Today's Date: ______________

Dear ____,

Thank you for selecting Evron Endocrinology Associates as your endocrinologist. We would like to take this opportunity to welcome you to our practice. Together with our staff, we are committed to providing you with the highest quality of care.

Your first office visit is scheduled for ________________________________ at ___________ **AM / PM**

To ensure that you have a meaningful first visit with our practice, we ask that you please:

PRIOR TO YOUR VISIT

- **Complete and return ALL of the enclosed forms to the office.** You may return the completed forms by mail, fax, or bringing them with you to your scheduled appointment. The forms included in this packet are:
  - **New Patient Registration** (1 page)
  - **St. Clair Medical Group Policies & HIPAA** (1 page)
  - **Medical History Form** (4 pages)
  - **Authorization for Use or Disclosure of Protected Health Information*** (2 pages)
    - **To have your previous primary care provider / endocrinologist release your health records to our office, please fax / mail / hand-deliver a completed "Authorization for Use or Disclosure of Protected Health Information" to your previous primary care provider office.*
    - *Please ask the office to include the following:*
      - *Demographic Sheet*
      - *Two most recent office notes*
      - *List of ALL medications and allergies*
      - *Two most recent lab work results*
      - *As Applicable: Most recent report of thyroid ultrasound, adrenal CT, or Pituitary CT/ MRI with pathology*

DAY OF YOUR VISIT

- Arrive **20 minutes early** to your scheduled appointment time.
- Bring a list of **ALL the medications/supplements** that you are currently taking (including over-the-counter).
- Bring the results of **ALL the recent testing and/or blood work** you have completed.
- Bring a **valid photo ID** and **medical insurance card**(s) to your appointment.
  - *Please call your insurance company to verify that Evron Endocrinology Associates will be covered under your specific insurance plan.*

Our office is located at 2000 Oxford Drive, Suite 405 Bethel Park, PA 15102. Our office phone number is 412-942-7295 and our fax number is 412-942-7287. We look forward to seeing you in the office. If you have any questions, please do not hesitate to call. Our staff will be happy to assist you.

Sincerely,

Evron Endocrinology Associates

St. Clair Health

St. Clair Medical Group

Today's Date: __________

New Patient Registration Form

Patient Demographic Information

Full Legal Name: ____
Last | First | Middle

Date of Birth: ____________________ **Sex:** ☐ Male ☐ Female ☐ Other ____________________
MM / DD / YYYY | *Please Specify*

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Please Address As: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Race/Ethnicity: ☐ AmerIndian/Alaskan ☐ Asian ☐ Black/AfricanAmer ☐ Hawaii/PacificIsland ☐ Hispanic/Latino ☐ Not Disclosed ☐ Unknown ☐ White

Address: ____
STREET | APT #

____
CITY | STATE | ZIP CODE

Phone Number: ____
Please circle preferred: HOME | CELL | WORK

Email Address: ____

Employment: ☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Student Full-Time ☐ Student Part-Time

Employer: ______________________________ **Occupation:** ______________________________

Emergency Contact: ____
Name | Relation | Phone Number

If Minor, Parent / Guardian: ____
Name | Relation | Phone Number

Primary Insurance	Secondary Insurance (If applicable)
Insurance Company: ______________________	**Insurance Company:** ______________________
Policy Holder Name ______________________	Policy Holder Name ______________________
ID# ____________ Group # ____________	ID# ____________ Group # ____________
Address ______________________	Address ______________________
Phone # ______________________	Phone # ______________________
DOB ____________ SS# [optional] ____________	DOB ____________ SS# [optional] ____________
Relationship to Patient ______________________	Relationship to Patient ______________________

Workers Compensation/Auto (if applicable)

Name of Insurance Company ____________________ Phone # ____________________ Fax # ____________________

Claim # ____________________ Date of Injury ____________________ SS# [optional] ____________________

Billing Address ____

Adjuster Name ____________________ Phone # ____________________

Employer Contact ____________________ Phone # ____________________

St. Clair Health

St. Clair Medical Group

ASSIGNMENT OF BENEFITS: I hereby assign all medical/surgical benefits to which I am entitled including major medical, Medicare, private insurance or other heal th plan benefits to the St. Clair Medical Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

MEDICARE: I request that Medicare benefits be made on my behalf to St. Clair Medical Group for healthcare services furnished. I authorize any holder of medical information about me to release to HCFA and its agent any information needed to determine these benefits or the benefits payable for related services; I understand that my signature authorizes the release of medical information needed to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physicians agree to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and any non covered services. Co-insurance and deductible amounts are based upon the charge determination of the Medicare carrier.

