Texas Endocrinology, PLLC
Dean Blevins, MD

PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently.
Please note that if any changes to the following information occurs, it is your responsibility to update us promptly.
Thank you!

Patient Name: (*First, M.I., Last)*_____Date of Birth: _____

Gender (please circle one): Male / Female Marital Status (please circle one): Single/ Married/ Separated/ Divorced/ Widowed

Address:_____City_____State_____Zip_____

Race (Please circle one): White / African American / Asian / American Indian / Other: _____

Ethnicity: _____ Preferred Language:_____ E-mail: _____

Social Security #: _____ Driver's License #:_____ State: _____

Employer: _____ Phone: _____

Employer Address: _____City_____State_____Zip_____

Emergency Contact:_____ Phone: _____ Relation: _____

Referring Physician: _____Phone:_____

Insured's Name: _____ Relationship to Patient (Please circle one): Self/ Spouse/ Dependent

Primary Insurance: _____Policy #:_____ Group#:_____

Secondary Insurance: _____Policy #:_____ Group#:_____

Pharmacy Benefits: _____ Policy #: _____

RX Group#: _____ RX Bin#: _____

Insured's Information **if not Self**:

Insured's Employer: _____ Phone Number: _____

Employer Address:_____

Insured's Social Security#: _____ Date of Birth: _____ Gender (Please circle one): Male / Female

Modes of Communication

Please indicate your preferred method for receiving appointment reminders, lab results and general information:
☐ Home ☐ Cell ☐ E-mail

Home#: _____Cell #: _____ E-mail:_____

I hereby assign, transfer, and set over to Texas Endocrinology, PLLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature: _____ Date: _____

* **PATIENTS WHO ARE MINORS**- Please provide your Parent or Guardian's Name & Social Security

Parent/Guardian Name: _____Parent/Guardian Signature:_____

Parent/Guardian Social Security #: _____

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Patient Information

Please read the following information about your upcoming visit. Being prepared and knowledgeable about your appointment will help ensure a more timely and efficient visit. Should you have any questions or concerns please feel free to ask our office. Thank you!

Appointments:
*****Please plan to arrive AT LEAST 15 minutes prior to your appointment time so that we may ensure all the necessary paperwork has been completed.**

What to Bring to Your Appointment:

- Your insurance card/s
- Your driver's license
- A list of medications you are currently taking
- All pertinent tests, lab work, and/or imaging ordered by other physicians involved in your healthcare that may not have been forwarded to our office. If any tests, lab work, and/or imaging has been ordered by our office please complete BEFORE your scheduled appointment.
- Method of payment for co-pays, co-insurance, deductibles, and self-pays. We will collect payment at the time of check-in before your visit.

No-Show Policy:
We do our best to not overbook our office schedule and we strive to see you as close as possible to your scheduled appointment time. When you are scheduled for an appointment, that time is allotted solely for you and is not available to another patient. Although we do our utmost to contact you prior to your scheduled appointment, sometimes we are unable to reach you. It is your responsibility to remember your appointment time. If you are late in arriving to your appointment, you will be asked to reschedule. If you are unable to make your appointment time, we ask that you please **call the office to cancel or re-schedule your appointment AT LEAST 24 hours** in advance of your scheduled appointment time. This allows us to make your time available to another patient who needs it. You will NOT be charged a 'no-show' fee in this case. In order to maintain a culture of mutual respect for time, we will charge a **$50.00 nominal 'no-show' fee** to patients that do same day cancellations or who do not call to cancel or re-schedule their appointments in advance. All new patients that do not show up to their initial visit will be required to pay the **$50.00 'no-show' fee** before being able to reschedule. Please note that payment of any 'no-show' fees is due in full at the time of your next appointment. Please understand that this charge is not billable or covered by your insurance company. Three consecutive 'no-shows' will result in patient's dismissal from the practice since we can not provide proper healthcare to you.

