Monroe Rheumatology and Endocrinology

Office Policies - Read Carefully

- **NEW PATIENT PAPERWORK -** needs to be turned in before we schedule your appointment.
- **PERTINENT LABS/RECORDS -** are needed before scheduling in order to make your first visit go smoothly.
- **SCHEDULING -** new patients are only allowed a ONE time reschedule if notified over 48 business hours. New patient appointments which are canceled less than 48 hours or no show WILL NOT BE RESCHEDULED.
- **APPOINTMENTS** - reminder text message, email and phone calls will be sent at least 48 hours prior. This is just a courtesy call. It is the patient's responsibility to remember their appointment. 24 hour notice is required when canceling an appointment. A **NO SHOW** fee of $50 will be charged if you fail to notify the office. There is a 15 minute grace period before appointments are canceled.
- **LABORATORY/IMAGING TESTING** - prescriptions are given for blood work or imaging testing and it is required to be done prior to your visit. If you fail to have your tests done, your office visit will be canceled and will be rescheduled at the next available time. It is the patient's responsibility to make sure the test results are faxed over to our office. Test results will be discussed at the time of the next visit.
- **INSURANCE** - copays are to be collected prior to your visit with the doctor. This applies to both in person and televisits. If you have a new insurance plan, it is your responsibility to update the office 72 hours prior to your appointment.
- **PRIOR AUTHORIZATIONS** - certain medications, lab testing and imaging studies require prior authorization. It usually takes 1-2 weeks turnaround time depending on the insurance companies.
- **REFERRALS** - if required, it is the patient's responsibility to obtain one when needed. Referrals should be obtained from your primary care physicians office.
- **PRESCRIPTIONS** - refills must be called in 48-72 business hours prior to when needed. Please plan accordingly. Prescriptions will be refilled during office hours and not on weekends/holidays as reviewing the chart is required. If appointments are not kept, then a 1 month will only be refilled and no future refills will be given unless the patient is seen.

Monroe Rheumatology and Endocrinology

- **MEDICAL RECORDS** - when requested, must give a 72 hour notice to the office staff. Copies under 20 pages must be picked up at the office and sign the release form. We do not mail out medical records. Any records over 20 pages will require a charge of $1 per page. Patients transferring to another physician will need to have the new physician send us a Records Request Form and should give the office 7 days to process this.

- **COMMUNICATION** - please use the patient portal for communication. Do not use the admin email. Please limit calls to the office as we are with patients most of the day and can better respond to portal messages.

- **AFTER HOUR CALLS** - this includes weekends are only for emergencies. Scheduling/refills or other issues will only be addressed during business hours. After hour calls may require a telemedicine appointment which may apply to your copay/deductible.

- **STAFF** - please note they are working hard and covering multiple tasks at any given time. DO NOT CALL REPEATEDLY. We have a busy clinic. ANY TASK CAN TAKE UP TO 3 BUSINESS DAYS.

- **RUDE BEHAVIOR** - please note that rude behavior of any kind is not acceptable and is grounds for dismissal from the practice. We value our employees. We value our patients. We expect mutually respectful communication. NO EXCEPTIONS.

- **COMPLIANCE** - all patients are expected to be compliant with their medications and follow up appointments. If patients are not compliant, they will be dismissed from our practice.

Patient Signature _____

Date _____

Monroe Rheumatology and Endocrinology

Nisheet Prasad MD, Shilpi Singh MD, MPH

PATIENT DEMOGRAPHIC INFORMATION SHEET

(PLEASE PRINT CLEARLY)

Name: _____ Social Security #: ____-____-_____
(Last) (First) (Middle Initial)

Address: _____ Apt. # _____

City: _____ State _____ Zip _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____- _____

Cell Phone: (_____)_____-_____ Email Address: _____

Date of Birth: _____ Sex: (M / F) Marital Status : (S / M / W / D)

In Case of Emergency Contact: _____ Phone: (_____)_____- _____

Purpose of visit or Diagnosis: _____

Referring Physician's Name: _____ Phone (_____)_____-_____

Primary Care Physician: _____ Phone (_____) _____-_____ Pharmacy:

_____ Phone (_____)_____- _____

Employer Name: _____

PRIMARY INSURANCE

Ins. Co. Name:_____

Policy #: _____ Group # _____

Relationship to Patient: _____ ___

Insured Name : _____ ___

Insured Date of Birth: _____ M / F

Insured SS#: _____-_____-_____ ___

SECONDARY INSURANCE

Ins. Co. Name: _____

Policy #: _____ Group # _____

Relation to Patient: _____

Insured Name : _____

Insured Date of Birth: _____ M / F

Insured SS#: _____-_____-_____

To protect patient confidentiality, we will only disclose your medical information as you instruct us to. Please answer the following:

May we leave message on your answering machine with the appointment time?_____Yes _____ No

May we leave messages on the answering machine about medication changes? _____ Yes _____ No

May we call you at work? _____ Yes _____ No

What family member may we discuss your medical condition with?