____ Signature of Patient or if a minor, Responsible Party

____________________________ Date

St. Clair Health
St. Clair Medical Group

St. Clair Medical Group Policies & HIPAA

*Welcome to **St. Clair Medical Group** and thank you for choosing us as your healthcare provider. We would like to take this opportunity to advise you of our practice policies. These policies help us to provide quality care in an efficient manner. Please do not hesitate to contact our office manager if you have any questions about these policies.*

NOTICE OF PRIVACY PRACTICES

We value our patients' rights to privacy in regard to their health information. Please take a moment to review our Notice of Privacy, which provides a complete description of permitted uses and disclosures of healthcare information.

DISCLOSURE OF HEALTH INFORMATION (HIPAA)

I wish to allow disclosure to the following family members, friends, or individuals. I understand that I may change this list at any time:

NAME	RELATIONSHIP	PHONE NUMBER	DISCLOSURE	LIMITATIONS
			☐ FULL ☐ LIMITED	
			☐ FULL ☐ LIMITED	
			☐ FULL ☐ LIMITED	
			☐ FULL ☐ LIMITED	

In the event that we need to contact you, are we permitted to leave a message on your answering machine? ☐ **Yes** ☐ **No**

In case of an emergency, may we contact an individual listed above *(marked as "full" disclosure)?* ☐ **Yes** ☐ **No**

ST. CLAIR MEDICAL GROUP POLICIES

- You are responsible for notifying us of any changes to your address, personal information, or insurance information.
- **St. Clair Medical Group** is pleased to process your insurance claim for reimbursement. However, please remember that:
  - You must present your insurance card and photo ID at each visit.
  - Your insurance is a contract between you, your employer, and the insurance company. **St Clair Medical Group** is not a party to your health insurance contract.
  - Not all services are covered benefits on all insurance contracts. Some insurance companies have certain services that they will not cover.
- All copayments are to be paid in full at the time of service.
- If you do not have health insurance coverage or do not bring proof of health insurance coverage to each visit, payment in full will be due at the time of your visit.
- We accept payments in the form of cash, personal check, and most major credit cards. However, we **do not accept Care Credit.** If you are in need of financial assistance, please review St. Clair Medical Group policy on https://www.stclair.org/billing-insurance/financial-assistance/
- **St. Clair Medical Group** and/or agencies working on St Clair Medical Service's behalf may need to contact patient or guarantor via land phone line or cell phone regarding balance due for services.
- Out of consideration to our other patients, if you arrive more than 15 minutes late to your appointment, there may be a delay in your visit, or you may be asked to reschedule your appointment.
- Please understand that our appointment times are limited. If you are unable to keep your scheduled appointment please notify us at least **24 hours in advance** to reschedule.
- **St. Clair Medical Group** requests previous medical records so that we may have the best understanding of your medical history.

PATIENT ACKNOWLEDGEMENT

I have read and understand my responsibilities as outlined above. I acknowledge the receipt of the Notice of Privacy Practices.

______________________________ ______________________________ ______________

Patient Name (PRINTED) **Signature of Patient or Responsible Party, if a Minor** **Date**

FOR OFFICE USE ONLY
A good faith effort was used to obtain written acknowledgement of the Notice of Privacy Practices on:
Office Staff Name (PRINTED):______________________ Office Staff Signature ______________________ Date:__________

St. Clair Health
St. Clair Medical Group

Today's Date: __________

Adult Medical History Form

Patient Legal Name: ________________________ **Patient Date of Birth:** ________________

Pharmacy for Prescription Medications: ________________________________

Previous Endocrinologist (if applicable): ________________________________

Primary Care Provider: ________________________________

Reason for visit:

