

ENDOCRINOLOGY CONSULTANTS, P.C.

ADULT & PEDIATRIC WELLNESS CENTER

www.endocrinewellness.com

229 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

221 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

199 Engle Street Englewood, NJ 07631
201.567.8008 • Fax: 201.567.3003

Endocrinology Consultants is pleased to take part in your medical care. Listed below are some phone numbers and information.

Appointment Date: _____ **Time:** _____

PLEASE BE HERE 15 MINUTES BEFORE YOUR APPOINTMENT TIME

Directions to the office:

From GEORGE WASHINGTON BRIDGE and NJ-4 WEST:

Merge on to **NJ-4 WEST** toward **PARAMUS**. Take **GRAND AVENUE** ramp toward **ENGLEWOOD**. Continue on **GRAND AVENUE / CR-501** for 1.4 miles. **GRAND AVENUE** becomes **ENGLE STREET**. End at **199 ENGLE STREET/229 ENGLE STREET** (199 ENGLE ST: Office building is located on the right side of the street. Small parking lot is located in back of the building. 229 ENGLE ST: Office building is located on the right side of the street. For parking turn right on Hamilton Ave).

From PATERSON area and NJ-4:

Merge onto **NJ-4EAST**. Take the ramp toward **GRAND AVENUE/ENGLEWOOD** (second Englewood exit). Turn **RIGHT** onto **ROCKWOOD PLACE** for 1 mile. Turn **RIGHT** onto **GRAND AVENUE / CR-501**. Continue to stay on **GRAND AVENUE** for 1.6 miles. **GRAND AVENUE** becomes **ENGLE STREET**. End at **199 ENGLE STREET/229 ENGLE STREET** (199 ENGLE ST: Office building is located on the right side of the street. Small parking lot is located in the back of the building. 229 ENGLE ST: Office building is located on the right side of the street. For parking turn right on Hamilton Ave).

Test Results:

New patients please bring any blood work or scans that have been done in the last 6 months for your initial visit. The test results will be reviewed with you at your visit. If you have missed your appointment, please be sure to reschedule.

Prescription Refills:

Call your pharmacy first. If you need a written prescription, contact our office at 201-567-8999.

Billing Questions:

For billing questions about your doctor's bills, please call the billing department at 1-201-567-8008. Please make sure if you require a referral it is valid for the day of your visit.

Patient's Personal Information Sex: [] Male [] Female

Home Address: _____ (Last Name) _____ (First Name) _____ (Middle Initial) Apt #: _____
City: _____ State : _____ Zip Code: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
Email Address: _____ Date of Birth: ____/____/____
Social Security#: _____ - _____ - _____

Employer Information

Occupation: _____
Employer Name: _____
Address: _____ Suite/Unit #: _____
City: _____ State: _____ Zip Code: _____
Work Phone: (____) _____ - _____

Patient's / Responsible Party Information Relationship to Patient: [] Self [] Parent [] Other: _____ Name: _____

Date of Birth: ____/____/____ (Last Name) _____ (First Name) _____ (Middle Initial) Social Security#: _____ - _____ - _____
Home Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone (____) _____ - _____

Patient's Insurance Information * Please present insurance cards to receptionist. *

Relationship to insured: [] Self [] Spouse [] Child [] Other: _____

PRIMARY Insurance Name: _____

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

Name of insured: _____ Date of Birth: ____/____/____

Policy #: _____ Group #: _____ Co-pay : \$ _____

Relationship to insured : [] Self [] Spouse [] Child [] Other: _____

SECONDARY Insurance Name: _____

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

Name of insured: _____ Date of Birth: ____/____/____

Policy #: _____ Group #: _____ Co-pay : \$ _____

Patient's Referral Information

Referred by: _____ Phone: (____) _____ - _____

Patient's Primary Medical Doctor

Name: _____ Phone: (____) _____ - _____

Patient's Other Medical Doctors

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Pharmacy Information

Name: _____

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

Phone: (____) _____ - _____ Fax: (____) _____ - _____

Emergency Contacts

Name: _____ Relationship _____

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

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone (____) _____ - _____

Name: _____ Relationship _____

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

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone (____) _____ - _____

Patient Name (print): _____ Signature of Patient (or Parent/Guardian): _____

Name of Parent/Guardian (if applicable): _____ Relationship to Patient: _____ Date: _____

ENDOCRINOLOGY CONSULTANTS, P.C.

