Cary Endocrine & Diabetes Center, P.A.

REGISTRATION FORM – PLEASE PRINT

PATIENT REFERRAL INFORMATION		
Today's date:	Primary Language:	
Referring Physician:	Primary Care Physician:	
Pharmacy (Name, Street, and City):		
PATIENT INFORMATION		
Last Name:	First:	Middle:
Date of Birth:	Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid	
Former Name (if any):	Social Security #:	
Street Address:	P.O. Box:	
City:	State:	ZIP Code:
Preferred Phone #: ☐ Cell ☐ Home	Alternate Phone #: ☐ Cell ☐ Home	
Email Address:	Employer/School:	
Occupation:	Student: ☐ Full-time ☐ Part-time	
RACE: (check as many as applicable): ☐White ☐African American ☐American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander		
ETHNICITY: ☐Not Hispanic or Latino ☐Hispanic or Latino		
INSURANCE INFORMATION		
Name of **Primary** Insurance Company:		
Please complete information below if you are ***NOT*** the primary subscriber		
Subscriber's Name:	Date of Birth:	
Address (if different):	Home Phone #:	
Occupation:	Employer:	
Subscriber's Social Security #:	Patient's Relationship to Subscriber: ☐Spouse ☐Child ☐Other	
Name of **Secondary** Insurance Company (if applicable):		
Subscriber's Name:	Date of Birth:	
Subscriber's Social Security #:	Patient's Relationship to Subscriber: ☐Spouse ☐Child ☐Other	
IN CASE OF EMERGENCY		
Name of Nearest Relative or Local Friend:	Relationship to Patient:	
Phone #:		
Name of Nearest Relative or Local Friend:	Relationship to Patient:	
Phone #:		
ASSIGNMENT AND RELEASE		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for all charges or any balance not paid by my insurance. I also authorize Cary Endocrinology & Diabetes Center to use my signature on all insurance claims and to release to my insurance company or it agents any information required to process my claims, determine benefits, or obtain prior authorization for any procedures that require such authorization.		
Patient/Parent/Guardian Signature:	*Date:*	
Print name of Patient/Parent/Guardian:	*Date:*	
Relationship to Patient IF Parent or Guardian:		

Cary Endocrine & Diabetes Center, P.A.

Medical History Form

Date:		
Last Name:	First:	Middle:
DOB:	Occupation	
Pharmacy:	Primary Care Physician:	
List Allergies (include medications; food):		

Reason for your visit today (include any symptoms you are currently having, approximate date of onset, issues you would like to discuss with your provider today): _____

_____

_____

_____

_____

Past Medical History: Problems for which you have seen a physician or been treated for:

YES	NO		YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Seizures
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Sexual Problems
☐	☐	Asthma	☐	☐	HIV	☐	☐	Stroke
☐	☐	Cancer	☐	☐	Kidney Disease	☐	☐	Thyroid Disease
Type:_____			☐	☐	Nerve Damage	Type:_____		
Date:_____			☐	☐	Osteoporosis	How long:_____		
☐	☐	Cholesterol/Lipids	☐	☐	PCOS	☐	☐	Tuberculosis
☐	☐	COPD	☐	☐	Pregnancy	☐	☐	Ulcers
☐	☐	Depression/Anxiety	Number:_____			☐	☐	Vision Problems
☐	☐	Diabetes	Births:_____			Other:		
☐	☐	High Blood Pressure	# of Children:_____			_____		
			☐	☐	Reflux	_____		
						_____		

Please List Previous Surgeries/Hospitalizations:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Family History:

1. Diabetes/Who: _____
2. Thyroid Disease/Who:_____
3. Heart Disease/Who:_____
4. Stroke/Who:_____
5. Cancer/Who/Type:_____
6. High Cholesterol/Who:_____
7. High Blood Pressure/Who:_____
8. Autoimmune Disorder Who/What Type: _____

Social History (please check and explain if "Yes"):

Whom do you live with? _____

YES	**NO**	
☐	☐	Have children: _____
☐	☐	Exercise/type/how often: _____
☐	☐	Smoke: _____ Prior Smoker ☐ Yes ☐ No Stopped When? _____
☐	☐	Alcohol/how often: _____
☐	☐	Recreational Drugs: _____

Please provide a list of your medications or list them below (include name and dosage):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

(Write on the back if you need more room)

Please complete the following if you have diabetes:

☐ **TYPE 1** ☐ **TYPE 2** Age at Diagnosis: _____

How often do you check your blood sugar? _____

Month/Year of last dilated eye exam? _____

Flu vaccine up to date? ☐ YES ☐ NO ☐ DECLINE FLU VACCINE

I understand that I need to bring my blood glucose meter to each visit: ☐ AGREE

Patient/Parent/Guardian Signature: *Date:*

Print name of Patient/Parent/Guardian: *Date:*

Relationship to Patient if Parent or Guardian:

