alcohol dependency, Laboratory test results, medical history, treatment, or any other such related information. I understand this authorization is voluntary and I may refuse to sign, I further understand that my health care and the payment of my care will not be affected if I do not sign this form. Additionally, I understand that is the recipient authorized to receive the information is not a covered entity, for example insurance company or nonhealthcare provider, that the released information nay no longer be protected by federal or state privacy regulations.

Description of information to be released:

Emergency Room	Radiology Report	Hospital Admission Records
History & Physical	Consultation Report	Laboratory Report
Radiology Films	Progress Notes	Billing Records

Other: _____

I understand that this shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature. I further understand that I may revoke this authorization at any time by notifying Southern Endocrinology in writing at one of the addresses noted below, I also understand that the written revocation must be sign ed and dated with a date that is later that this date of authorization. The revocation will not affect any actions taken before receipt of the written revocation.

_____ _____

Patient signature or Representatives Date

Name: _____

Current Medications with dose (please attach list if available)

_____ _____

_____ _____

_____ _____

_____ _____

Medical History/Hospitalizations: _____

_____

Surgeries:

_____

_____

Drug Allergies: _____

Social History:

MARITAL STATUS:	O MARRIED O SINGLE O WIDOWED O DIVORCED	
SMOKER:	O YES	O NO
ALCOHOL:	O YES	O NO
ILLICIT DRUG USE:	O YES	O NO

Family History:

MOTHER: O DIABETES O HYPERTENSION O HEART PROBLEM O CANCER O HIGH CHOLESTEROL

Living _____ Deceased _____

FATHER: O DIABETES O HYPERTENSION O HEART PROBLEM O CANCER O HIGH CHOLESTEROL

Living _____ Deceased _____

SIBLINGS: O DIABETES O HYPERTENSION O HEART PROBLEM O CANCER O HIGH CHOLESTEROL

Living _____ Deceased _____

OTHER: O DIABETES O HYPERTENSION O HEART PROBLEM O CANCER O HIGH CHOLESTEROL

Past / Current Medical History:

ASTHMA	O YES	O NO
DIABETES	O YES	O NO
HYPERCHOLESTROLEMIA	O YES	O NO
(Presence of high levels of cholesterol in the blood)		
COPD	O YES	O NO
(Chronic Obstructive Pulmonary Disease)		
ARTHRITIS	O YES	O NO
DEPRESSION	O YES	O NO
HEART FAILURE	O YES	O NO
HIGH BLOOD PRESSURE	O YES	O NO
STROKE (THOMBOTIC)	O YES	O NO
OBESITY	O YES	O NO
BACK PAIN	O YES	O NO
SLEEP APNEA	O YES	O NO
CANCER	O YES	O NO
GERD/reflux	O YES	O NO
(Chronic digestive disease)		
CAD	O YES	O NO
(Coronary Artery Disease)		
HEPATITIS C	O YES	O NO
CIRRHOSIS	O YES	O NO
CHRONIC STEROID USE	O YES	O NO
KIDNEY PROBLEMS	O YES	O NO

Please answer the following questions if you have or recently have had the following:

CONSTITITIONAL:

FEVER	O YES	O NO
CHILLS	O YES	O NO
THIRST	O YES	O NO
FATIGUE	O YES	O NO
WEIGHT GAIN	O YES	O NO
INSOMNIA	O YES	O NO
TIREDNESS	O YES	O NO

ENDOCRINOLOGY

EXCESSIVE URINATION	O YES	O NO
SENSITIVE TO COLD TEMPERATURE	O YES	O NO
SENSITIVE TO HOT TEMPERATURE	O YES	O NO
BREAST TENDERNESS	O YES	O NO
BREAST DISCHARGE	O YES	O NO
POOR LIBIDO	O YES	O NO
(Low sex drive)		

ENT

TINNITUS	O YES	O NO
(Ringing or buzzing in the ears)		
ALLERGIES	O YES	O NO
PERSISTENT HOARSNESS	O YES	O NO
DECREASED HEARING	O YES	O NO
NASAL DISCHARGE	O YES	O NO
EARACHE	O YES	O NO

EYE

CATARACT	O YES	O NO
(Clouding of the eye's natural lens)		
DECREASED VISION	O YES	O NO
CORRECTIVE LENS	O YES	O NO
DRY EYES	O YES	O NO
RETINOPATHY	O YES	O NO
(Diabetes complication that affects eyes)		
LASER TREATMENT	O YES	O NO
GLAUCOMA	O YES	O NO
(Condition that causes damage to your eye's optic nerve)		

Hematology

EASY BRUISING	O YES	O NO

CARDIAC

CHEST PAIN OR PRESSURE	O YES	O NO
PALPITATIONS	O YES	O NO
(Rapid, strong, or irregular heartbeat)		
LEG SWELLING	O YES	O NO
SHORTNESS OF BREATH	O YES	O NO
HIGH BLOOD PRESSURE	O YES	O NO
CLAUDICATION	O YES	O NO
(Pain and/or cramping in the lower leg)		

GASTROINTESTINAL

NAUSEA	O YES	O NO
HEARTBURN	O YES	O NO
ABDOMINAL PAIN	O YES	O NO
VOMITING	O YES	O NO
DIARRHEA	O YES	O NO
CONSTIPATION	O YES	O NO

NEUROLOGIC

FREQUENT HEADACHE	O YES	O NO
TINGLING	O YES	O NO
TREMORS	O YES	O NO
(Involuntary quivering movement)		
NUMBNESS	O YES	O NO
MIGRAINES	O YES	O NO
BURNING PAIN IN FEET	O YES	O NO
LANCINATING PAINS IN FEET	O YES	O NO
(Feels like electric shocks)		
VERTIGO	O YES	O NO
(Feels as if you or the objects around you are moving when they are not)		
SCIATICA	O YES	O NO
(Pain affecting the back, hip, and outer side of the leg)		

DERMATOLOGY

EXCESSIVE DRY SKIN	O YES	O NO
HAIR LOSS	O YES	O NO
ACNE	O YES	O NO
PLANTAR WART	O YES	O NO
(Warts are hard, grainy, or fleshy growths that can be painful)		
DRY SKIN	O YES	O NO
ITCHING	O YES	O NO
SKIN ULCER	O YES	O NO
(Sore on the skin)		
VITILIGO	O YES	O NO
(Loss of skin color in blotches)		
SKIN LESIONS	O YES	O NO

GYNECOLOGICAL

AMMENORHEA	O YES	O NO
(Abnormal absence of menstruation)		

URINARY

DYSURIA	O YES	O NO
(Painful or difficult urination)		
NOCTURIA FREQUENCY	O YES	O NO
PENILE DISCHARGE	O YES	O NO
DIFFICULTY URINATING	O YES	O NO

ALLERGY

DRUG ALLERGIES (listed elsewhere)	O YES	O NO
SINUS CONGESTION	O YES	O NO
EAR FULLNESS	O YES	O NO
(Feeling that your ears are clogged, stuffed or congested)		

PHYCHIATRIC

DEPRESSION	O YES	O NO
HIGH STRESS LEVELS	O YES	O NO
SLEEP DISTURBANCES	O YES	O NO
EATING DISORDER	O YES	O NO
SUICIDAL IDEATION	O YES	O NO