Lake Endocrinology and Diabetes

New Patient Demographics

Patient Information

Last Name: First Name: Middle Initial:

Date of Birth: Social Security: Marital Status:

Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Race: Ethnicity: Gender: ☐Male ☐Female

Emergency Contact: Relationship: Phone:

◯Summer ◯Winter Add: City: State: Zip:

Financial Information

Responsible Person: Relation: DOB:

Insurance Name: Subscriber ID:

Specialist Co-Pay: Payer ID:

Secondary Insurance: Secondary ID:

Primary Care Physician (PCP): Phone:

Referring Provider (if other than PCP): Phone:

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Lake Endocrinology and Diabetes, PLLC, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient or Legal Guardian Printed Name:

Signature: Date:

13123 66th St Largo, FL 33773
PHone: 727-477-1039 Fax: 727-477-0498

Lake Endocrinology and Diabetes

Review of Systems

PATIENT INFO:

Last Name: _____ First Name: _____ Date of Birth: _____

Review of Systems: Please check/circle the problems you are currently experiencing:

GENERAL
__Extreme fatigue
__Fever
__Weight Gain/Loss

EYES
__Blurred Vision
__Bulging Eyes
__Dry Eyes

NECK/Thyroid
__Enlargement
__Thyroid nodules
__Difficulty swallowing
__Change in voice

RESPIRATORY Wheezing
__Chronic cough
__Shortness of breath

HEME/ONC
_History of Cancer
_Easy Bruising
_New/Growing lump

CARDIOVASCULAR
__Chest pain
__Swelling legs
__Wheezing
__Heart Racing
_High blood pressure

GASTROINTESTSINAL
__Nauseas/vomiting
__Diarrhea/ constipation
__Indigestion
__Abdominal pain
__Feeling full early
__Frequent urination

GYN/BREAST
__Irregular Menstrual
__Breast Pain
__Nipple Discharge

GENITOURINARY
__Frequent Urination
__Very thirsty
__Erectile dysfunction
__Prostate enlargement
__Abnormal cycles
__Poor sex drive

NEUROLOGICAL
_Headaches
_Dizzy upon standing
_Numbness/Tingling
_Loss of consciousness

ENDOCRINE
__Heat intolerance
__Very thirsty
__Very hungry
__Weight loss
__Weight gain
__Increased urination

INFECTIOUS DISEASE
_Fever

MUSCULOSKELETAL
__Bone pain
__Muscle weakness
__Pain or cramping
__Joint pain
_Hip area symptoms

MENTAL HEALTH
__Anxiety
_Severe Depression

SKIN
__Rash
__Wide purple stretch marks
__Skin Tags
_Loss of hair
_Increased dark hair
_Sores will not heal

Medication List: Please list current medications, over-the-counter meds, vitamins, & supplements:

Medication Name	Dose (mg)	Frequency Day/Week		Medication Name	Dose: (mg)	Frequency Day/Week

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Lake Endocrinology and Diabetes

Review of Systems Continued

Past Medical History: Please check all the diagnoses you have a history of:

__Type 1 Diabetes
__Type 2 Diabetes
__Thyroid Nodules
__Hyperthyroidism (overactive)
__Hypothyroidism(underactive)
__Thyroid Cancer
__Osteoporosis
__Heart Disease
__High Blood Pressure
__High Cholesterol
__Stroke
__Lung Disease
__Kidney problems
__Heart Attack
__Cancer: _____
__Other: _____
_____

Allergies: Please list medication allergies and your reaction to them:

Medication Name	Reaction

Surgical History: Please list surgeries you have had and what year:

Name of Surgery	Date		Name of Surgery	Date

Hospitalizations: Please list the reason and date for any hospitalizations:

Reason	Date		Reason	Date

Family History: Please list any medical problems your immediate family members have /had.

Immediate Family:	List diagnoses or medical problems:	Age at Death:
Father		
Mother		
Brother(s)		
Sister(s)		
Child/Children		
Paternal Grandparents		
Maternal Grandparents		

Social History: Please complete the following:

Marital Status:	Married Widow Single Divorced Partner Other:					
Do you smoke?	Yes	No	Packs per day:		Quit Date:	
Do you drink?	Yes	No	Drinks per week:		Type:	
Do you use drugs?	Yes	No	Frequency:		Type:	
Do you Exercise?	Yes	No	Times per week:		Type:	

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HIPAA PRIVACY ACT CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not the patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have received our Privacy Notice (Confidentiality of Patient Medical Records) and have the right to review it, to request restrictions, and to revoke consent in writing.

