TEXAS DIABETES & ENDOCRINOLOGY, P.A.

6500 North Mopac*Bldg. 3, Ste. 200*Austin, TX 78731
5000 Davis Ln*Ste 200*Austin, TX 78749
110 Deer Ridge Dr*Round Rock, TX 78681
Phone: (512) 458–8400*Fax: (512) 458-8593

PATIENT DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____Legal Gender: M or F
Address: _____City_____ State_____
Zip_____
Marital Status (please circle) : Single / Married / Separated / Divorced / Widowed / Other _____
Race (please circle): White / African American / Asian / American Indian / Other _____
Ethnicity: _____ Preferred Language: _____ Email address: _____
Social Security Number: _____ Drivers License: _____
State: _____
Employer Name: _____ Phone: _____
Address: _____
Primary Insurance: _____ Policy #: _____
Group #: _____
Secondary Insurance: _____ Policy #: _____
Group #: _____
Pharmacy Benefits: _____ Policy #:_____
RX Group#_____ RX Bin#_____
Emergency Contact: _____. Phone: _____
Relation: _____
Referring Physician: _____ Phone: _____

Most convenient means of communication for appointments, lab results and general information:
Please note: if you provide an email address, we can communicate to you via our patient portal.
Home Phone: _____ Cell Phone:_____
Work Phone: _____ Email address: _____

Appointment reminders are sent through an automated service via Text Message and/or Email.
If this is not convenient, please let us know.
If you wish to not be reminded of any future appointments at all, please select this box: ☐ DO NOT CONTACT

****PLEASE INFORM OUR OFFICE OF ANY INSURANCE, PHONE NUMBER, OR ADDRESS CHANGES PRIOR TO ANY FUTURE VISITS****

Signature: _____ Date:_____

MINOR PATIENTS – please provide a parent or guardian's Name and Social Security Number

Parent/Guardian (print) _____

Parent/Guardian (signature) _____

SS#_____

Please be advised that our Privacy Policy is posted in our waiting room for you to review.
Should you have any questions concerning this policy, please inquire at the front desk.

Patient Information

Due to the many changes in healthcare and our ability to comply with those changes and the growth in our practice, we have implemented the following policies and procedures for our office.

Appointments: We will make every effort to schedule an appointment within a reasonable time frame with one of our practitioners. We appreciate our patients and understand that your time is valuable. Our goal is to be as punctual as possible and to see you in a timely manner. We require a 24 hour notice to cancel your appointment. This allows us to give your appointment to another patient. There is a $50 charge for no show appointments and same day cancellations.

Physician Extenders: Texas Diabetes & Endocrinology utilizes physician assistants and advanced practice nurses to assist in the delivery of medical care. Physician assistants and advanced practice nurses are not doctors, however they can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. A physician assistant is a graduate of a certified training program and is licensed by the state medical board. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. Nurse Practitioners and Clinical Nurse Specialists are advanced practice nurses. Your signature below indicates your understanding that some services may be rendered by a Physician Extender.

Lab Reporting and Review: Lab testing is a necessary tool in the treatment of chronic conditions. It is important that you get your lab tests done and keep your follow up appointments to discuss your plan of care. If lab testing is done between visits, results will be reported within two weeks through our patient portal or via mail. You may be contacted via phone by a nurse with instructions. Please allow two weeks before contacting our office to allow time for lab processing, review, and mailing of results. If you would like for us to review and interpret labs done elsewhere, please get copies of the labs and bring them with you to the appointment. ***PLEASE NOTE: ALL LABORATORY ORDERS ARE SENT ELECTRONICALLY TO CLINICAL PATHOLOGY LABORATORIES (CPL), AS OUR DESIGNATED LAB. IF YOU USE A DIFFERENT LAB, PLEASE NOTIFY YOUR PROVIDER AT YOUR VISIT. WE ARE NOT RESPONSIBLE FOR OBTAINING LABS DONE AT OTHER OFFICES.***

