WELCOME

Capitol Endocrinology, Inc.
Jaiwant Rangi, MD, FACE
1600 Creekside Drive, Suite 2700 — Folsom, CA 95630
Tel: (530) 677-0700 Fax: (530) 676-7850

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

3 PHONE NUMBERS

Home (_____) _____ Cell (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

ALIVE DECEASED	FATHER ☐ ☐	Present health or cause of death	MOTHER ☐ ☐	Present health or cause of death	SPOUSE ☐ ☐	Present health or cause of death
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**
☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other _____

5 HEALTH HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

6 MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (_____) _____

List allergies to medications or substances _____

_____

7 HEALTH HABITS

Check (✓) which you use and how much:

- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check (✓) if your work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

Your occupation _____

8 SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

CAPITOL ENDOCRINOLOGY INC

1600 Creekside Drive, Suite 2700 Folsom, CA 95630
Phone: (530) 677-0700 Fax: (530) 676-7850
www.capitolendo.com

FORM #3: AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO CAPITOL ENDOCRINOLOGY INC.

Patient's Name:		Date of Birth:	
Previous Name:		Social Security #:	
I request and authorize (Primary care doctor or referring physician)			
To release healthcare information of the patient named above to:			
Capitol Endocrinology Inc. 1600 Creekside Drive, Suite 2700 Folsom, CA 95630 Phone: (530) 677-0700, Fax: (530) 676-7850			
This request and authorization applies to:			
☐	All healthcare information		
☐	Healthcare information relating to the following treatment, condition, or dates:		
SIGN IN THE SPACE BELOW			
Patient Signature:		**Date Signed:**	
THIS AUTHORIZATION EXPIRES 12 MONTHS AFTER IT IS SIGNED			

- **UPON COMPLETION OF THIS FORM, IF POSSIBLE, PLEASE FAX TO (530) 676-7850.**
- **IF YOU ARE UNABLE TO FAX PRIOR TO YOUR VISIT, PLEASE COME 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME AND BRING THIS TO THE FRONT DESK. THANKS!**

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION FROM

CAPITOL ENDOCRINOLOGY INC., TO FAMILY MEMBERS

Patient's Name:			
Date of Birth			
I authorize the Capitol Endocrinology Inc. to release medical and billing information, either in person, over the phone, or in writing, to the following people:			
Name:		Name:	
Home Phone #:		Home Phone #:	
I understand that the person(s) that I have named above to receive private health information may be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect it			
SIGN IN THE SPACE BELOW			
Patient Signature:		**Date Signed:**	
THIS AUTHORIZATION EXPIRES 5 YEARS AFTER IT IS SIGNED			

CANCELLATION AND MISSED APPOINTMENT POLICY

Our practice philosophy is to provide comprehensive patient care by reserving dedicated blocks of time for each patient. Therefore, if you are not able to keep your appointment, we request that you **call as soon as possible** to let us know. This will allow us to provide more timely care to other patients who could be scheduled into your reserved time slot.

At least 24 hours notice is required for the cancellation of all appointments. A $25 charge will be added to your account if 24 hours notice is not received prior to a missed appointment. Insurance will not pay for this charge.

We reserve the right to end the physician-patient relationship in the case of a missed initial or multiple follow-up appointments.

FINANCIAL POLICY

As a courtesy to its patients, Capitol Endocrinology Inc. will file insurance claims upon the receipt of a current insurance card. If coverage is denied, you will be billed and payment in full is due upon the receipt of the bill. You will also be responsible for all co-payments (co-pays) at the time of the visit, as well as deductibles and balances due following insurance payments.

It is your responsibility, with the help of Capitol Endocrinology Inc., to ensure that all referrals and authorizations are obtained prior to receiving medical care. If the referral/authorization is not obtained and your claim is denied, you will be responsible for the balance.

In the event that your account, following insurance payments and the normal billing cycle of Capitol Endocrinology Inc., is not paid in full within thirty days from the date of service, you will be responsible for any additional special handling fees should your account fall into past due status.

