Sierra Endocrine Associates

Endocrinology, Diabetology & Metabolism

Joseph B. Hawkins, Jr., MD, FACE, CDE
Chhaya Makhija, MD

Charles Morales, MSN, NP, CDE
Theresa Flemming, MSN, NP, CDE
Diana Alexis, MSN, NP,CDE

Patient Name: _____ Provider: _____

Consultation Date: _____ Arrival Time: _____

Next 2 week Appointment: _____ Arrival Time: _____

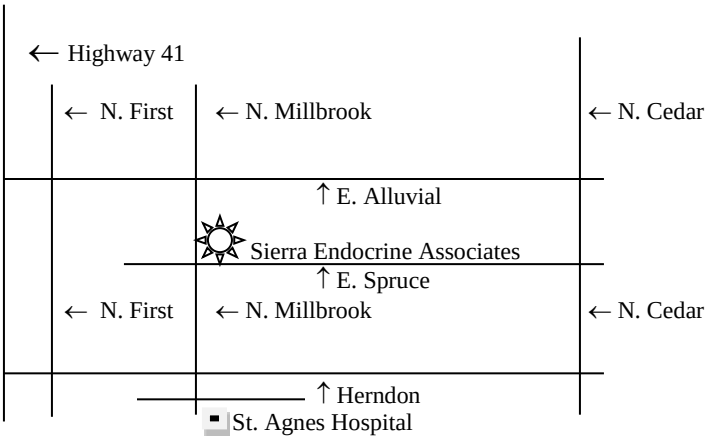
Thank you for choosing Sierra Endocrine Associates as your specialty endocrine provider. Enclosed is your new patient packet. **Please complete all paperwork and bring it with you at the time of your first appointment.** We will also need a copy of your identification and valid insurance cards. If you are seen for diabetes, please bring your glucose meter to every appointment.

Co-payments and deductibles are due at the time of service and may be different for a specialist. Please make sure you know your co-pay amount for a specialty office visit. **Additionally, please be aware that we are not contracted with any HMO insurance plans**.

Our normal office hours are Monday through Friday from 8:00am to 5:00pm. For your convenience, our onsite laboratory hours are Monday through Friday 6:30am to 5:00pm.

Our office is located on the northeast corner of N. Millbrook and E. Spruce, from Herndon, turn north onto N. Millbrook. Sierra Endocrine Associates is at the first intersection.

Map to our office:



If you have any questions, please feel free to call. We look forward to serving you.

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559-431-6197

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Office Policies

Thank you for choosing Sierra Endocrine as your Endocrinology Specialist. We will strive to provide you the most excellent medical care and customer service. The following are policies we have implemented that will assist us in achieving excellent medical care and customer service. Please read and initial where indicated.

New patients please arrive 15 minutes before your appointment time with your completed new patient packet in hand. You must have a valid insurance card and current identification at the time of the first visit as required by law and you will be asked to bring this to each appointment and lab services.

Prescription refills: New prescriptions, prescription changes, and samples are available to you during your scheduled visit. Between visit refill requests should be made directly to your pharmacy allowing 72 business hours for prescription refills. Please request your refills well in advance and do not rely upon samples for your medication needs. _____*patient initials.*

Laboratory: Patients **are expected to utilize Sierra Endocrine's full research laboratory onsite** to ensure lab results are current, correct, and available *at your next scheduled visit.* Lab results are not released by staff members over the phone prior to the next appointment. _____*patient initials.*

Cancellation policy: Our office has a policy of charging a rescheduling fee when a scheduled appointment is missed without a 24 hour notice. If you do not give us a 24 hour notice, that time slot is lost. Patients who need an urgent visit are being forced to wait longer than necessary.

The rescheduling fee for consultations is $150.00 and will be due before another appointment is given. Rescheduling fee for follow up visits is $50.00. After 2 missed appointments you may be considered for discharge from the practice. _____*patient initials.*

Medical records: If another practitioner is requesting your records, they can be sent electronically, faxed, or mailed at no charge to you. Otherwise, to obtain a copy of your medical records, a fee per page is paid on request, and may take up to two weeks. The patient must sign a medical release, and their records can be picked up at the office. Upon request they may be mailed Certified/Return Receipt for an additional $6.00. _____ *patient initials.*

Financial Contract

Insurance copays are due at the time of service: Sierra Endocrine is a specialty practice, which is required by some insurance to collect a higher copay. **All payments for copays and outstanding balances are expected at the time of lab services and office visits.** We accept cash, checks, and all major credit cards for your convenience. There is a $35.00 service charge for a returned check. Insurances are billed as a courtesy and the patient has financial responsibility for **payment in full for service rendered.** _____*patient initials*.

Non-covered services: It is the patient's responsibility to know their plan benefits. All charges not covered, excluded or denied by your insurance carrier as "not medically necessary" are patient responsibility regardless of your contractual insurance and payments will be immediately due upon receipt of denial. _____*patients initials*.

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We do not accept HMOs of any kind: If you are going to change insurance providers, please verify that it is not an HMO plan. If you present with an HMO card, you will be required to pay cash for your visit at the time of your appointment. HMO insured patients may arrange to be seen on a cash-pay basis. _____*patient initials.*

Preauthorizations: Pre-authorizations for specific services are the responsibility of the patient and notification to the patient is provided in writing directly from the insurance company to their patient. If services are provided in good faith and denied due to lack of preauthorization, the patient is responsible for all services rendered regardless of contractual status. _____*patient initials*.