ADULT & PEDIATRIC WELLNESS CENTER

www.endocrinewellness.com

229 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

221 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

199 Engle Street Englewood, NJ 07631
201.567.8008 • Fax: 201.567.3003

Assignment of Benefits – Appointment as Authorized Representative

I hereby acknowledge and confirm that, by signing this Assignment of Benefits (“AOB”), I have requested medical treatment, diagnostics and/or other medical or healthcare services (the “Medical Services”) from Endocrinology Consultants P.C. (“the Practice”) on behalf of myself and/or my dependents. I hereby assign all applicable health insurance benefits and payment (each such payment or benefit, a “Benefit”) and all rights and obligations that I and any of my dependents are entitled to (or have actually received), whether it be from a private insurance payor, government source (including, without limitation, Medicaid and/or Medicare) or any other third-party payor (any of the above payment and benefit sources, an “Insurance Payor”), in connection with the Medical Services to the Practice. This authorization fully applies to any and all fees regardless of whether the Practice is in-network or out-of-network with the Insurance Payor providing such Benefit. I hereby appoint the Practice as my authorized representative (my “Authorized Representative”) with the power to:

- ✓ File and process medical claims with the Insurance Payor.
- ✓ File appeals and grievances with the Insurance Payor.
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party, including the Insurance Payor.
- ✓ Institute and pursue on my behalf any claim, right or cause of action, including any necessary litigation and/or complaints against the Insurance Payor (even to name me as a plaintiff in such action).
- ✓ Act with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the Medical Services I received from the Practice and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from the Practice are paid in full. I also understand that I am financially responsible for any and all fees and payments associated with any and all Medical services rendered to myself and/or to my dependents (the “Fees”), including without limitation, any co-pays, coinsurance and deductibles. I understand that no guarantees have been made by the Practice or any other party in respect of any Medical Services or whether the Fees associated with such Medical Services will be paid for by any Insurance Payor and that I have the right to receive care elsewhere. I understand that I am fully responsible for any Fees due to the Practice in connection with the Medical Services that have not been actually received by the Practice for any reason, including without limitation, due to a nonpayment or claim denial by any Insurance Payor. I agree to assist the practice in its efforts to obtain payment for any Medical Services from any Insurance Payor. However, I fully understand that it is ultimately my responsibility to pay any and all Fees and to obtain any and all required authorizations, referrals and/or precertification(s) for any and all Medical Services. If my insurance plan has a pre-existing conditions clause, or requires an authorization or referral and I do not obtain one for the Medical Services I receive, I understand that I am responsible for all Fees, even if the provisions of my plan stipulate I otherwise wouldn't be. I understand that this AOB incorporates and supersedes any prior and contemporaneous understandings or agreements between the parties with respect to the subject matter of this AOB.

Authorization

I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above and certify that the information that I have provided is correct. This Assignment of Benefits shall remain in full force and effect until there are no Fees owed to the Practice in connection with the Medical Services. **I authorize the Practice to obtain the following governing plan documents for the purposes of applicability of compliance with PPACA: (1) Summary Plan Description (SPD); (2) 5500 Form (Plan Annual report); (3) Certified Copy of Certificate for PPACA Grandfathered Plan.**

Patient Name (print): _____ Signature of Patient (or Parent/Guardian): _____

Name of Parent/Guardian (if applicable): _____ Relationship to Patient: _____ Date: _____


ENDOCRINOLOGY CONSULTANTS, P.C.
ADULT & PEDIATRIC WELLNESS CENTER

www.endocrinewellness.com

229 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

221 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

199 Engle Street Englewood, NJ 07631
201.567.8008 • Fax: 201.567.3003

**ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

Endocrinology Consultants, P.C. (the “**Practice**”), and its staff and providers, may use and disclose my Protected health Information (“**PHI**”) to carry out treatment, payment and healthcare operations (“**TPO**”). I understand and acknowledge that the Practice’s Notice of Privacy Practices (the “**Notice**”) has a more complete description of such uses and disclosures.

I permit the Practice to leave e-mail, telephone and text messages regarding my appointments, prescription renewals, lab results, and all other PHI on voicemail systems, or to provide such information to the person(s) who answer the phone, using the contact information provided.

