# HIGHPOINT
## ENDOCRINOLOGY ASSOCIATES
HIGHPOINT HEALTH PARTNERS

Megan McCauley, MD, FACE

Phone: (615) 328-3380 Fax: (615) 328-3381

Welcome to HighPoint Endocrinology Associates!

Appointment Date and Time: _____

Arrival Time: _____

Please bring the following with you to your visit to ensure optimal care:

- All medications or a current updated medication list including any vitamins, herbs, or supplements
- All insurance cards, including pharmacy/drug insurance cards
- Driver's license
- Co-payment
- Blood sugar log or blood sugar meter if you are being seen for diabetes
- Completed new patient paperwork

Office Location:

Sumner Station

225 Big Station Camp Blvd.

Suite 205

Gallatin, TN 37066

Located just off of Big Station Camp Blvd, exit 12 on Vietnam Veterans Blvd (Highway 386)

Today's Date ____/____/____

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

| Patient Name Last | First | Middle | ◻ Mr ◻ Mrs ◻ Miss ◻ Ms | Marital Status (circle) Single/ Married / Divorced /Sep/ Widow |
|---|---|---|---|---|
| Is this your legal name? ◻ YES ◻ NO | If not, what is your legal name? | | Birthdate / / | Age Sex ◻ M ◻ F ◻ T |
| Street or Mailing Address (circle one) | City | State | Zip Code | Home Phone Number ( ) |
| Cell Phone Number ( ) | E-Mail Address (To be used for appointment reminders) | | | Social Security - - |
| Occupation | Employer | | Employer Phone Number | |

**Employment Status:** ◻1 – Full-Time ◻2 – Part-Time ◻3 – Not Employed ◻4 – Self-Employed ◻5 – Retired ◻6 – Active Military
**Student Status:** ◻F – Full-Time Student ◻P – Part-Time Student ◻N – Not a Student

**Race:** ◻American Indian/Alaska Native ◻Asian ◻Native Hawaiian/Pacific Islander ◻Black/African American ◻White ◻Hispanic ◻Other ◻Declined

**Ethnicity:** ◻Hispanic or Latino ◻Not Hispanic or Latino ◻Declined

**Language:** ◻English ◻Spanish ◻Indian ◻Japanese ◻Chinese ◻Korean ◻French ◻German ◻Russian ◻Other _____

**Pharmacy:** Do you have a living will? ◻ YES ◻ NO

Referred By ( Please check one box)
◻ Dr. _____ ◻ Insurance ◻ Hospital ◻ Family ◻ Friend ◻Yellow Pages ◻ Other _____

Other Family Members Seen Here

PCP Name Phone #

## RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party: ◻Another Patient ◻Guarantor ◻Self ◻Check here if information is same as patient

| Name | Address | Home Phone Number |
|---|---|---|
| Birth Date / / | E-Mail Address | ( ) |
| Occupation | Employer | Employer Address / Employer Phone Number ( ) |

## INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ◻ WORKERS COMPENSATION (WC)
◻ OCCUPATIONAL MEDICINE (OM) ◻ MOTOR VEHICLE ACCIDENT (MVA) ◻ ACCIDENT DATE _____

Does the patient have healthcare coverage? ◻ YES ◻ NO **Insurance Name**

| Name of Insured | Social Security Number | Birth Date | Effective Date | Group ID | Subscriber ID (Policy Number) |
|---|---|---|---|---|---|
| | - - | / / | / / | | |

Patient Relationship to Insured ◻ Self ◻ Spouse ◻ Child ◻ Other _____

| Name of Secondary Insurance | Name of Insured | Date of Birth | Group ID | Subscriber ID (Policy Number) |
|---|---|---|---|---|
| | | / / | | |

Patient Relationship to Insured ◻ Self ◻ Spouse ◻ Child ◻ Other _____

## EMERGENCY CONTACT

| Name (Last, First) | Relationship to Patient | Home Phone Number | Other Phone Number |
|---|---|---|---|
| | | ( ) | ( ) |

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

_____ _____

Patient/ Guardian Signature Date

SUMNER
PHYSICIAN PRACTICES
HIGHPOINT HEALTH SYSTEM

**HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY**

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

| NAME | RELATIONSHIP | CONTACT NUMBER |
|---|---|---|
| | | |
| | | |
| | | |

III. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my

primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form

of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

**VI. FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

**VII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS:** If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

Printed Name of Patient or Representative

Signature of Patient or Representative

Date

SUMNER
PHYSICIAN PRACTICES
HIGHPOINT HEALTH SYSTEM

Relationship to Patient (if other than patient) _____

**CLINIC STAFF USE ONLY**

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

Date: _____

**This Facility and its affiliates comply with the applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.**

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# Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

## Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

## Appointment Confirmation

Our office will place a personal reminder call to you 5 days prior to your appointment and an automated reminder call to you 48 hours prior to your appointment. We ask that you call us back to confirm your appointment if you are not able to confirm at the time of the automated call or if you need to reschedule.

## No Show Policy

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in the medical record as a "no-show". Three "no-show" or late cancellation (less than 24 hours' notice) appointments may result in dismissal from the clinic.