Please describe what brings you into the office today: ________________________________

What medication(s), strength & dose are you currently taking (i.e.—insulin, oral diabetic medication, thyroid medication, etc.):

________________________ ________________________

________________________ ________________________

________________________ ________________________

Did you have any recent testing (i.e.—bloodwork, ultrasound, CT scan etc.): ☐ NO ☐ YES

If **YES**, please answer the following questions:

What type of test(s) did you have? ________________________

Where was the test(s) completed? ________________________

When was/were the test(s) completed? ________________________

For Diabetic Patients ONLY:

What type of Diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Gestational

If Gestational, what is the name of your OB Provider? ________________________

Are you on insulin? ☐ **NO** ☐ **YES**

If **YES**: *What type insulin did you have?* ________________________

What dosage are you on? ________________________

If you use a pump, what type is it? ________________________

Do you use diabetic orthopedic shoes? ☐ **NO** ☐ **YES**

If **YES**: *What type of support to you use?* ________________________

For Patients with Thyroid Disorders ONLY:

What medication are you currently taking? ________________________

What dose are you currently taking? ________________________

Past Medical History: *Please check the boxes of any medical problems that you currently have or had in the past*

- ☐ Cancer
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ COPD / Emphysema
- ☐ Pneumonia
- ☐ Seizure Disorders
- ☐ Ulcers
- ☐ Gastric Reflux / GERD
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Blot Clots (DVT or PE)
- ☐ Bleeding Tendencies
- ☐ Congestive Heart Failure
- ☐ High Cholesterol
- ☐ Peripheral Vascular Disease
- ☐ Hepatitis A / B / C
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fractures
- ☐ Thyroid Disease
- ☐ Immune Disorder
- ☐ Multiple Sclerosis
- ☐ Alcoholism
- ☐ Mental Illness
- ☐ Depression / Anxiety
- ☐ Other: ____

Past Surgical History:

Year	Type of Operation

Medications:

Current Medication	Dose	Frequency	Current Medication	Dose	Frequency

Allergies: *Please list all known allergies and the reactions that you have to each.*

Allergy	What reaction did you have?
☐ No Known Allergies	
☐	
☐	
☐	

Family History: *Please check the illnesses that have occurred in any of your blood relatives & specify which relative(s).*

☐ Diabetes ____________________
☐ Lung Disease_________________
☐ Asthma____________________
☐ Tuberculosis (TB) ______________
☐ Alcoholism___________________
☐ Ulcers_____________________
☐ Hepatitis A/B/C_______________
☐ Gastrointestinal Disease__________
☐ Depression / Anxiety_____________
☐ Liver Disease____________________

☐ Heart Disease____________________
☐ High Blood Pressure_________________
☐ Stroke___________________
☐ Heart Attack_________________
☐ Blot Clots (DVT or PE) ________________
☐ Bleeding Tendencies________________
☐ Congestive Heart Failure______________
☐ High Cholesterol______________
☐ Peripheral Vascular Disease__________
☐ Kidney Disease______________

☐ Cancer ____________________
☐ Osteoporosis______________
☐ Arthritis______________
☐ Seizure______________
☐ Thyroid Disease______________
☐ Immune Disorder_____________
☐ Kidney Disease______________
☐ Mental Illness______________
☐ Other______________

Social History:

What is your work status (please select one)?

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student ☐ Homemaker

What is your occupation? ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Do you have any children? ☐ No ☐ Yes If so, how many? ____

Who lives at home with you? ____

Social History (continued):

Do you currently use tobacco? ☐ No ☐ Yes Did you previously use tobacco? ☐ No ☐ Yes

☐ Cigarettes ____ pack/day ☐ Pipe ☐ Cigar ☐ Chewing Tobacco Number of years _________

Do you use alcohol? ☐ No ☐ Yes If yes, # of drinks _____ Daily _____Weekly _____Monthly

Do you use any street drugs? ☐ No ☐ Yes If yes, describe____

Do you have any history of drug or alcohol abuse? ☐ No ☐ Yes

If yes, describe____

Health Maintenance/Testing:

