BERKELEY ENDOCRINE CLINIC
Hormonal Health and Wellness

3000 Colby Street, Suite 203B, Berkeley, CA 94705. P: (510) 883-9005, F: (510) 883-9006

Registration

Name (First, Last) _____ Gender: *Male* *Female* *Transgendered*

Birth Date: _____ Social Security #: _____

Address: _____

Best Number to reach you: _____ Email Address: _____

Alternate Phone number : _____

(No need to answer questions 2-3 if the information was provided on our website)

1. Main Reason you are visiting our office:

_____

2. List any medical conditions AND surgeries that you have currently or had in the past:

_____

_____

_____

3. List of any medications that you are taking (prescription or over-the-counter) with the dose and frequency:

_____

_____

_____

4. Please list the name and address of your pharmacy:

_____

5. Please list your preferred lab

_____

6. Your Primary Care Provider: _____

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Office Policies

Thank you for choosing the "Berkeley Endocrine Clinic" for your Endocrine care. Our office aims to provide you excellent medical care and customer service. We have implemented policies that will assist us to achieve our goals that we would like to bring to your attention:

1-New patients please arrive 15 minutes before your appointment time. You must have a valid insurance card and current identification at the time of the first visit.

2- Insurance co-pays are due at the time of service: Patients who do not pay their co-pay are billed a $15.00 service charge in addition to their co-pay. If you have an outstanding balance at the time of your appointment, payment will be expected. We accept cash, checks, and all major credit cards for your convenience. There is a $25.00 service charge for a returned check. Insurances are billed as a courtesy and the patient has financial responsibility for payment in full for services rendered.

3- Insurance coverage: We recommend that you check with your insurance company whether we are listed under the network and what's your expected payment.

4- Appointment and Cancellation policy: We recommend arrival 15 minutes prior to the visit. Late arrivals will be seen only upon the discretion of the provider. We request the courtesy of an **advanced notification of 24 business hours.** If you fail to notify us of your inability to keep your appointment, a "no-show" for your appointment time will be noted in your chart. After two consecutive no-shows, you may be considered for discharge from the practice. All patients who fail to present for their visits or cancel within 24 hours of their appointment will be subject for a $ 50 fee.

5-Prescription refills: New prescriptions and prescription changes are available to you during your visit. Refill requests should be made to your pharmacy. Please do not wait until you are out of medication to request a refill and allow 72 hours for prescription refills.

6- Lab copies: Most of the time, your labs will be available to be seen through the patient portal online. Paper copies of your labs can be requested during your visit as well.

7- Medical records: If another practitioner is requesting your records, they can be sent electronically or faxed to the requesting provider at no charge after you sign a medical release. Otherwise, to obtain a copy of medical records a fee of $ 25.00 and may take up to two weeks. The records can be picked up at the office. Upon request they may be mailed Certified/Return Receipt for an additional cost of the mailing fee.

8- Online Communication: As a courtesy to our patients, we respond to your requests online through the patient portal. We recommend that the online communication be brief and limited to simple questions and answers. Please allow 24 - 48 hours for a response from our office. For urgent matters, we recommend that you call our office.

9**. Phone visits:** Communication with the physician through the portal is provided as a courtesy to our patients. Follow up visits on the phone upon the discretion of the provider.

10. After-hour phone calls: We are happy to answer the phone during our regular business hours, which is Monday to Friday, 8:00 am till 5:00 pm and we are closed for lunch between 12:00 pm and 1:00 pm. If you call our office after 5:00 pm or over the weekend, we advise that you leave a message and we will respond to you the next business day. If you have a matter that requires urgent medical attention, we advise that you visit the nearest Emergency Room.

I read the office policies for the Berkeley Endocrine Clinic and I agree to all of them

Name _____Signature _____

Please read carefully, initial next to each statement and sign the form.

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Consents

1. _____ I have read and **received a copy** of this practice's Notice of Privacy Practices and the office policies.

Consent to release medical information

2. _____ I give **consent to release medical information** to the following parties: Third party payors covering the medical services, other health care professionals, institutions involved in my care, the proponent of any legally sufficient subpoena, or in response to a court order, employees and agents of the practice, pharmacies and other parties as otherwise required by law.

Consent to use Surescripts

3. _____ I authorize the "**Berkeley Endocrine Clinic"** use SureScripts, Inc. a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy.

Assignment of Benefits

4. _____I hereby **assign all medical benefits**, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), to issue payment check(s) directly to " Berkeley Endocrine Clinic" for the medical services rendered to myself.

Consent to treat

5. _____ I give permission for **Berkeley Endocrine Clinic** to give me medical treatment. I understand that I have the right to discuss all medical treatments with my provider and to refuse any procedure or treatment.