- I agree that my PHI may be shared with my spouse (if applicable)
- I agree that my PHI may be shared with the following other people:

_____ Relationship to Patient: _____

- I understand that I can change or revoke any of the foregoing agreements, at any time, by giving written notice to the Practice to the attention of the Privacy Officer. I understand and acknowledge that the Practice may decline to provide me with any services should I decline to sign this agreement, or should I later revoke this agreement.
- I agree that my PHI may be shared with my credit card vendor(s) if I contest any credit card charges, so that the practice can submit records to support its charges.
- I agree that the Practice may contact me at any phone numbers or email addresses provided by me regarding both PHI and non-PHI.

My signature below acknowledges that I agree with the above statements and have received the Practice’s Notice and/or have been provided with an opportunity to review it.

Signature of Patient

Date

Print Name

SPOUSE/HEALTH CARE POA/LEGAL GUARDIAN
(Please circle one if signing on behalf of the patient)

ENDOCRINOLOGY CONSULTANTS, P.C.

ADULT & PEDIATRIC WELLNESS CENTER

www.endocrinewellness.com

229 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

221 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

199 Engle Street Englewood, NJ 07631
201.567.8008 • Fax: 201.567.3003

FINANCIAL POLICIES

Registration: Upon scheduling and registration with Endocrinology Consultants, P.C. (the "Practice"), we require you to provide your medical insurance card (if you are utilizing its coverage, it must be brought to every visit), all third-party payor coverage information, photo identification, address, date of birth and phone number. If you receive health benefits through a spouse, partner or parent, we require you to also provide that person's full address, date of birth, and phone number. For collection purposes, we also require social security numbers. Should you be unable to produce this documentation, you may pay in full at the time of service and submit the claim to your insurance plan for reimbursement. Please notify us of changes to your insurance coverage or contact information, otherwise you may be responsible for charges we were unable to recover.

Medicare: If you have coverage with Medicare (including both original Medicare and commercial Medicare Advantage plans), it is your responsibility to understand the provisions of your health insurance plan and coverage. Every original Medicare beneficiary is responsible for an annual deductible and coinsurance. Medicare Advantage beneficiaries may be responsible for an annual deductible, coinsurance and/or a copayment. Any portion of copayment, coinsurance and deductible which is not covered by a supplemental carrier will be your financial responsibility to pay. You are wholly responsible for your coverage limitation, regardless of whether you are aware of the details. If you have both Medicare coverage and also commercial insurance, you are responsible for providing the correct primary insurance at your visit. If you have supplemental insurance that does not cross over automatically, you will be billed for the deductible and coinsurance, and you may be given a receipt to submit yourself. By signing below, you specifically agree to these terms, and exempt yourself from any protections your insurance plan may offer you regarding these provisions.

Commercial Health Insurance Plans: Although we will advise you whether we believe we participate with your insurance plan, we are not responsible for any verbal assurances made to you regarding whether particular services rendered in this Practice are covered by your plan. You and you alone are responsible to understand the provisions of your insurance plan and coverage. We recommend contacting your plan prior to receiving services in order to verify your financial responsibilities. If your insurance plan, including Medicare, issues payment to you instead of to us, you are responsible to turn the entire payment over to us immediately upon receipt together with the complete explanation of benefits form. You may be responsible for an additional balance, depending on how your insurance plan adjudicates such a claim.

Referrals: You are responsible to obtain all necessary referrals prior to your appointment, if required by your health plan and assure it is presented at the time of your visit. If your plan requires a referral, precertification or authorization that you do not obtain, your appointment may have to be rescheduled. Otherwise, if as a result your health plan refuses to pay for any claim, you explicitly agree to be responsible for our charges for any affected visits, even if the provisions of your plan stipulate you otherwise wouldn't be (you are waiving that defense). Further, it is also your responsibility to keep track of the number of visits you have used on your referral and the expiration date of your referrals and obtain new ones as needed. We will do our best to ensure you have one if you need one, but the ultimate responsibility is yours.

Cancellation/No Show Policy: If a new patient consultation has to be cancelled or rescheduled, please call the Practice forty-eight hours in advance or there will be a \$75 charge. If you miss two appointments there will be a \$25 charge.