Test or Vaccine (as applicable)	Approximate Date & Results if Known
Mammogram	
Colonoscopy or other colon cancer screening test	
DEXA (bone density test)	
Pneumovax	
Influenza	

Patient Signature: ____ Date: __________________________

St. Clair Health
St. Clair Medical Group

Today's Date: ______________

Authorization for Use or Disclosure of Protected Health Information

Completion of this document authorizes the disclosure and/or use of your protected health information, as set forth below, consistent with Federal law concerning the privacy of such information. **Both sides must be completed and signature is REQUIRED. Failure to provide *all* information requested may invalidate this Authorization.**

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: ____ **Date of Birth:** ____________
(LAST) (FIRST) (M.I.)

Address:
____
STREET APT #
____
CITY STATE ZIP CODE

Phone Number: ____
Please circle preferred: HOME CELL WORK

Use and Disclosure of Protected Health Information

Evron Endocrinology Associates is authorized to (circle one): **SEND** *OR* **RECEIVE**
Practice Address: **2000 Oxford Drive, Suite 405 Bethel Park, PA 15102** *Phone Number:* **412-942-7295** *Fax Number:* **412-942-7287**

____________________________________ is authorized to (circle one): **SEND** *OR* **RECEIVE**
(PERSON(S) / ORGANIZATION(S))

Practice Address: ____
(STREET) (SUITE #) (CITY) (STATE) (ZIP CODE)

Phone Number: ______________________ *Fax Number:* ______________________

My health information will be used for the following purpose(s): ________________________________

This Authorization applies to the following information (select all applicable):

❑ **ALL** health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: ____

OR

❑ **ONLY** the following records or types of health information:

❑ Inpatient ❑ Outpatient ❑ TCC
❑ Discharge Summary ❑ Imaging Reports ❑ IRU ❑ PT/OT/Speech/Audiology

Treatment Dates: ____

❑ History & Physical ❑ Laboratory Reports ❑ Operative Reports ❑ Emergency Department Record
❑ Consultations ❑ Transfer Abstract ❑ Transfer Abstract ❑ Pathology Reports
❑ Surgical Slides and/or Tissue

❑ Drug or alcohol abuse, Drug or alcohol dependence, Drug or alcohol related conditions
❑ HIV testing, HIV diagnosis, HIV related illness, AIDS diagnosis, AIDS related illness, and Sexual preference/contacts
❑ Mental health, Psychiatric condition/care, Psychological conditions/care, Behavioral health services
❑ Specific Exclusions: ____

NOTE: If you want to authorize a use or disclosure of psychotherapy notes, a separate authorization form must be completed. This information has been disclosed to you from records protected by Pennsylvania Law.

NOTE: If this Authorization is for marketing purposes, please note the following: The organization authorized to use or disclose my protected health information ❑ will or ❑ will not receive direct or indirect compensation for the use or disclosure of my information.

Expiration of Use and Disclosure of Protected Health Information

This Authorization expires **[insert date or event]** if less than ninety days:____

Patient Rights Regarding Protected Health Information

I understand that I may refuse to sign this Authorization.

I may revoke this authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to the following address: **Evron Endocrinology Associates 2000 Oxford Drive, Suite 405, Bethel Park, PA 15102**

My revocation will be effective upon receipt, but will not be effective to the extent that St. Clair Hospital, its affiliates, and/or others have acted in reliance upon this Authorization.

I understand that I have the right to receive a copy of this Authorization.

I understand that a fee may be assessed to process this request.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on me providing or refusing to provide this authorization.

Patient / Patient Representative Signature

Date: ____________________________ **Time:** ___________________________________ AM / PM

Signature: ____

(Patient or Representative)

If signed by someone other than the patient, please state your legal relationship to the patient: ________________________________

❑ ***Verbal response given (patient physically unable to give written consent)***

A verbal consent requires two (2) witness signatures. I witness that the patient (or responsible party) is definitely unable to provide a signature at this time but understands the nature of the release and freely gives his/her consent.

____ _______/_______/________

Witness Date

____ _______/_______/________

Witness Date