



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 _____



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: _____

Past Medical History

Patient Name: _____ DOB: _____

	YES	NO
High Blood Pressure	___	___
Diabetes	___	___
High cholesterol	___	___
Heart attack or stroke	___	___
Congestive Heart failure	___	___
Sleep apnea	___	___
Heart disease	___	___
Seizures	___	___
Kidney disease	___	___
Gall stones	___	___
Kidney stones	___	___
Pancreatitis	___	___
Peptic ulcer disease	___	___
Thyroid disease	___	___
Thyroid cancer	___	___
Prostate cancer	___	___
Other cancers	___	___
Low testosterone	___	___
Chronic steroid use	___	___
COPD/asthma	___	___
Anemia	___	___
Menopause	___	___
Psychiatric illness	___	___
Joint replacements	___	___
Osteoporosis	___	___
Bone fractures	___	___
Rheumatologic disease	___	___

Other Conditions:

Prior surgeries:

Medications

List any drug allergies:

Current prescription medications, OTC medications, and supplements:

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

Social History

If yes, how much?

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	_____	_____

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
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_____	_____	_____
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_____	_____	_____
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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: _____