Cary Endocrine & Diabetes Center, P.A.
www.caryendocrine.com
Sung-Eun Yoo, M.D.
100 Parkway Office Court
Suite 112, Cary, NC 27518
P: 919-378-2332
F: 919-378-2333

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services @ www.hhs.gov

We have adopted the following policies:

1. Patient information is kept confidential except as is necessary to provide services or to ensure administrative matters related to your care is handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding that identifies a patient's condition or information that is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by phone text, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents that may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or provider.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

10. As a courtesy, we may share some limited health information with family members, such as appointment information, payment information, medication information, etc.

☐ I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward. However, I may withdraw or modify this consent at any time in writing.

IF YOU DO NOT WANT LIMITED HEALTH INFORMATION SHARED WITH FAMILY MEMBERS INITIAL HERE:_____

PRESCRIPTION HISTORY

☐ I consent for Cary Endocrine & Diabetes Center to access my prescription history from other providers using RX HUB.

IF YOU DO NOT WANT CEDC TO ACCESS RX HUB INITIAL HERE:_____

CONSENT FOR TREATMENT

I consent to treatment as determined necessary by the physician(s) and other healthcare providers at Cary Endocrine & Diabetes Center. I understand that treatment may consist of a variety of procedures/services based upon my health needs. I also understand that the practice of medicine is not an exact science and that the clinic does not guarantee the results of treatment provided.

CONSENT FOR PHONE MESSAGES AND/OR EMAIL MESSAGES

☐ I consent for CEDC's staff to leave messages on any and/or all phone numbers and/or E-mail addresses listed on your registration form**.**

IF YOU DO NOT WISH TO HAVE MESSAGES LEFT INITIAL HERE:_____

FINANCIAL RESPONSIBILITY

I understand that my actual charges may be different from any charge estimates given to me. I also understand that if I do not have health insurance coverage or have not provided accurate insurance information, I will be responsible for the payment of all charges. In addition, I understand that my insurance company(s) may not pay the full amount of all charges, and I will be responsible for paying the remainder.

Patient/Parent/Guardian Signature:	*Date:*
Print name of Patient/Parent/Guardian:	*Date:*
Relationship to Patient IF Parent or Guardian:	

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HIPAA Disclosure Information Form

(optional form if authorizing information sharing with family member)

PATIENT'S NAME: _____ DOB: ____ / _____ / _____

I hereby authorize use or disclosure of my protected health information to the following individuals:

1. The following person/persons may receive disclosure of my protected health information:

Primary Person	**Relationship to Patient**
Additional Person(s)	**Relationship to Patient**
Additional Person(s)	**Relationship to Patient**

UNLESS YOU SIGN HERE, ***NO*** INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, MENTAL HEALTH, OR SEXUAL ACTIVITY AND/OR PREVENTION WILL BE DISCLOSED:

☐ **YES -** DISCLOSE THIS INFORMATION: Initial: _____

☐ **DO NOT** DISCLOSE THIS INFORMATION: Initial: _____

2. I may revoke this authorization by notifying CEDC **in writing** of my desire to revoke my current HIPAA disclosure. However, I understand that any action already taken **cannot be reversed**, and my revocation will not affect those actions.

3. This authorization expires on _____ / _____ / 20_____, **OR** upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me.

_____

THIS FORM MUST BE COMPLETED FULLY BEFORE YOU SIGN:

_____	_____	_____
Signature of Individual*	**Date of Individual's Signature**	**Date of Birth**

*The person about whom the information relates

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FINANCIAL POLICY / PRACTICE INFORMATION

Thank you for choosing Cary Endocrine & Diabetes Center (CEDC) for your medical care. Our goal is to provide quality healthcare for you and/or your family. We intend to keep you well informed of office policies that may affect you. The following is a statement of the financial policies and practice information of Cary Endocrine & Diabetes Center, which we require you to read and sign prior to the initiation of medical care. If you would like a copy, please feel free to speak with one of our front office staff and they will be happy to assist you.

FULL PAYMENT, CO-PAYMENT, OR ANY OUTSTANDING BALANCE IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, PERSONAL CHECKS, AND MASTERCARD/VISA/DISCOVERY.
CO-PAYMENTS THAT ARE NOT PAID MAY BE SUBJECT TO A $10.00 SERVICE FEE.