Medication Refills: We provide 30 and/or 90 day prescriptions for up to one year, when notified by your pharmacy that your prescription has expired. However, if you do not routinely keep your appointments, do follow up lab work as requested, or stay in compliance with your Plan of Care, we will **only** allow refills to get you to your next appointment (usually 3-4 month supply only). This is strictly for patient safety and compliance. We send prescriptions electronically, so if you are using a mail order company please notify them when you would like your prescriptions filled and shipped. If you need a refill between visits, please do not contact our office. Contact your pharmacy and they will send a refill request on your behalf. Please allow 48 hours for processing of these refills.

Nurse Call Backs: To better serve your needs, nurses are available via phone from 8:00a.m. – 12:00p.m. and 1:30p.m. – 4:30p.m. If the nurses are unavailable, please leave a voicemail message. Voicemail is checked several times throughout the day. If you are a portal patient, please send a portal message for all your needs- you should get a response within 24 hours or sooner. If you do **not** want to join our portal, and need to call and leave a message, please know it *may* take up to 72 hours for a return call for all **NON-URGENT** items. If you have an urgent request, please speak directly with the front desk and do not leave a message.***Please note: MyTDE patient portal is the most convenient means of communication for appointments, lab results, and general information. If you provide an email address, we can communicate to you via our MyTDE patient portal.***

Letters & Forms: If you request that we generate a letter on your behalf, your account will be charged $25.00. The fee is due when the letter is requested. This is not a covered insurance benefit and will be billed directly to the patient. Should you misplace any forms generated by this office there will be a $10.00 charge for replacing them. This is not an insurance benefit and is due at the time of the request. This includes lost prescriptions, lab requisitions, and physician orders for testing.

Contacting You: Texas Diabetes & Endocrinology and any of our affiliates or vendors, such as collection agencies, may contact you by telephone or text message using any phone number you have provided to us, or any other phone number associated with your account, including wireless or mobile phone numbers. We may use any method to contact you at these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. You must notify us if you have given up ownership or control of any such phone numbers.

Signature: _____ Date: _____

Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our Office Manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

All payments are due at the time of service. This includes co-pays, deductibles, and coinsurances.

Your Insurance:

If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of service. IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE. Many insurance plans have "timely filing deadlines". If we are not provided with accurate information at the time of service, you will be responsible for payment in full for all services rendered. Please keep in mind that your insurance is a contract between you and the insurance company. Not all insurances will cover procedures. **While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by you or your insurance is correct. It is your responsibility to know what services may or may not be covered by your insurance.** Texas Diabetes & Endocrinology has preferred provider contracts with most major insurance companies. Please contact your insurance company directly to determine your coverage.

Please note: If you have Medicaid or obtain Medicaid at any time during your care, you understand TD&E is accepting you as a private pay patient and that you are responsible for payment of any and all services rendered at time of service. TD&E will not file a claim to Medicaid for the services that are provided to you. Your signature below indicates your understanding and agreement with this policy.

Private Pay Patients:

- Effective 6/15/20, all New & Existing Private Pay patients will be required to securely store a Credit Card on file prior to their scheduled appointment. The following business day, a 20% discount will be applied before the balance is deducted from the Credit Card on file. *(See section titled "Convenient Auto-Payment" below for more details)*
- If placing a Credit Card on file is not preferred by the patient, the estimated out of pocket expense for the appointment will be required in full prior to checking-in. Payment can be made over phone or in person.

Minor Patients:

- For all services rendered to minor patients, the accompanying adult or the parent/guardian with custody is responsible for payment.

Other Fees:

- In certain circumstances, your provider may charge for telephone services that include more extensive medical discussions. This charge will be billed to you directly.