Cash Pay and Out of Network Patients: Prior to scheduling a non-refundable $100 deposit will be applied toward your account. If the new patient visit is cancelled or "no-showed" without 24-hour advance notice the deposit is forfeited. _____*patient initials*.

Past Due Accounts: Account balances unpaid more than 60 days will result in the prevention of scheduling any future non-emergent appointments until the account is paid in full or brought to current status. Accounts remaining unpaid for more than 90 days will be sent to collections and may result in dismissal from the practice. Accounts referred to collections are to **direct all account inquiries to the collection agency and not to the practice.** Patient/guarantors will be responsible for any additional fees assessed, accrued interest and legal fees resulting from collection activities._____ *patient initials*.

Medicare beneficiaries: I request that payment of any authorized Medicare benefits be made on my behalf. I assign the benefits payable to Joseph B. Hawkins Jr. MD, Inc. DBA Sierra Endocrine Associates and/or its providers. **I further agree to immediate payment of all deductibles, copays, and services specifically not covered when I am notified with an Advanced Beneficiary Notification (ABN).**_____*patient initials*.

Financial Agreement: We will gladly discuss any questions relating to your account, however, we must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. Not all services are covered benefits in all insurance contract plans and some carriers will have treatment exclusions. **ALL CHARGES INCLUDING PLAN EXCLUSIONS ARE THE PATIENT RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** We realize that emergencies do arise that may affect timely payment of your account. If such extreme cases do occur, we encourage you to contact our billing department right away to avoid allowing your balance to interfere with your ongoing care._____ *patient initials*.

Code of Conduct Policy

Our practice believes in mutual respect to and from our patients, therefore we have enforced a **Zero Tolerance Policy against any verbal or physical abuse to our providers and/or to our staff members.** Any form of such abuse or violence either in person or by telephone will result in immediate dismissal from the practice. _____*patient initials*.

_____ _____ _____

Patient or Guarantor Signature | Print Patient Name | Date

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Patient Demographics

First Name: _____ **Initial:** ___ **Last Name:** _____

Birth Date: _____ **Gender:** *Male Female* **Marital status:** *S M D W*

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **ext.** _____

Cell Phone: _____ **Email Address:** _____

Would you like to be reminded of your appointments by: *Email Home Phone Cell Phone*

Driver's License #: _____ **Social Security #:** _____

Employer: _____ **Occupation:** _____

Primary Doctor: _____ **Referring Doctor:** _____

Emergency Contact: _____ **Phone #:**_____

Relationship: _____

Primary Insurance	Policy Holder's Name	Policy Holder's Employer	Policy Holder's Soc. Sec. #	Policy Holder's D.O.B.
Second Insurance	Policy Holder's Name	Policy Holder's Employer	Policy Holder's Soc. Sec. #	Policy Holder's D.O.B.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private and other health plans, to Sierra Endocrine Associates. A copy of this assignment is considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Sierra Endocrine Associates to release all information necessary to secure payment. In Medicare assigned cases, I am responsible for the coinsurance and deductible, which Medicare determines. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay claims.

I have read and understand the Office Policies. If I am unable to keep a scheduled appointment I will notify the office no less than 24 hrs in advance. I understand that I may be discharged from the practice if I fail to keep and/or cancel my appointments.

Signature: _____ Date: _____

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HIPAA Authorization to Release Information and Consent Form

Patient: _____ Birth Date: _____

For Discussion with Family and/or Friends

In connection with the medical services that I am receiving from the physician group, I hereby give authorization to release information and/or discuss my medical condition including my protected health information such as psychological or psychiatric impairment, drug and/or alcohol use/abuse, or Acquired Immuno-Deficiency Syndrome (AIDS), or tests for infection with Human Immuno-Deficiency virus (HIV) to any third party payer covering the medical services to the patient, other health care professionals and institutions involved in the delivery of the health care to the patients, any legally sufficient subpoena, pharmacies and other parties as otherwise required by law, and with the person(s)/entities listed below:

Person/entity name: _____Phone # _____

Relationship to Patient (or other description) _____

Person/entity name: _____Phone # _____

Relationship to Patient (or other description) _____

Person/entity name: _____Phone # _____

Relationship to Patient (or other description) _____

Person/entity name: _____Phone # _____

Relationship to Patient (or other description) _____

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

Patients Signature: _____ Date: _____

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Patient Name: _____ Birth Date: _____ Date: _____

Prescription Medications Currently Being Taken

Please list all prescription medicines you are taking at this time.
BRING ALL CURRENT MEDICATIONS WITH YOU TO YOUR VISIT

Name of Medicine	Strength	# per day	Prescribed By	For Treatment Of

Non Prescription Medications Currently Being Taken

Please list all non-prescription vitamins and/or medicines you are taking at this time.

Name of Product	Strength	# per day	For Treatment Of

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Patient Name: _____ Birth Date: _____ Date: _____

What is the most important problem YOU want addressed at your appointment?

_____

Medical History: Please list any medical diagnosis (diabetes, high blood pressure, etc.) Hospitalizations, Surgeries, Pregnancies as well as any diagnostic tests (example: Mammograms, x-rays, CT scans, MRI's Ultrasounds, Biopsies, Allergies, etc.) If you do not know the exact date, at least the year would be helpful. Please try to list in the order in which the diagnosis or event occurred. If additional space is needed, please feel free to add another page.

Date (mm/dd/yyyy)	Medical Event
	Please list any allergies to medications below