INSURANCE

In most cases, we will accept your insurance benefits. You are responsible for your portion of the bill (also known as co-payments/co-insurance) at the time of service. We cannot waive or discount this fee due to our contracts with insurance companies. If not paid, we reserve the right to charge a $10.00 service fee. **The balance is your responsibility whether your insurance company pays your claim or not.**

We cannot file a claim to your insurance company unless you give us your correct insurance information. Please present your insurance card at the time of check-in. It is necessary for us to keep a copy of the card in your medical records chart. **Unless we are in-network with your secondary insurance, we will not bill to your secondary insurance carrier. We will not bill for any Tertiary Insurance. We will provide all necessary information for you to file to your insurance carriers and be reimbursed directly.**

Your insurance policy is a contract between you and your insurance company. **We are not a party to that contract**. Please be aware that some, and sometimes all, of the services provided may **NOT** be covered by your insurance.

In the event that a charge is not covered by your plan, you will be billed the balance after we obtain an Explanation of Benefits from your insurance carrier. Our practice is committed to providing the best medical treatment for our patients and we charge the usual and customary fees for the services rendered. Therefore, outstanding charges are due upon receipt. Accounts with balances that remain unpaid 120 days from the original date a claim was filed to your insurance will be placed with a collection agency. You will be responsible for any collection cost.

NON-CONTRACTED INSURANCE PLANS

Cary Endocrine & Diabetes Center welcomes those patients whose insurance companies are not contracted with this office (example: Medicaid, Tricare Prime, Blue Local, Duke Select, and some independent plans) as self-pay. We request payment at the time of service for all office visits and surgical procedures.

CONSENT TO TREAT

I voluntarily consent to medical treatment under the professional judgment of Sun-Eun Yoo, MD and her staff. I understand that the medical treatment performed is necessary or beneficial to my condition.

PLEASE INITIAL (*page 1)* _____

RETURN CHECKS
There will be a $25.00 service charge for all returned checks. This service charge will be added to your account balance and will be your responsibility. There may be additional charges placed on your account by your bank.

OFFICE HOURS
Monday – Thursday: 7:30am – 12:00pm & 1:00pm – 4:30pm Friday: 7:30am – 4:00pm.
We are closed for major Holidays and at the discretion of the providers.

AFTER HOURS EMERGENCY CARE
Call 911 or go directly to the emergency room as designated by your insurance company. We do not provide after-hours coverage in the office. Request endocrine service at hospital check-in.

MEDICAL ADVICE
Generally, our office will return calls within 24 hours or the next available business day.

REFILLS
Call your pharmacy and ask them to fax refill request to our office @ 919-378-2333. **DO NOT** wait until you are out of medicine to request a refill. Please note that refill requests may take 24 to 48 business hours.

LABORATORY
For your convenience, LAB CORP is located in our office for your laboratory needs. All insurances will be billed directly by LAB CORP. It is your responsibility to understand your insurance plan. Should there be any unpaid claims for your lab services, you will be billed directly from LAB CORP.

MISSED APPOINTMENTS
Please remember to call and cancel your appointment. Your failure to do so prevents another patient from being seen. Our policy requests a 24 hours' notice. We charge a **"NO SHOW"** or **"CANCEL WITH LESS THAN 24 HOURS NOTICE"** fee of $50.00 when you have failed to show or cancel an appointment. Three consecutive **"NO SHOWS"** may jeopardize future appointment availability and is subject to a discharge from our practice.

A new patient appointment must be rescheduled or cancelled ***at least 24 hours*** before the appointment time. A fee of $75.00 will be charged to your account when you have failed to show or cancel the appointment. Your new patient deposit will be applied to this fee.

LATE ARRIVAL
If you arrive more than 20 minutes late for your appointment, you may be asked to reschedule or encounter a waiting period, as we must continue patient care.

MEDICAL RECORDS & FORM FEES
We are happy to provide you with copies of your medical records when needed; however, there is a fee for this service. There is a minimum base charge of $10.00. The copying of medical records is $0.75 for the first 25 pages and $0.50 per additional pages. When a provider needs to complete any forms/paperwork, there is an administrative charge of $20.00. These fees are payable upon request of service. Please allow 24 to 48 hours for our office to prepare your medical records. There are no charges if our office faxes your medical records to another medical provider upon receipt of your signed Medical Release form.

I have read CEDC'S HIPAA & FINANCIAL POLICY and have received a copy if I so desire.

OTHER SUGGESTIONS:

- **Patients with diabetes should bring their meter to EVERY appointment**
- Arrive 20 minutes before your appointment time
- Always bring your insurance card
- Always bring a medication list or your medications

I have read, understand, and accept the above information.

_____ _____
Patient/Parent/Guardian Signature Date