Financial Policy

6._____ I understand that the "Berkeley Endocrine Clinic" will bill my insurance for the visit as a courtesy. I am still responsible to pay all expenses in case the insurance does not submit the payment on time.

Releasing medical information to friends and family

7. _____ I hereby **give authorization to release information** and/or discuss my medical condition including my protected health information with the person(s)/entities listed below:

Person/entity name: _____Phone # _____

Relationship to Patient (or other description)_____

This authorization can be revoked at any time upon my request in writing.

Patient's Signature: _____Date: _____

Print Full Name : _____

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For Diabetic Patients ONLY

1. Which Type of Diabetes do you have? _____ Type 1 _____ Type 2
2. What year were you diagnosed with Diabetes? _____
3. Do you have any complications of diabetes :

   ___ Retinopathy (Eye problems from diabetes)

   ___ Neuropathy (Nerve damage in the feet causing numbness, tingling or burning in the feet)

   ___ Nephropathy (kidney problems or increased protein in the urine)

4. When was the last time you had an eye examination : please mention the estimated date and the eye clinic

   Eye Clinic (Name of the clinic, Address, Phone number, Doctor's name):

   _____

   _____

   Date of the last eye examination: _____

5. Please mention if you received any of the following vaccinations and the date?

   Vaccine Date Location

1. Flu vaccine_____
2. Pneumovax _____
(Pneumonia vaccine)
3. Shingles Vaccine _____
4. Tetanus Shot _____

Name _____ Signature _____ Date _____

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Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that you notify us of your cancelation more than 24 hours ahead of time. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification are subject to a **$ 50.00 cancellation fee.**

Patients who don't show up to their appointments without a call to cancel an office appointment will be considered a **NO-SHOW**. Patients who have (2) or more **NO-SHOWS** in a 12-month period may be dismissed from the practice. Patients may also be subject to a **$ 50.00 fee** for office appointment NO-SHOW.

The cancellation and the **NO SHOW** fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

The Berkeley Endocrine Clinic believes that good physician / patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to our office staff.

Please sign that you have read, understand and agree to this cancellation and no show policy.

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Signature of patient or patient representative Date

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Electronic Mail Consent Form

Before allowing electronic mail ("email") communications with Berkeley Endocrine Clinic, INC please read and agree to the following information regarding the risks and conditions of email use:

The Risks of Using Electronic Mail

We offer patients and other individuals the opportunity to communicate by email. However, transmitting patient information by email has a number of risks that should be considered. These include, and are not limited to, the following risks:

- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Email senders can easily misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email may exist even after sender or recipients have deleted their copy.
- Employers and on-line services have a right to archive and inspect emails transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used as evidence in court.

Conditions for the Use of Electronic Mail

We will use reasonable and appropriate means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by our intentional misconduct. Thus, individuals must consent to the use of email for information. Consent to the use of email includes agreement with the following conditions:

1. All emails to or from patients concerning diagnosis or treatment may be printed out and made part of patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
2. We may forward emails internally to the practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. We will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
3. Although we will endeavor to read and respond promptly to an email, we cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, patients should NOT use email for medical emergencies or other time-sensitive matters.
4. If the individual's email requires or invites a response, and the individual has not received a response within a reasonable time period, it is the individual's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.

5. Individuals should not use email for communication regarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
6. Individuals are responsible for informing us of any types of information that they desire not to be sent by email, in addition to those out in the above paragraph.
7. The individual is responsible for protecting his/her password or other means of access to email. We are not liable for breaches of confidentiality caused by the individual or any third party.
8. We will not engage in email communication that is unlawful, such as unlawfully practicing medicine across state lines.
9. It is the individual's responsibility to follow up and/or schedule an appointment if warranted.

Communicating by email

To communicate by email, patients and other individuals shall:

1. Limit or avoid the use of his/her employer's computer.
2. Inform us of changes in his/her email address.
3. Include the patient's name in the body of the email, if the sender is not the patient.
4. Review the email to make sure that it is clear and that all relevant information is provided before sending.
5. Take precautions to preserve the confidentiality of email, such as using screen savers and safeguarding his/her computer password.
6. Withdraw consent only by email or written communication to the practice.

Acknowledgment and Agreement

I acknowledge that I have read and fully understood this consent form. I understand the risks associated with the communication of email between Berkeley Endocrine Clinic and me, and consent to the conditions outlines herein. In addition, I agree to the instructions for communicating by email outlined herein, as well as any other instructions that Berkeley Endocrine Clinic may impose to communicate using email.

Patient Signature _____

Patient Name _____

Date _____