Copayments, Coinsurance and Deductible: If your plan has a copayment, co-insurance or deductible, it is your responsibility to pay it at the time of service, even if the amount is not printed on your insurance card. Please have your payment ready upon check-in. We are out-of network healthcare providers with some health plans, meaning we have no contract with some health plans to participate in their network of participating providers and in many instances, they do not pay our charges for medical services in full. As a result, we have an obligation to bill our out-of-network patients their ordinary co-insurance, deductibles and cost share amounts as per your insurance agreement. If you fail to pay your coinsurance, deductibles or cost share amounts upon receipt of our invoice, you may be subject to collection activity and may be further responsible for the interest on the balance owed the Practice. However, we recognize that not all of our patients will be able to afford their patient cost share amounts. As a result, we have created a financial hardship policy which legally permits us to reduce, and in some cases, waive your patient cost share responsibility, if you qualify for the waiver. If you believe you might qualify, you may ask our staff for a copy of our financial hardship policy. Accordingly, you agree by signing this document to be responsible for your patient cost share amount, unless you qualify for financial assistance under the Practice's financial hardship policy.

Non-Payment: Any fees that are due and payable for over thirty (30) days may accrue interest at the monthly rate of thirty percent (30%). I understand that if a balance is unpaid, my account may be referred to an external collection action.

I have read, fully understand and agree with all the above policies. I fully understand and accept my financial responsibility for the charges I, or my dependents, may incur at this office.

Patient Name (print): _____ Signature of Patient (or Parent/Guardian): _____

Name of Parent/Guardian (if applicable): _____ Relationship to Patient: _____ Date: _____


ENDOCRINOLOGY CONSULTANTS, P.C.
ADULT & PEDIATRIC WELLNESS CENTER

www.endocrinewellness.com

229 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

221 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

199 Engle Street Englewood, NJ 07631
201.567.8008 • Fax: 201.567.3003

**PATIENT RESPONSIBILITY
FOR FOLLOW-UP CARE PLEDGE**

I, _____ (print last name), _____ (print first name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Signature _____ Date _____

ENDOCRINOLOGY  CONSULTANTS, P.C.
ADULT & PEDIATRIC WELLNESS CENTER

www.endocrinewellness.com

229 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

221 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385

199 Engle Street Englewood, NJ 07631
201.567.8008 • Fax: 201.567.3003

NOTE: This form is being provided as a courtesy “model” form and should not be considered legal advice. No warranty of use of this form is being provided by Endocrinology Consultants, PC or any of its representatives. Use of this form is solely the responsibility of the physician practice and physician(s) agree to hold harmless Endocrinology Consultants, PC from any use and reliance of this form.

FAMILY HEALTH HISTORY:

(Such as heart disease, high blood pressure, stroke, cancer, diabetes, thyroid disease, mental illness)

Relationship to you	AGE IF STILL LIVING	IF NOT ALIVE, AGE PERSON DIED	DISEASES PERSON HAS OR HAD AND CAUSE OF DEATH IF DECEASED
Mother			
Father			
Brother			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			
Sister			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Maternal Aunt			
Maternal Uncle			
Paternal Aunt			
Paternal Uncle			
Cousins			

Birth history:

Where was your child born? _____

Full term _____ Preterm _____ # of weeks _____

Normal vaginal delivery _____ C-section _____

Birth weight _____ Birth Length _____

Any concerns during pregnancy (like diabetes, hypothyroidism, hypertension etc)? _____

Was the mother taking any medication during the pregnancy? _____

Any complications during or after birth? _____

Was your child in the NICU after birth? If yes, for how long? _____

Menstrual history (in females):

Age at first period: _____

Are the periods _____ regular or _____ irregular

If irregular; explain how _____

Social history:

Lives with _____

Parents are _____ married; _____ divorced; _____ separated; _____ adopted/parental history unknown

Mother's age and height: _____

Father's age and height: _____

Mother's occupation _____

Father's occupation _____

of siblings _____; their gender and age _____

School information:

Grade level _____

Any learning disability: _____

Does your child receive/ received any therapies: PT __; OT __; Speech therapy _____

Puberty:

Does your child have early puberty (before the age of 8 in girls and before the age of 9 in boys)? _____

If yes,

at what age did you notice axillary odor? _____

at what age did you notice axillary hair? _____

at what age did you notice Pubic hair ? _____

at what age did you notice breast development (in girl) and testicular/penile growth (in boys)? _____

at what age did the mother get her period? _____

at what age did the father start shaving? _____

Has your child had an X-ray of the left wrist (Bone age) or any other evaluation? _____. If yes, please bring a CD of the X-ray and any other medical records to the visit.

