LAUREL ENDOCRINE & Thyroid Specialists, PA

ERIC HORST, MD • MARJAN KAREGAR, MD • LAURA LABOONE, MD
JANELLE HINSON, PA-C • MEREDITH EVERETT, FNP, GINA MCKELVEY, FNP

Patient Information

Reason for consult: _____ DATE _____
Account Number _____ Patient's name_____
Date of Birth _____-_____-_____ Age _____ M / F
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Emergency Contact _____ Phone Number _____
Patient's SSN _____ Referring Physician _____
Employer _____
Email _____
Pharmacy _____ Phone Number_____ Address _____

Primary Insurance Co. _____ Policy ID # _____
Name of Insured _____ Date of Birth _____
Relation to Patient _____ SSN _____

SECONDARY INSURANCE CO _____ POLICY ID # _____
Name of Insured _____ Date of Birth _____
Relation to Patient _____ SSN _____
Employer _____ Group Number _____

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION TO:
LAUREL ENDOCRINE AND THYROID SPECIALISTS, P.A.
Eric Horst, MD; Marjan Karegar, MD; Laura LaBoone, MD; Janelle Hinson, PA; Meredith Everett, FNP; Gina McKelvey, FNP

I authorize Laurel Endocrine and Thyroid Specialists, P.A. to obtain any medical information needed from any physician or hospital.

Patient Signature _____

ASSIGNMENT OF INSURANCE BENEFITS

I request payment of medical benefits be made to Laurel Endocrine and Thyroid Specialists, P.A. or their physicians for services rendered to me.

I UNDERSTAND THAT IN THE EVENT MY INSURANCE DOES NOT PAY, I AM RESPONSIBLE FOR PAYMENT IN FULL. I AUTHORIZE LAUREL ENDOCRINE AND THYROID SPECIALISTS, P.A. TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES ANY INFORMATION NEEDED FOR THIS CLAIM OR A RELATED MEDICARE/INSURANCE CLAIM. I permit this authorization or a photostatic copy of the original to be used and request payment of medical benefits be made to Laurel Endocrine and Thyroid Specialists, P.A.

Patient Signature _____ **Date** _____

LAUREL ENDOCRINE & Thyroid Specialists, PA

1740 St. Julian Place, Columbia, SC 29204
Phone: 803-256-3534 Fax: 803-254-7032

The following policies have been adopted to give each patient our most effective care and treatment. We ask for your understanding of the policies.

PRACTICE POLICIES:

1. Please have your updated demographics and complete medication list each visit.
2. Please let us know at check-in of any lab work performed at another location.
3. **You will need to be up to date on your appointments in order to receive refills between appointments. Otherwise, you may need to wait until your next appointment or make a new appointment.**
4. Our providers do not accept refill requests from pharmacies. Please contact your provider directly.
5. MyChart messages are checked on the days that the office is open. You should receive a response in 1-2 business days, however certain messages or questions may require an appointment.
6. It is not always possible for the provider or medical assistant to speak with you immediately. Your call will be returned within 1-2 business days, or as the schedule permits.
7. If it is an emergency, please go to the emergency room or call 911 for immediate care.
8. No lab specimens or glucometers can be accepted by our front office staff. Please notify the receptionists and a clinical staff member will be called to assist you.
9. There will be a $25 charge per form for the completion of any forms (e.g. pregnancy, FMLA, CDL, or physician exam forms).

FINANCIAL POLICIES:

1. All copays, coinsurances, and previous balances are due at check-in. Failure to pay in full will result in a $15 service charge being added to your account and you may have to reschedule for a future date.
2. We require a 48-hour notice for any appointment. Any consultation, visit, or in-office procedure not cancelled or rescheduled in that time will be charged a $100 fee. You must pay all fees before rescheduling an appointment.
3. If you are more than 15 minutes late to your appointment, you may be considered a “no-show,” which means that you will not be seen for your appointment and you will be charged the $100 fee.
4. If you are unable to make the payment in full, please contact our billing office to make financial arrangements.
5. Failure to pay your balance could result in your care being transferred back to your referring provider.
6. Please bring your insurance card with you to each visit. Insurance is filed as a courtesy to our patients. If you have insurance, but cannot produce a valid card, you will be considered “self-pay” and payment in full will be expected at each visit until we can verify your insurance. No insurance will be filed on services over 45 days old.

PLEASE SIGN AND DATE BELOW INDICATING YOUR UNDERSTANDING OF THE ABOVE POLICIES.

Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

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Gestational Diabetes History

Patient Name: _____ DOB: _____

Estimated Delivery Date: _____

Have you ever had high blood sugars in the past? _____
If so, have you ever had diabetes education? _____
How many times per day do you check your sugar levels? _____
Is there someone you live with who can help you in case you have a low blood sugar? _____

What was your pre-pregnancy weight? _____
Do you have a family history of diabetes? _____
Number of previous pregnancies: _____
Number of live births: _____
What was the birth weight of each baby? _____
Any complications with previous pregnancies? _____

Gynecologist: _____ Last appointment: _____
Primary Care Doctor: _____ Last appointment: _____

Medications

List any drug allergies

_____
_____
_____

Current prescription medications, OTC medications, and supplements:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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Past Medical History

High Blood Pressure	___	Pancreatitis	___
Diabetes	___	Peptic ulcer disease	___
High cholesterol	___	Thyroid disease	___
Heart attack or stroke	___	Thyroid cancer	___
Congestive heart failure	___	Prostate cancer	___
Sleep apnea	___	Other cancers	___
Heart disease	___	Low testosterone	___
Seizures	___	Chronic steroid use	___
Kidney disease	___	COPD/asthma	___
Gall stones	___	Kidney stones	___

Other Conditions:

_____
_____
_____
_____

Prior Surgeries:

_____
_____
_____
_____

Social History

Do you smoke? ___ _____
Do you drink? ___ _____
Do you use recreational drugs? ___ _____

What is your occupation? _____ Married / Widow(er) / Single / Divorced

Family History

Has anyone in your immediate family (only parents, siblings, children) had:

	YES	NO
High Blood Pressure	___	___
Diabetes	___	___
High cholesterol	___	___
Heart attack or stroke	___	___
Heart failure	___	___
Prostate cancer	___	___
Calcium disorders	___	___
Thyroid cancer	___	___
Psychiatric illness	___	___
Thyroid cancer	___	___
Other thyroid disease	___	___
Pituitary problems	___	___
Kidney disease	___	___

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Review of Systems

Circle any symptoms you have:

General
- Fever / chills
- Weight loss
- Weight gain
- Night sweats
- Weakness/fatigue

Endocrine
- Cold intolerance
- Heat intolerance
- Excessive thirst
- Excessive urination
- Excessive sweating
- Flushing
- Tremulousness
- Changes in body hair

Skin
- Rash/purple or red spots/pigment
- Fingers/toes turn colors in the cold
- Nail problems
- Dry skin
- Skin ulcers

Neurologic
- Migraines
- Headaches
- Numbness/tingling
- Muscle weakness
- Seizures
- Muscle cramps
- Difficulty thinking or remembering

Scalp/Head
- Hair loss
- Scalp tenderness
- Headache

Eyes
- Blurry vision
- Double vision
- Decreased peripheral vision
- Eye pain
- Dry eyes

Ears/Nose/Throat
- Noticeable swelling in neck
- Hearing loss
- Ear pain
- Ringing in ears
- Vertigo
- Nasal congestion
- Loss of sense of smell
- Hoarse voice

Musculoskeletal
- Painful joints
- Muscle pain
- Back pain

Mouth
- Sores in mouth
- Dry mouth
- Dental problems
- Loss of taste
- Difficulty swallowing

Allergy
- Frequent sneezing
- Seasonal allergies

Respiratory
- Shortness of breath
- Cough
- Wheezing
- Chest pain with breathing

Blood/Lymph
- Easy bruising
- Enlarged lymph nodes

Gastrointestinal
- Nausea / vomiting
- Constipation / diarrhea
- Hemorrhoids
- Change in appetite
- Food intolerance
- Need for antacids

Genitourinary
- Irregular menses / Hot flashes
- Frequent urination
- Blood in urine
- Decreased urine stream
- Prostate problems
- Frequent urinary tract infections
- Frequent yeast infections
- Decreased sexual desire

Heart
- Chest pain
- Stabbing chest pain/pericarditis
- Irregular or rapid heart rate
- Lightheadedness / Passing out
- Need to sit up to breathe
- Leg swelling

Psychological
- Anxiety
- Depression
- Difficulty sleeping
- High stress

Breasts
- Lumps
- Pain
- Discharge

Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____

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HIPAA PATIENT AUTHORIZATION

Patient Name: _____

Address: _____ City: _____ ST: _____ Zip:_____

Birthdate: _____/_____/_____ Home phone: (_____)_____ Work Phone: (_____)_____

Purpose of Request
I authorize the Practice to disclose or provide my protected health information to the following individual, who is authorized to act as my personal representative for the purposes of receiving all of my protected health information. I will inform my personal representative of the last four digits of my social security for identification purposes when inquiring about my health information. As my personal representative, they may exercise my right to inspect, copy, and request amendments to my protected health information. They may also consent or authorize the use or disclosure of my protected health information:

Personal Representative:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Description of Information to be Disclosed
I authorize the Practice to disclose all of my protected health information to my designated personal representative.

Expirations or Termination of Authorization
This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to Revoke or Terminate
As stated in our Privacy Notice, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Laurel Endocrine and Thyroid Specialist
Attn: Privacy Manager
1740 St. Julian Place
Columbia, SC 29204

Re-Disclosure
I understand the Practice has no control over the person(s) I have listed as my personal representative. Therefore, any protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the Practice.

Patient Signature: _____ **Date:** _____