Please list Family Members or Persons to whom you want Medical Information disclosed to:

_____ _____
Name of person **Relation to you *(ex. Spouse/Mother)***

_____ _____
Name of person **Relation to you**

_____ _____
PRINT Patient Name **Date of Birth**

_____ _____
Signature of Patient or Guardian **Date**

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Lake Endocrinology and Diabetes
RECORDS REQUEST AUTHORIZATION

PATIENT INFORMATION

Patient Last Name: _____ Patient First Name: _____ Date of Birth: _____ Phone: _____

I AUTHORIZE THE RELAESE OF MY MEDICAL RECORDS FROM:

Doctor: _____ Fax: _____ Phone: _____

Address: _____ City: _____ State: ___ Zip: _____

Additional Doctors, Hospitals, or Facility: _____ Fax: _____ Phone: _____

PLEASE SEND MY MEDICAL RECORDS TO:

LAKE ENDOCRINOLOGY AND DIABETES NPI: 1619418563
Dr. Brian Lake NPI:1295887040 and/or Kimberley Philip, ARNP NPI 1538130919
Address: 13123 66th Street Largo, FL 33773 Phone: 727-477-1039 Fax: 727-477-0498

FOR THE FOLLOWING REASON(S):

☐ Specialist Care ☐ Consult/Second Opinion ☐ Moving out of Area ☐ Personal Information ☐ Legal ☐ Transfer of Care

☐ Other: _____

MEDICAL HEALTH INFORMATION AND DOCUMENTS TO BE DISCLOSED (*Check all that apply*):

☐ Office Notes and Reports (Last 3 Visits) ☐ Radiology/Diagnostic Reports ☐ Lab Reports ☐ Hospital Records ☐ Billing

☐ Previous Endocrinology Notes (1 year) ☐ Other (Please list) _____

I AUTHORIZE THE RELEASE OF THE FOLLOWING SENSITIVE PROTECTED HEALTH INFORMATION (*Must select Yes or No*):

HIV/AIDS/HBV,TB, or other Communicable Disease ○ Yes ○ No
Mental Health Information and Records ○ Yes ○ No
Genetic Testing Information and records ○ Yes ○ No

Domestic Violence: ○ Yes ○ No
Drug/Alcohol Information* ○ Yes ○ No
*Specify: _____

Notice, Consent, and Authorization:

Please allow 10 days for processing. Incomplete information will delay the processing.
I understand that I may be charged for copies. ○ **Yes or** ○ **No.**
Initial Here _____ to request and authorize records can be sent or received by unencrypted email which can be less secure than portal, direct upload, fax, or mail. Approved email: Info@lakeendocrine.com, Use of this information for any other reason than the stated purpose is prohibited. This information is for the designated recipient only and cannot be provided to another agency. If received in error, please notify the sender by phone at 727-477-1039.
This authorization has no expiration unless I have listed the expiration date as: ___/____/____. I understand that I have the right to refuse to sign this authorization and that my treatment is not contingent upon whether or not I sign this authorization. It may be revoked at any time upon written notification by the signatory or patient, but revocation has no effect on action previously taken.
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 by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the federal substance abuse confidentially Requirements.
I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric testing, physical abuse, or drug and alcohol abuse. This information is being released, received, and used for the purposes of coordinating my care, evaluating my needs and providing services to me.
I understand that I have the right to refuse to sign this authorization and that my treatment is not contingent upon whether or not I sign this authorization. It may be revoked at any time upon written notification by the signatory or client, but revocation has no effect on action previously taken.

SIGNATURE of PATIENT or Representative: _____ Date: ___/___/____

PRINT Representative Name if not patient: _____ **Relationship:** _____

Please contact our office if you have any questions or concerns at Phone: 727-477-1039.

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OFFICE POLICIES

Welcome to the office of Brian Lake, D.O, of Lake Endocrinology and Diabetes, PLLC. In order to provide our patients with the best quality of care in a compassionate and timely manner, we have established these policies. Please feel free to contact our office if you have any questions. We look forward to establishing and maintaining a positive relationship while improving your health.

OUR POLICIES

- **Office Hours:** Monday – Thursday 8:00a.m.- 5:00p.m., Fridays 8:00am to 12:00pm. We are closed for lunch and to complete paperwork or return phone calls between 12:00pm and 1:00pm daily. Subject to change.

- **Emergencies:** For medical emergencies please dial 911. The physician will be on call 24/7 for emergencies. All non-emergencies will be directed to wait until the next business day. If you need to see the doctor the same day, ask for an urgent/same day appointment. If one is available, you may be scheduled. If not, you may need approval from the nurse or the physician or may be directed to the nearest urgent care or emergency room.