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Signature Date

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## PATIENT HISTORY FORM

**Past Medical History**: Please check if you have had or are currently diagnosed with the following medical conditions.

| | | |
|---|---|---|
| _____ Diabetes | _____ COPD/Lung Disease | _____ Migraines |
| _____ Adrenal Disease | _____ High Cholesterol | _____ Seizures |
| _____ Pituitary Disease | _____ Gout | _____ Parkinson's Disease |
| _____ Cancer | _____ Rheumatoid Arthritis | _____ Alzheimer's |
| _____ Depression | _____ Autoimmune Disease | _____ Breast Cancer |
| _____ Anxiety | _____ High Blood Pressure | _____ Thyroid Disease |
| _____ Other Mental Illness | _____ Osteoporosis | _____ Parathyroid Disease |
| _____ Heart Disease | _____ Stroke | _____ Calcium Problems |
| _____ Seasonal Allergies | _____ Asthma | _____ Kidney Disease |
| _____ Crohn's Disease | _____ Liver Disease | _____ Pancreas Disease |
| _____ Ulcerative Colitis | _____ Glaucoma | _____ Cataracts |

Any other medical problems not listed above:

_____

_____

**Past Surgical History**: Please list all surgeries or Procedures that you have had.

| | **Procedure** | **Approximate Date** |
|---|---|---|
| 1. | _____ | |
| 2. | _____ | |
| 3. | _____ | |
| 4. | _____ | |
| 5. | _____ | |
| 6. | _____ | |
| 7. | _____ | |
| 8. | _____ | |
| 9. | _____ | |

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**Family Medical History**: Please check if your family members have had any of the following medical conditions.

| Disease | Mother | Father | Sibling(s) | Child(ren) | Grandparent(s) |
|---|---|---|---|---|---|
| **Adrenal Disease** | | | | | |
| **Pituitary Disease** | | | | | |
| **Cancer** | | | | | |
| **Diabetes** | | | | | |
| **Heart Disease** | | | | | |
| **High Cholesterol** | | | | | |
| **High Blood Pressure** | | | | | |
| **Osteoporosis** | | | | | |
| **Stroke** | | | | | |
| **Thyroid Disease** | | | | | |
| **Parathyroid/Calcium Disease** | | | | | |

Any other family medical problems not listed above:

_____

_____

**Social History**:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower

Occupation: _____ Retired? _____

Education (highest level attained): _____

Tobacco Use: ☐ Never Smoked ☐ Current Smoker ☐ Previous Smoker

☐ Current Chew / Dip

How Many Packs / Day _____ Year Began _____ Year Quit _____

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Alcohol Use:

How many glasses of alcohol do you drink per day? _____ per week? _____

Drug Use:

Do you currently use any illegal drugs? _____ If yes, which one(s)? _____

Any previous/current IV drug use? _____ If yes, which one(s)? _____

**Preventive Care**:

Date of last flu vaccination: _____

Date of pneumonia vaccination: _____

Last Eye exam: _____ Where: _____

Bone Density: _____ Where: _____

**Allergies**: ☐ **No Known Drug Allergies**

| | **Name of Medication/Food** | **Reaction (hives, nausea, etc.)** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

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# HIGHPOINT
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**Review of Systems**: Please check if you have RECENTLY had any of the following:

General: ☐ Chills ☐ Fatigue ☐ Fever ☐ Night Sweats ☐ Weight Loss (Amount _____,)
☐ Weight Gain (Amount _____,)
Cardiovascular: ☐ Chest Pain ☐ Irregular Heartbeat ☐ Swelling of Extremities ☐ Leg Cramps
Neurological: ☐ Burning Sensation ☐ Decreased Memory ☐ Dizziness ☐ Headaches
☐ Numbness / Tingling ☐ Tremor
Gastrointestinal: ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea / Loose Stools ☐ Heartburn
☐ Nausea / Vomiting
Skin: ☐ Dryness ☐ Excessive Sweating ☐ Hair Loss ☐ Itching ☐ Rash
Psychiatric: ☐ Feeling of Depression ☐ Anxious Feeling ☐ Mood Changes ☐ Panic Attacks
Genitourinary: ☐ Blood in Urine ☐ Frequent Urination ☐ Kidney Stones ☐ Painful Urination
Eyes / Ears / Nose / Throat: ☐ Double Vision ☐ Visual Disturbances ☐ Hearing Loss ☐ Hoarseness
Endocrine: ☐ Appetite Changes ☐ Cold Intolerance ☐ Sexual Dysfunction ☐ Excessive Thirst
☐ Excessive Urination ☐ Menstrual Irregularity ☐ Libido Change
Pulmonary: ☐ Cough ☐ Shortness of Breath ☐ Wheezing
Musculoskeletal: ☐ Backache ☐ Joint Pain ☐ Joint Swelling ☐ Muscle Weakness
Hematologic / Lymphatic: ☐ Anemia ☐ Easy Bruising ☐ Enlarged Glands
Breast: ☐ Breast Mass / Swelling ☐ Breast Pain / Tenderness ☐ Nipple Discharge

**Medications/Herbs/Vitamins/Supplements:** Please list everything that you take daily, as well as those that you take only occasionally or as needed.

| | Name | Strength | How Often It's Taken | Prescribed By |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

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| | Name | Strength | How Often It's Taken | Prescribed By |
|---|---|---|---|---|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. | | | | |
| 13. | | | | |
| 14. | | | | |
| 15. | | | | |
| 16. | | | | |
| 17. | | | | |
| 18. | | | | |

Any other medications/herbs/vitamins/supplements not listed above:

Signature Date

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