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BOYNTON BEACH ENDOCRINOLOGY, P.A.
10150 HAGEN RANCH RD STE 201
BOYNTON BEACH, FL 33437

Michael J. Mellman, M.D.
Diplomat American Board
of Endocrinology & Metabolism

PATIENT INFORMATION (PLEASE USE YOUR LEGAL NAME)

Last Name:	First:	MI:	Date of Birth: _____/______/__________

Email Address:

Mailing Address:

____
Street City State Zip Code

Home (Primary) Phone: ( )	Cell Phone: ( )	Social Security Number (SSN): - -
Employer:	**Work Number:** ( )	**Emergency Contact:** **Phone:** **Relationship:**

(Please Circle)

Sex: Male / Female / Transgender
Marital Status: Single / Married / Divorced / Widowed
Race: Black / White / Hispanic / Asian / Other ________________
Ethnicity: Hispanic / Non - Hispanic
Language: English / Spanish / Creole / Other ________________

INSURANCE INFORMATION

Primary Insurance Name:	Policy Number:	Group Number:

*****IF SUBSCRIBER IS DIFFERENT FROM PATIENT:**

Subscriber's Name:	Relationship to subscriber:
Date of Birth:	Spouse / Child

Secondary Insurance Name:	Policy Number:	Group Number:

*****IF SUBSCRIBER IS DIFFERENT FROM PATIENT:**

Subscriber's Name:	Relationship to subscriber:
Date of Birth:	Spouse / Child

The above information is true best to my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize BOYNTON BEACH ENDOCRINOLOGY, P.A. or insurance company to release any information required to process my claims.

Patient/Guardian Signature:______________________________ **Date:**________________

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Name: ____________________ DOB: ____/____/______

Primary Care Physician (PCP)
Name: ____________________ Telephone: ________________

Referring Physician
Name: ____________________ Telephone: ________________

PLEASE LIST OTHER MEDICAL DOCTORS YOU SEE AND THEIR SPECIALTY:

____

____

Family History

(Check all that apply)

	SELF	MOTHER	FATHER	BROTHER	SISTER
Heart Disease					
Diabetes					
Hypertension					
Thyroid Disease					
Cancer					
Seizure Disorder					
Ulcer Disease					
Arthritis					
Headache					
Anxiety					
Depression					
Asthma					
Low Testosterone					
Pituitary Disease					
Elevated Blood					
Alive	---				
Deceased	---				
Cause of Death	---				

List any medications you are allergic to (if applicable):

____

List all surgeries you've had in the past:

____

Do you smoke? Y ☐ N ☐ **If yes, how much** ____________________

Do you drink alcohol? Y ☐ N ☐ **If yes, how much** ____________________

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BOYNTON BEACH ENDOCRINOLOGY, P.A.

Date: ____________________________ Name: ____

Height: ______________

Pharmacy (name and phone #):____

Please ***circle*** **symptoms you are having:**

fatigue insomnia anxiety/feeling jittery tremors palpitations

shortness of breath chest pain leg swelling muscle cramps joint aches

back pain muscle weakness abdominal pain heartburn diarrhea

constipation hot flashes irregular menses increased thirst/urination

weight gain weight loss tingling/numbness burning pains

other____

SECTION BELOW ONLY FOR DIABETIC PATIENTS:

How often do you check your blood sugars? _________________

What brand of glucose meter do you have? ____________________________

How often do you have blood sugars under 70? ________________________

How often do you exercise? _________________________________

What kind of exercise? ____

What kind of diet do you follow? _______________________________________

Please give an estimate of your blood sugars at the following times:

Before breakfast:__________________ Before lunch:____________________

Before dinner:____________________ At bedtime:_____________________

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Name:___________________________________ DOB:___________________

DIABETIC PATIENTS ANSWER BELOW:

1. When were you diagnosed with diabetes? ________________________________
2. Any medication changed in the past 30 days? Yes ☐ No ☐

   If yes, explain _______________________________________
3. Date of last eye examination __________________________
4. Any history of any of the following?

   Please check all that apply:

   Retinopathy (retinal bleeding) ☐

   Neuropathy (burning/tingling/numbness to feet) ☐

   Kidney Disease ☐

   Amputation ☐
5. Have you completed a 24-hour urine collection recently? Yes ☐ No ☐

   If yes: Date: _____________ Ordering Physician: _____________________

THYROID PATIENTS ANSWER BELOW:

1. When were you diagnosed with your thyroid condition? ________________________
2. Have you ever had any of the following?