- **Scheduling appointments:** You may call the office to schedule. Because we offer quality and compassionate care, our next available new patient appointment may be in 3-4 months from the time you call. Your physician may request an urgent appointment by contacting Dr. Lake. Completing new patient paperwork thoroughly and immediately will help us to obtain your records, referrals, medication list, prep your chart for your visit.

- **Wait-List:** We offer a wait-list to anyone who would like a sooner appointment and has completed their new patient paperwork. In the event someone cancels or reschedules, we will offer that appointment to patients on our wait-list. Priority will be given to those who are urgent, symptomatic, available, or have completed paperwork and have records on file. This is also available for follow up patients if needed.

- **Medical Records:** Dr. Lake reviews your labs, radiology, and records prior to your visit. Please complete our records request for your PCP and/or previous Endocrinologist or referring doctor or contact their office to request your records. Many offices require 10 days to complete records request. Please allow ample time. You will be automatically opted in to a records network such as Common Well for continuity of care and accessing and providing external records to your physicians. You may opt out by contacting our office.

- **Referrals:** If you have a managed care insurance plan or HMO, your insurance requires a referral authorization to see a specialist. We will make every reasonable effort to obtain these authorizations from your primary care provider (PCP) on your behalf. You or your PCP must request a referral authorization from your insurance and send it to us. This may take 5-10 business days. Appointments without authorized referrals will be denied by your insurance, canceled by our office, and /or rescheduled until proper authorization is received.

- **Phone Calls-** If we are with patients and unable to answer, please leave your detailed message and phone number and someone will return your call same day or within 24 hours.

- **Forms:** We ask for 72 hours for forms to be completed. A current office visit may be required.

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OFFICE POLICIES-Continued

- **Office Visits-** Office visits are made by appointment only. Dr. Lake prides himself on giving quality care and being on-time.We do not double book appointments. Therefore, we ask that you also arrive in a timely manner:
    - **New Patients**: Arrive 30 minutes prior to your appointment time to check-in, complete paperwork, and see the nurse prior to the appointment with the doctor. As of 01/01/23, Check-in time will be the same time as the appointment time.
    - **Follow up appointments**: Arrive a few minutes early to check-in and confirm insurance, and demographic and HIPAA information with the receptionist.
    - **All Patients**: Please have your insurance card, ID, co-payment, referral, records, glucose meter or log book, sensor and insulin pump ready (if applicable) for check-in.
    - **Virtual visits/Telemedicine**: May be available during pandemics or other unforeseen natural disasters. These appointments must be pre-approved by the physician. Please call to arrange ahead of time.
    - **Late Arrivals:** Reasonable requests will be accommodated, time and availability permitting. However, if you will be late, please call. No-Show, same day cancellations or late arrivals subject to fees.

- **No-Shows/Same Day Cancellations/Late Arrivals**: We understand emergencies happen. If you are unable to keep a scheduled appointment, please call our office as early as possible so we can reschedule or accommodate you at another time, free of charge.
  $35 fee applies to Established patients appointments broken with less than 24-hour business notice, No-Show, or arrive too late to be accommodated. Established Patients may be discharged after three occurrences.
  $75 fee applies to New Patients appointments broken with less than 24-hour business notice, No-Show, or arrive too late to be accommodated and will not be rescheduled without prior approval from the physician.

- **Ultrasounds and Biopsies:** Ultrasounds and Biopsies can be scheduled for established patients. We are happy to obtain a pre-authorization for these procedures if your insurance requires one. Please make sure it is covered and authorized.

- **Coordinated Care-** We send our office notes to your primary care physician (PCP) and other specialists that you see for the best coordinated care possible. We also request that they do the same and forward your labs, office notes, and radiology to us. Please let our office know if any of your other physicians have changed.

- **Nondiscrimination and Accessibility** - We comply with applicable Federal Civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, or sexual orientation. If you need an interpreter, or paperwork in another language, or accommodations, please notify the office.

- **Prescriptions and DME-** If you need a refill, please contact your pharmacy and allow 48 business hours for your request to be completed. The doctor does not call in prescriptions after business hours, and for safety reasons may not be able to renew your prescription until you have been seen. If you haven't seen the doctor recently, you may need to make an appointment to review your medical history and make any necessary changes before prescriptions or durable medical equipment (DME) can be refilled. Some prescriptions and DME require prior authorization from your insurance company and this may take up to a week, so please call well in advance of your needs. Always provide the name of the medication, dosage, 90 or 90day supply requested, and the pharmacy used when calling the office.