Past due amounts that are **greater than 90 days overdue are subject to being turned over to a collection agency**. You are strongly encouraged to pay all past due amounts promptly or set up a payment plan with us.

There is a **$25.00 charge for returned checks**. If two (2) checks are returned, you will no longer be able to write checks in our office. Payments must then be made either by cash, credit card, money order, or certified check.

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INSURANCE AUTHORIZATION

You authorize any holder of medical or other information about you to be released to the insurance payor or other secondary insurance, as listed in your file, any information needed for the insurance claim(s). You permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to you or to Capitol Endocrinology Inc., who accepts assignment.

SIGN IN THE SPACE BELOW		
Patient Name (printed):		
Patient Signature:	x	**Date Signed:**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices (NOPP) provides information about how we may use and disclose personal health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have reviewed a copy of the Capitol Endocrinology Inc. Notice of Privacy

Practices. I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Capitol Endocrinology Inc., if I do not understand any information contained in the Notice of Privacy Practices.

Patient's Printed Name	
Patient's Signature	x
(if applicable) Patient's Personal Representative & Relationship	
(if applicable) Patient's Personal Representative's Signature	
Date	

The following section is for use by Capitol Endocrinology Inc., personnel if unable to obtain a written acknowledgement of receipt of the NOPP from the patient.

I have made a good faith effort to obtain a written acknowledgement of receipt of the Capitol Endocrinology Inc's Notice of Privacy Practices from the above named patient, but was unable to for the following reason(s):

- ☐ Language Barrier
- ☐ Patient Cannot Read
- ☐ Patient Objects
- ☐ Read Later and Return
- ☐ Unable to Sign
- ☐ Other:

Employee Name and Date: _____

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Notice of Privacy Practices (Keep for your records)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, please contact our privacy office at the address or phone number at the bottom of this notice.

Who will follow this notice?

Capitol Endocrinology Inc., provides health care to our patients in partnership with other health care professionals. The information privacy practices in this notice will be followed by:

• Any healthcare professionals who treat you at any of our locations.

• All employees, medical staff, trainees, students, or volunteers of the entities listed above.

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by any of the separate facilities and providers described above. We are required by law to:

• Keep medical information about you private;

• Give you this notice of our legal duties and privacy practices with respect to medical information about you;

• Follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you:

• We may use and disclose medical information about you without your prior authorization for treatment (such as sending medical information about you to another healthcare provider or specialist as part of a referral) (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment (such as sending billing information to your insurance company or Medicare); and to support our healthcare operations (such as comparing patient data to improve treatment methods or for professional education purposes) (Note: only limited psychiatric or HIV information may be disclosed for billing purposes without your authorization). If you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures other than emergencies).

• Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you.

• We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you, without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal process.

• Under certain circumstances, we may use and disclose health information about you for research purposes, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protections.

• If admitted as an inpatient, unless you tell us otherwise, we will list in the patient directory your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation, and may release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to clergy members, even if they do not ask for you by name.

• We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information:

• In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Right to Access and or Amend Your Records:

• In most cases, you have the right to look at or get a paper or electronic copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

• If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:

• You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions.

•To request this list of disclosures, indicate the relevant period, which must be after November 1, 2008. You must submit your request in writing to the Privacy Office listed below.
• You will be notified within 30 days in the event of a breach of the privacy or security of a your protected health information.

Right to Request Restrictions:

• You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. Furthermore, if treatment is paid fully out of pocket, you may restrict disclosure of this information to your insurer. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. We will inform you of our decision on your request. All written requests or appeals should be submitted to the Privacy Office listed below.

Requests for Confidential Communications:

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Right to request a paper copy of this Notice:

You may receive a paper copy of this Notice from us upon request.

Changes to this Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas. You can receive a copy of the current notice at any time. The effective date is listed at the end. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:
• If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact the Privacy Office listed below.
• If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Privacy Office
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