Is your child being referred for poor growth; obesity, prediabetes or diabetes? _____

If yes, Please provide us with information about your child’s eating habits by bringing a 3 day record of what your child eats and drinks including snacks and nighttime bottles.

For patients with Diabetes:

Type of diabetes ____ Type 1; ____ Type 2

What medications are you currently taking? _____

If on insulin, are you using injections or a pump? _____

If using a Pump, what type of pump are you using? _____

Are you using a continuous glucose monitoring (CGM) device? _____

If yes, which one? _____

Last HbA1c: _____ Date: _____

PAST Medical History

Genetics	
Psychological	
Cardiology	
Allergy	
Other	

REVIEW OF THE SYSTEMS:

EYES, EARS, NOSE, THROAT (CHECK THOSE YOU HAVE)

- Loss of hearing ____
- Earache or drainage ____
- Loss of balance or vertigo ____
- Lightheadedness ____
- Hoarseness ____
- Loss of sense of smell ____
- Sinus trouble ____
- Constant or frequent nasal stuffiness ____
- Loss of ability to taste food ____
- Repeated nose bleeding ____
- Chronic dryness of the mouth ____
- Wear glasses or contacts ____
- Blurred vision and glasses don't help ____
- Double vision ____
- Glaucoma ____
- Sense of something in the eyes all the time ____
- Year last saw dentist: _____ Name of dentist: Dr. _____
- Year last saw eye doctor: _____ Name of eye doctor: Dr. _____

LUNGS and HEART (CHECK THOSE YOU HAVE)

- Short of breath even with little effort ____
- Heart murmur ____
- Wake up at night very short of breath ____
- Exposed to tuberculosis ____ Year _____ Treatment given? _____
- Positive skin test for tuberculosis ____
- Pain, discomfort, or tightness in chest ____
- High blood pressure ____
- Persistent cough ____
- Cough up blood ____
- Cough up phlegm or sputum ____
- Asthma ____
- Palpitations or racing of the pulse ____
- Drenching night sweats ____
- Severe pain in the calves while walking or running ____

STOMACH, INTESTINES & LIVER (CHECK THOSE YOU HAVE)

- Frequent nausea ____
- Have frequent or unexplained vomiting ____
- Vomit blood ____
- Stomach or abdominal pain ____
- Bloody bowel movements ____
- Loose bowels most of the time ____
- Constipation most of the time ____
- Rectal pain or bleeding ____

KIDNEYS & BLADDER (CHECK THOSE YOU HAVE)

Get up at night just to urinate ____ How many times a night? ____

Unable to control bladder and have accidents ____

Weaker and slower urine stream ____

Blood in urine ____

Urinary, kidney or bladder infections ____

Burning or pain during urination ____

Constant feeling of a need to urinate ____

MUSCLES, JOINTS & SKELETON (CHECK THOSE YOU HAVE)

Had fractures of bones ____

Severe or unusual muscle cramps ____

Stiff joints ____

Painful muscles ____

Swollen joints ____

Pain or stiffness in spine ____

NERVOUS AND PSYCHIATRIC (CHECK THOSE YOU HAVE)

Psychiatric treatment ____ Treated by _____

Unusual weakness of muscles ____

Sick headaches ____

Numbness of part of body ____ Which part? _____

Pass out, fainting or loss of consciousness ____

Seizures or convulsions ____

Unusual shaking or trembling ____

Depressed ____

Easily annoyed or irritable ____

ENDOCRINE (CHECK THOSE YOU HAVE)

Big problem with heat or hot weather ____

Big problem with cold or cold weather ____

Excessive perspiration ____

Trouble swallowing ____

Goiter or enlarged thyroid gland ____

Nodule on thyroid gland ____

Tender thyroid or pain in the front of your neck ____

Excessive appetite ____

Poor appetite ____

Exhaustion or fatigue most of the time ____

Breast discharge ____

Change in voice ____

Excessive body or facial hair ____

Problem with acne ____