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OFFICE POLICIES-Continued

- **Medical Students-** From time to time, the doctor may have medical residents or students who are in training working with him. If you do not wish to have one of these students or residents see you, please let us know in advance.

- **Nurse Practitioner-** We have added our Nurse Practitioner (ARNP) to better serve your needs and to alleviate wait times for new patient appointments. Dr. Lake will see all new patients and coordinate care with the nurse practitioner. Follow up appointments can alternate between Dr. Lake and the nurse practitioner for continuity of care.

- **Financial Responsibility-** The patient or patient's guardian is responsible for payment of all services rendered by our physicians/providers.

- **Payment-** Payment in cash, check, or credit card is expected at the time of service unless other arrangements are made in advance. We accept most major credit cards.

- **Co-Payments-** All insurance co-payments are due at the time of the office visit prior to seeing the doctor. According to your insurance contract, we are unable to bill for co-payments.

- **Insurance-** We file claims to insurances with which we have a contract. Please check with your insurance company, or with us prior to seeing the doctor to make sure we accept your plan. Claims for any other insurance companies with which we are not contracted must be filed by you. After you pay us, we will provide you with the receipt you will need to send to your insurance company. You are responsible for paying the full balance due of any co-pays, deductibles, co-insurance, denied, or non-covered claims in a timely fashion. If your Insurance is Out of Network (OON), please request a Good Faith Estimate (GFE) to see the fees you will be responsible for or that will be applied to your OON benefits.

- **Delinquent Accounts-** If you fail to pay your bill or the bill of anyone for which you are financially responsible (such as a child or spouse), routine appointments will be held until the matter is resolved. There is a fee of **$25** for all checks returned to us due to insufficient funds or other non-payment by your bank. Balances not paid after 3 statements will be referred to a collections agency. You will then be responsible for any costs incurred from that agency, in addition to the amount you owe us. Allowing this to happen may affect your personal credit. If we take you to court because of an unpaid balance, you are responsible for any and all costs incurred, including, but not limited to, lawyer's fees and legal filing fees.

- **Living wills and Powers of Attorney-** Please inform the receptionist if you have living wills or powers of attorney that pertain to your care. We will need copy to put into your chart.

- **Medical Records-** Are provided free of charge and available 24/7 on the patient portal. If you need a copy of your medical records, please complete and sing the appropriate paperwork so we can release them. A copying charge of up to $1.00 per page plus postage and fess or other fees will apply.

I have read the above office policies. I understand them and I agree to them as a condition for being seen by my doctor.

_____ _____

Patient's Printed Name **Date of Birth**

_____ _____

Patient's Signature **Date**

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Formulary Benefits Data Consent Form

Formulary Benefits Data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below, I give permission for Lake Endocrinology and Diabetes to access my pharmacy benefits date electronically through RxHub. This consent will enable Lake Endocrinology and Diabetes to:

- ❖ Determine the pharmacy benefits and drug copays for the patient's health plan.
- ❖ Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- ❖ Display therapeutic alternatives with preference rank (if available) within drug class for non- formulary medications.
- ❖ Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- ❖ Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____ _____

PRINT Patient Name Date of Birth

_____ _____

Signature of Patient/Guardian Date

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Patient Portal Authorization

1. Purpose

The purpose of the Patient Portal Consent Form is to get consent from patients who will use the Patient Portal with given credentials in order to access, view and monitor their medical conditions.

It is intended to present possible risks, benefits and conditions of the Patient Portal to patients with this Patient Portal Consent Form.

2. Patient Portal

Patient Portal is a web portal which allows patients to view and reach their medical records which are lab results, medical history and medications. The patient can access the secure Patient Portal via the internet.

3. Confidentiality

Medical and personal information of the patient are protected by the state and federal laws. The patient can access the Patient Portal via his or her credentials and it is the patient's responsibility to protect the credentials from unauthorized people, services or organizations.

4. Risks

The medical information, personal information and communication channels in the Patient Portal are protected securely. However, the patient needs to be careful while using the portal. The patient should be sure that the message is sent to the correct email address.

If the patient thinks that the credentials are stolen, he or she needs to notify the Healthcare Center immediately.

Patient Name _____ DOB_____

Personal Email: _____ (Personal recommended)

I have been informed about the potential risks, benefits and confidentiality of the Patient Portal. I acknowledge that the information I have given is accurate and complete. By signing below, I, as a patient or a representative, accept all the terms & conditions and I accept that I am the responsible party for protecting my credentials that are used to access the Patient Portal. I have fully understood the policies and wish to participate in the Patient Portal.

Patient Signature: _____ Date: _____

Address: 13123 66th Street Largo, FL 33773
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