   A). 131 therapy No ☐ Yes ☐ Date:____________

   (a radioactive pill ingested to slow down the thyroid function)

   B). A thyroid ultrasound No ☐ Yes ☐ Date:____________

   C). Thyroid uptake and scan No ☐ Yes ☐ Date:____________
3. Have you changed your thyroid medication (brand or dosage) in the past 2 months?

   If yes, explain _____________________________________

HYPOGONADISM PATIENTS ANSWER BELOW:

1. Have you had an MRI of the brain/pituitary? No ☐ Yes ☐ Date:_________
2. Have you ever used any testosterone replacement?

   No ☐ Yes ☐ Name: _________________________
3. If you currently take testosterone injections:

   Date of last injection: _________________ Dose injected: ________________

CURRENT MEDICATION LIST

Name of Medication	Strength	How many tabs/caps do you take?	Frequency

STATEMENT OF FINANCIAL RESPONSIBILITY

The service you have elected to participate in implies financial responsibility on your part. The responsibility obligates you to ensure payment in full of our services. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of services and care received from the physicians of Boynton Beach Endocrinology, P.A.

Co-payment Policy

1. All co-payments, co-insurances, and deductibles are due and payable at the time of visit and are required by your insurance to be paid at each visit before you are seen by the physician.

Returned Checks Policy

2. There is a $25.00 service charge on all returned checks. After receiving a returned check from the patient, Boynton Beach Endocrinology, P.A. will then only accept credit card, money order, or cash.

Cancellation/No Show Policy

3. While understanding there may be times when you miss an appointment due to emergencies or obligations, Boynton Beach Endocrinology, P.A. requires at least 24 hours notice on all cancelled appointments. Our office charges a fee of $25.00 for appointments not cancelled or rescheduled 24 hours in advance. We withhold the right to rescind the cancellation/no show fees on a case-by-case basis.
4. Cancellation/no show fee must be paid prior to your next appointment.

Referrals

5. Many HMO insurance policies require that the patient obtain a referral from their primary care physician (PCP) prior to seeing a specialist. It is the patient's responsibility to know if his or her insurance requires referral and to obtain it prior to the visit. Patients who wish to be seen without a referral may choose to do so and take full responsibility for charges incurred.

I have read and understand Boynton Beach Endocrinology, P.A.'s statement of Patient Financial Responsibility. I agree to assign insurance benefits to Boynton Beach Endocrinology, P.A. whenever necessary. I authorize Boynton Beach Endocrinology, P.A. to release information to a collection agency or attorney. In the event of nonpayment or default, I am responsible for all cost and reasonable collection and/or attorney fees. Boynton Beach Endocrinology, P.A. reserves the right to change or amend this statement at any time and at its discretion.

Signature of responsible party Printed name of signer

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HIPAA CONSENT

CONSENT TO THE USE AND DICLOSURE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name______________________________________ **Date of Birth**_____/_________/_____________

Phone Number (_________) - ______________________ **Last 4 of SSN** _______________

I request that health information regarding my care and treatment be released as set forth on this form: This protected health information is being used or disclosed to carry out treatment, payment, and/or healthcare operations of Boynton Beach Endocrinology, P.A.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Boynton Beach Endocrinology, P.A. will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:
Inspect or copy the protected health information to be used or disclosed as permitted under federal law and state law to the extent the state law provides greater access rights.

I have signed the consent for Boynton Beach Endocrinology, P.A. and have been made aware of the practices "Notice of Privacy Policies."

I understand that I have the right to revoke this authorization in writing at anytime by sending such written notification to Boynton Beach Endocrinology, P.A. at 10150 Hagen Ranch Rd, Suite 201 Boynton Beach, FL 33437.

The use or disclosure requested under this authorization could result in direct or indirect remuneration to Boynton Beach Endocrinology, P.A. from a third party.

I hereby authorize Boynton Beach Endocrinology, P.A. to disclose my protected health information to the following individuals:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

I authorize Boynton Beach Endocrinology, P.A. to leave messages on my voicemail:

☐ **Appointments only** ☐ **Appointments and other detailed messages** (i.e. lab/test results, other health/billing concerns)

____ ______________________________

Signature of Patient or Personal Representative **Date**

*****If someone other than the patient is signing, please print name and describe authority below:**

____ ____

Name **Description**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ **Individual refused to sign** ☐ **Communication barriers** ☐ **Prevented by an emergency situation**