Name: _____ Relation: _____

Name: _____ Relation: _____

I have read the Office Policies: _____

(Sign)

I hereby authorize my insurance company benefits to be paid directly to **Monroe Rheumatology and Endocrinology LLC.** I realize I am responsible to pay any non-covered services, co-payment and co-insurance. I hereby authorize the release of pertinent medical information to the insurance company. I also realize that if my insurance plan requires a referral, I am responsible to have a valid referral at every office visit. If for any reason my insurance does not cover services rendered, I am responsible for payment in a timely manner.

_____

(Signature)

Revised 10/1/2017

Monroe Rheumatology and Endocrinology

PATIENT HISTORY FORM

Date: ____/____/____

Name: _____ Birthdate: ____/____/____

Last First M.I.

Briefly describe your present symptoms:

Preferred Pharmacy:

Preferred Lab:

Preferred Imaging Facility:

Current Medication

Drug Allergies: __no __yes To what? _____

Please list any medication that you are now taking. Include non-prescription medication & vitamins or supplements :

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Social history :

Occupation:_____

Smoking status:_____

Smoking(how much):_____

Tobacco years of use:_____

Former smoker quit time:_____

Illicit Drug Use:_____

What is your alcohol intake: __None __Occasional __Moderate __Heavy

PAST MEDICAL HISTORY:

Do you now or have you ever had:

__ Anemia
__ Ankylosing Spondylitis
__ Anxiety Disorder
__ Back Problems
__ Bladder or Kidney Problems
__ Blood Clot
__ Cancer (type:_____
__ Coronary Artery Disease
__ Crohn's Disease
__ Depression
__ Diabetes
__ Fibromyalgia
__ Gout
__ Heart Disease
__ Hepatitis
__ High Cholesterol
__ Hyperlipidemia
__ Hypertension
__ Hyperthyroidism
__ Hypothyroidism
__ Inflammatory Bowel Disease
__ Kidney Disease
__ Lung Disease
__ Lupus
__ Muscle/Joint/Bone Problems
__ Osteoporosis
__ PCOS
__ Pituitary Disorder
__ Psoriasis
__ Rheumatic Fever
__ Sjogren's Syndrome
__ Skin Problems
__ Thyroid Disease
__ Tuberculosis

Other medical conditions (please list):

_____

Surgical History:(please list starting with the most recent:)

- _____
- _____
- _____
- _____
- _____
- _____
- _____

FAMILY HISTORY: (PLEASE LIST IF ANY MEDICAL CONDITIONS RUN IN YOUR FAMILY):

Condition : Relationship to you:

- _____ - _____
- _____ - _____
- _____ - _____
- _____ - _____
- _____ - _____

Monroe Rheumatology and Endocrinology

Statement of Patient Financial Responsibility

Patient Name: _____ **DOB:** _____

Monroe Rheumatology and Endocrinology LLC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Monroe Rheumatology and Endocrinology LLC, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Monroe Rheumatology and Endocrinology LLC, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Cancellation / No Show Policy

We try to remind all of our patients of appointment at least 1 day prior. This is just a courtesy call. It is ultimately the patient's responsibility to remember their appointment. 24-hour notice is required when cancelling an appointment. A "NO SHOW" fee of $50 will be charged if you fail to notify the office. Your appointment will be rescheduled on the next available time.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

The Practice will notify you in writing via mail or via electronic methods of communication, if you are discharged from care.

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Monroe Rheumatology and Endocrinology LLC. I agree to pay Monroe Rheumatology and Endocrinology LLC, the full and entire amount of treatment given to me or to the above named patient at each visit.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Monroe Rheumatology and Endocrinology LLC

Consent for Treatment and Authorization to Release Information
HIPAA Acknowledgement

I hereby authorize Monroe Rheumatology and Endocrinology LLC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Monroe Rheumatology and Endocrinology LLC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

I, _____, acknowledge that I have received and reviewed the notice of Privacy practices of Monroe Rheumatology and Endocrinology, LLC and HIPAA regulations.

Patient Signature _____ Date _____

Monroe Rheumatology and Endocrinology

Nisheet Prasad MD, Shilpi Singh MD, MPH

REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby request that my records be released and sent to:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I hereby request that my records be released from:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Patient requesting transfer:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Dates of treatment: _____

Patient's Date of Birth: _____

_____ _____

Patient's Signature Date