After-Hours Calls:
We care about your healthcare and have a commitment to making ourselves available to our patients as much as possible. During regular business hours (Monday-Friday from 8am -5pm) we strive to address any medical concerns pertaining to your healthcare and treatment plan (e.g. prescriptions, appointments, referrals, etc…) and/or answer any questions or concerns that you may have. However, in order to prevent unnecessary calls from occurring outside of our normal business hours, we have established an after hours call line, MedLink, that should ONLY be used for emergency purposes. Patients who call the MedLink line to speak with Dr. Blevins after hours regarding a matter that is non-urgent will be charged $30.00. For routine calls, please contact our office at (979) 977-7012 during normal business hours. MedLink is for emergencies ONLY and can be reached at (512) 323-5465. In the event of serious illness or injury occurring outside of our regular office hours, please call 9-1-1 or go to the nearest hospital emergency room.

Referrals:
It is always recommended that you check with your insurance carrier to fully understand what providers and services are covered under your plan. Some insurances may require that you obtain a referral before being able to be referred to a specialist. If this is the case, you may need a referral to be able to be seen by our office. Please contact your primary care physician first to obtain a referral prior to your visit and be able to show proof at the time of your scheduled visit, otherwise you may be rescheduled.

Prescription Refills:
We provide 30 and/or 90 day prescriptions and refills. To obtain a refill for a regularly used medication, please request a prescription during your office visit. We send prescriptions electronically, so, if you are using a mail order company, we ask that you communicate with them when you would like your prescriptions filled and shipped. Some prescription refills may take up to 48 hours for processing or more if prior authorization is required. Please be patient and bear with us as we try to handle your requests as promptly as we can. Should you need a prescription refill before your next scheduled visit, please contact your preferred pharmacy and they will send a request on your behalf.

Medical Records:
To obtain copies of your medical records, please contact our office. Texas Endocrinology, PLLC requires you to sign a Medical Records Release Form prior to forwarding your information to any persons other than you. If you are requesting copies of records to be sent directly to another physician, there is no charge. However, there is a nominal service fee of $25.00 required in advance for obtaining copies of medical records for any other purpose. Please notify us well in advance of the date that you will need to obtain or forward a copy of your medical records.

Lab Reports & Review:
It is important to understand that ordered labs are a necessary and integral tool used in our plan of action for your treatment plan. In order to provide the most optimal healthcare to you, we need your help in doing so by getting your lab tests done PRIOR to your next scheduled appointment time so that we may make the most accurate decisions in your treatment. Of equal importance is the attendance of your follow-up visits so that we may track your progress and make changes to your treatment plan as is necessary. At your follow-up appointments, you should also bring other pertinent lab work that may have been ordered by another physician involved in your healthcare. No lab results will be given over the phone.

Letters & Forms:
If you request that we generate a letter or any document 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 includes lost prescriptions, lab requisitions, and physician orders for testing. This is also not a covered insurance benefit and will be due at the time the request is made.

Contacting You:
Texas Endocrinology and any of our affiliates or vendors, such as collecting agencies, may contact you by telephone or text message using any of the phone numbers you have provided to us. This includes wireless and mobile phone numbers. We may contact you through such means as Automated Telephone Dialing System (ATDS) or prerecorded message. It is your responsibility to notify our office if you have given up ownership or control of any of the phone numbers you have provided to our office.

ACKNOWLEDGMENT

By signing below, you acknowledge that you have read, fully understand, and will comply with the policies and practices set place at Texas Endocrinology, PLLC.

Patient Name: _____ Patient Signature: _____ Date: _____

Texas Endocrinology, PLLC
Dean Blevins, MD

Patient Financial Policy

Thank you for trusting and choosing Texas Endocrinology, PLLC to be a part of your healthcare. We are dedicated to providing you with the best possible care and in order to reduce any misunderstandings between the practice and our patients, we have adopted the following financial policies. It is important to our patient/physician relationship that you read and fully understand our financial policy. Please let us know if you have any questions about your financial responsibility. We are pleased to discuss our professional fees with you at any time.