Payments:

- We accept cash, debit cards, Visa, Mastercard, Discover, American Express and personal checks.
- Any outstanding balances are due within 30 days of your first payment reminder sent via email.
- If payment is not received within 60 days, your account may be sent to a collections agency. An administrative fee of 30% of your total balance will be added to your account. Please note: If you have an appointment scheduled, the total balance will be due upon check-in. If you are unable to pay the full amount, a payment arrangement can be made with a credit card on file. Failure to resolve your account will result in your appointment(s) being canceled.
- If you experience circumstances beyond your control, please contact our billing office and we will be happy to make payment arrangements.

Convenient Auto-Payment:

Retain your credit card on file in a safe encrypted environment. This feature is available to ensure all of your payments are received on time and helps you avoid the 30% administrative fee if paid after 60 days. By enrolling in convenient auto-payment, we can use to collect copays and bill your insurance first and notify you via email 5 days before your credit card is charged for balances due.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____

Printed Name of the Patient Date

_____ _____

Signature of Patient or Responsible party if a Minor Relationship to Patient

Assignment of Benefits Form

Financial Responsibility:

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Texas Diabetes & Endocrinology, P.A. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information:

I hereby authorize Texas Diabetes & Endocrinology, P.A. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Texas Diabetes & Endocrinology, P.A. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

HIPAA RELEASE OF INFORMATION/ PRIVACY PRACTICES

Please be advised that our Privacy Policy is posted in our waiting room for you to review.
Should you have any questions concerning this policy, please inquire at the front desk.

I acknowledge that I have received Texas Diabetes & Endocrinology's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice.

_____	_____
Patient Name	**Date of Birth**
_____	_____
Patient's Signature	**Date**
_____	_____
Personal Representative/Guardian Name	**Relationship to Patient**
_____	_____
Personal Representative/Guardian Signature	**Date**

Please list names, relationships, and contact numbers of all persons TDE is authorized to release medical information to.

_____	_____	_____
Name	**Relationship**	**Contact Number**
_____	_____	_____
Name	**Relationship**	**Contact Number**
_____	_____	_____
Name	**Relationship**	**Contact Number**

FOR OFFICE USE:

If the signed acknowledgement could not be obtained from the patient or representative, the reason(s) must be documented.

1. Please explain why the patient did not sign an acknowledgement form:
   - [ ] Patient Refused to Sign
   - [ ] Patient Communication Barrier
   - [ ] Emergency Situation
   - [ ] Other: _____
2. Completed by:

_____	_____	_____
Employee Signature	Title	Date

HEALTH SUMMARY REPORT

Texas Diabetes and Endocrinology, P.A.

Patient Name: _____ Date of Birth: _____
Referring Physician: _____ Phone: _____
Primary Doctor: _____ Phone: _____
OB/GYN: _____ Phone: _____
Pharmacy: _____ Phone: _____

Past Medical History: **Date:**

_____
_____

Past Surgeries: **Date:**

_____
_____

Medication List: **Dosage:**

_____
_____
_____

Drug Allergies:

_____

Family Medical History (not patient): **CHECK ALL THAT APPLY**

	Diabetes	Relationship:		Heart Attack	Relationship:		Other
	Thyroid	Relationship:		Stroke	Relationship:		
	Osteoporosis	Relationship:		High Blood Pressure	Relationship:		
	Cancer	Relationship:		Cholesterol	Relationship:		

(Father, Mother, Sibling, Children, Aunt, Uncle, Grandparent; please specify)

Social History:
Occupation:
_____

Marital Status: Married Single Divorced Widow Partner Children: # _____

Affirmed Gender (if different than legal gender): _____ Preferred Pronoun: _____

Tobacco Use: Y N Frequency: _____ Previous Smoker? Y N How long? _____

Alcohol Use: Y N Frequency: _____ Drug Use: Y N Frequency: _____

Complete ONLY if you are a Diabetic:

1. Recent flu shot? Y or N When? _____ 5. Last eye exam? _____
2. Pneumonia vaccine? Y or N When? _____ 6. Last foot exam? _____
3. 7. Last dental cleaning? _____

Office Use Only :