- We will bill your health plan for all services provided in the office. Any balance due is your responsibility and is due at the time of service. A credit card may be placed on file for you out of convenience, just ask the front desk.
- Texas Endocrinology, PLLC accepts most major insurance plans with the exception of Medicaid. If you have insurance coverage for a plan for which we do not accept, you are responsible for payment in full at the time of service. Please contact your insurance company for details about your coverage and schedule of benefits.
- Please be aware that any costs or services not covered by your insurance are due at the time of your appointment. This includes co-payments and deductibles. Your insurance plan may also require you to pay a portion ("co-insurance") of various medical care fees. For information, please contact your insurance company for details about your coverage and benefits.
- Full payment is due at the time of service for self-pay patients. For your convenience, we accept Visa, Discover, Mastercard, personal checks, and cash.
- Returned checks from the bank for insufficient funds will result in the patient's account being assessed a $30.00 fee per check returned.
- If you have Medicaid or obtain Medicaid at any time during your care, you understand that Texas Endocrinology 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. We will not file a claim to Medicaid for the services that are provided to you and your signature below indicates your understanding and agreement with our policy.
- Patients who are Minors: The accompanying Parent or Guardian is responsible for payments in full on services rendered to patients who are minors.
- Delinquent accounts may be assigned to a collection agency. All collection costs will be added to your outstanding balance. We will bill your health plan for all services provided in the office. Any balance due is your responsibility and is due at the time of service. Please be aware: If you have an appointment scheduled, your total outstanding balance will be due at the time of your check-in. We offer a payment arrangement plan if you are not able to pay the full amount. A credit card can be placed on file for you out of convenience, just ask a receptionist. Failure to resolve your account may result in your appointment/s being cancelled.

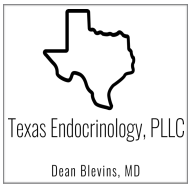
I have read and agree to the financial policy of the practice, and understand that the practice may amend such terms from time to time as deemed necessary.

_____ DOB: _____

Printed Name of the Patient

_____Date: _____

Signature of Patient or Responsible party if a Minor



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. 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 Endocrinology, PLLC 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 Endocrinology, PLLC 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 Endocrinology, PLLC 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

Texas Endocrinology, PLLC

Dean Blevins, MD

Acknowledgment of Notice of Privacy Practices
&
Requested Restrictions

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

Patient Name: _____ Patient Date of Birth: _____
(Please Print Name)

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional):_____. Date:_____

AUTHORIZED PERSONS:

*** Please include the following information for all persons Texas Endocrinology is authorized to release medical information to:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____. Phone #: _____

Name: _____ Relationship: _____. Phone #:_____

***FOR OFFICE USE*:**

If the signed acknowledgement could not be obtained from the patient or representative, the reason(s) must be documented.
Please explain why the patient did not sign the acknowledgement form:

{ } Patient Refused to Sign
{ } Patient Communication Barrier
{ } Patient Emergency
{ } Other

Completed by (Please Print name): _____

Signature: _____

Date: _____

Texas Endocrinology, PLLC
Health History

Today's Date: _____

Name: _____

Date of Birth: _____

Thank you for choosing our clinic. **Please complete ALL sections.**

Primary Care Physician (PCP) _____ PCP Phone No. _____
Preferred Pharmacy: _____ Pharmacy Phone No. _____
Who referred you to us: _____

1. **Chief Concern:** Please describe the reason for your visit today. _____
   _____
2. **Past Medical History:** Have you ever had any of the following: (please check all those that apply)
   - ☐ Diabetes ☐ Osteoporosis/Osteopenia ☐ Cancer (include type) _____
   - ☐ High Blood Pressure ☐ Stroke ☐ Other (please list)_____
   - ☐ Hyperlipidemia ☐ Thyroid Problems _____
   - ☐ Coronary Artery Disease ☐ Kidney Stones _____
3. **Past Surgical History:** *Please list any prior surgeries*
   Surgery _____ Year _____
   Surgery _____ Year _____
   Surgery _____ Year _____
4. **Pregnancy**
   Are you pregnant? ☐ No ☐ Yes Due Date: _____ Last Menstrual Period: _____
   Pregnancies? ☐ No ☐ Yes How many children do you have? _____
   Are you nursing? ☐ No ☐ Yes
5. **Past History of Hospitalization:** *Please list*
   Reason _____ Year _____ Hospital _____
   Reason _____ Year _____ Hospital _____
   Reason _____ Year _____ Hospital _____
6. **Medications:** *Please list all current medications*

Medication	Dose	Times per Day	Refill Needed (Y/N)?

7. **Allergies:** *List medications you are allergic to and describe reaction.* _____
   _____
8. **Family History:** What diseases are common in your family? *Please check all that apply and list affected family member (i.e. mother, father, siblings, grandparents, aunts/uncles, etc):*
   - ☐ High Blood Pressure ☐ Osteoporosis/Osteopenia ☐ Cancer (include type)_____
   - ☐ Hyperlipidemia ☐ Asthma ☐ Kidney Stones
   - ☐ Diabetes ☐ Thyroid Problems ☐ Other _____
   - ☐ Coronary Artery Disease ☐ Heart Attack
9. **Social History:** Occupation: _____
   Are you married? ☐ No ☐ Yes Do you have children? ☐ No ☐ Yes
   Smoking Status: ☐ Never ☐ Current ☐ Former ☐ Daily ☐ Some Days
   Year Started: _____ Quit: _____ Packs/Day: _____
   Alcohol Use: ☐ Never ☐ Socially ☐ Daily ☐ Quit Drinking Drinks per day: _____ Per week: _____
   Caffeine Use: ☐ Rare ☐ Sometimes ☐ Heavy. ☐ Never
   Drug Use: ☐ No ☐ Yes ☐ Former Type: ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other
   Exercise: ☐ Never ☐ Some Days ☐ Most Days ☐ Daily

Last Flu Shot? ☐ Yes ☐ No ☐ When? _____
Pneumonia Vaccine? ☐ Yes ☐ No ☐ When? _____
Hepatitis B Series? ☐ Yes ☐ No ☐ When? _____

Diabetic Patients ONLY:
Shingles Vaccine? ☐ Yes ☐ No
When? _____
Last Dental Cleaning? _____
Last Foot Exam? _____
Last Eye Exam? _____

Texas Endocrinology, PLLC

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Credit Card on File Policy
&
Auto Pay Withdrawal Authorization

At Texas Endocrinology, PLLC we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

This authorization relates to all payments not covered by your insurance company for services provided to you by Texas Endocrinology, PLLC. This authorization will remain in effect until you cancel this authorization. To cancel, you must give a 60-day notification to Texas Endocrinology, PLLC in writing and the account must be in good standing. You have a responsibility to notify Texas Endocrinology, PLLC in writing of any changes in your account information in a timely manner.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover *We do not accept AMEX
Cardholder Name (as shown on card): _____
Credit Card #: _____
Expiration Date (MM/YY): _____
Security Code: _____
Billing Physical Address:
Billing City and State:
Cardholder ZIP Code (from credit card billing address): _____

I, the undersigned, authorize Texas Endocrinology, PLLC to charge the portion of my bill that is my balance due for services rendered that my insurance company identifies as my financial responsibility to the following credit or debit card:

I certify that I am an authorized user of this account and I, _____, authorize Texas Endocrinology, PLLC to charge my credit card above for agreed upon medical services. I understand that my information will be saved to file for future transactions on my account.

Patient Name: _____ Patient Date of Birth: _____

Patient Signature: _____ Date: _____

E-mail: _____ Phone: _____

* Please additionally fill out the E-mail Consent for

For Office Use Only

Witnessed by: _____

Date: _____