CREEDMOOR CENTRE
ENDOCRINOLOGY
WHERE IT ALL COMES TOGETHER

Today's Date:_____

Patient Name: _____

Preferred Name: _____Preferred pronoun: _____

Date of Birth: _____ Cell Phone: _____

Email address: _____

Home Phone: _____ Work Phone: _____Ext_____

Preferred Contact Method: Home Phone ☐ Cell ☐ Work phone ☐ Email ☐ US Mail ☐

Address_____Apt_____City_____Zip_____

Primary MD: _____Name of office: _____

Referring MD: _____Name of office: _____

Sex: M ☐ F ☐ Other _____Gender Assigned at Birth: M ☐ F ☐

Gender Identity _____

Race: Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other_____

Language Spoken at Home: _____

Is patient under 18? No ☐ Yes ☐, If yes, please complete box below:

Name(s) of Parent(s) or Legal Guardian (paperwork must be presented):

_____

First Last

Email address: _____Cell phone: _____

Reason for visit: *If Diabetes, please complete the Diabetes information below.

_____

_____

Diabetes Type: Type 1 ☐ Type 2 ☐ Gestational ☐ Other_____

Date Diagnosed: _____Hospitalized at Diagnosis? No ☐ Yes → in DKA? No ☐ Yes ☐

Most recent Diabetes Education visit: _____

Details of Insulin Therapy

Insulin(s) currently using: Humalog ☐ Novolog ☐ Apidra ☐ U-500 ☐ Afrezza ☐ 50/50 ☐

Lantus ☐ Levemir ☐ Toujeo ☐ Tresiba ☐ Basaglar ☐ NPH ☐ Regular ☐ 70/30 ☐

Lyumjev ☐ Fiasp ☐

Mode of therapy: Inhaled ☐ Shots ☐

Pump, which one? _____ Start Date?_____

Testing Regimen: Meter: _____Tests/day: _____

Continuous Glucose Sensor_____

Medical History

Ongoing medical problems: (example: Diabetes, High Blood Pressure, etc.)

_____

_____

Allergy/Reaction: (example: Penicillin/Rash) No known drug allergies _____

_____

_____

Women: Pregnancies (#):_____ Live births(#):_____Miscarriages (#): _____

Are you pregnant? No ☐ Yes ☐ Due Date_____

Men: Have you fathered children? No ☐ Yes ☐

Family History:

Relation	Birth Year	Age at Death	Health Problems
Father			
Mother			
Brothers			
Sisters			
Children			

Do any Blood Relatives have? Diabetes ☐ Thyroid condition ☐ Cancer ☐ Osteoporosis

☐ Pituitary problem ☐ Heart Disease or Stroke

Surgical History: **None** ☐

Year	**Procedure**

Hospitalizations: **None** ☐ **Childbirth** ☐ **Surgeries Only** ☐

Year	**Reason**

Exercise: No ☐ Yes→ How many minutes per day? _____How many days per week? _____

Hours of sleep per night? _____

Recreational Substance Use:

	Ever Used?	Current use?	Quit date?	How much?	How often?
Tobacco	Yes ◯ No ◯	Yes ◯ No ◯			
Street Drugs	Yes ◯ No ◯	Yes ◯ No ◯			

Alcohol Use

Any alcohol use in the past year? If yes, please answer the following:

How many drinks per day? _____

How many drinks per week? _____

How many drinks per year? _____

Social history:

Marital Status: _____Occupation: _____

Last Completed or Current Grade in school: _____

Preferred Pharmacy Name_____

Street _____City_____Zip_____

and/or phone: _____

Current Medications and Dosing (please include vitamins and supplements)

Medication	Dose	Start Date

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Consent to Treat

I am a new patient at Creedmoor Centre Endocrinology, P.A. By signing this form, I consent to be treated by the providers of this practice.

My doctor needs more medical facts about my health. I, _____, ask for and allow Dr. Warren-Ulanch and staff to give me the needed medical treatment and services that he or she recommended.

I understand treatment and services may include:

- lab tests,
- screening tests (tests that can find an illness early, before a person shows signs of having the disease),
- diagnostic tests (tests that shows if a person has a certain illness or health problem), and
- routine exams.

I understand that no promises have been made to me about the results of any treatment or services.

_____ _____

Signature of Patient or Responsible Party Date and Time

****

Consent for treatment of a minor child:

I, being the parent or legal guardian of _____, ask and allow Creedmoor Centre Endocrinology, P.A. to do necessary health services for my child, even if I am not present.

Below is a list of people who are allowed to bring my child in for treatment:

_____ _____

_____ _____

_____ _____

_____

Signature of Patient or Responsible Party Date and Time

****

Consent for use of email:

By signing this form, I hereby grant permission for Creedmoor Centre Endocrinology, P.A. to contact me via email at the address provided. Please be case sensitive. This email address will not be shared with any other entity.

Email Address: _____

_____ _____

Signature of Patient or Responsible Party Date and Time

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Attention Patients and Caregivers

Late Appointment Policy

If you are an established patient and you arrive 15 minutes or more late for your appointment, you will likely be asked to reschedule your appointment unless the physician's schedule can still accommodate you.

Priority will be given to patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule.

Please be aware that when one patient is late, this causes the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

No Show Policy

While we make every effort to provide a reminder of your appointment, it is your responsibility to contact our office to reschedule your appointment. We charge a $50 missed appointment fee to patients that do not show up for their appointment. If this should happen more than twice, the practice may, at its discretion, choose to discontinue your care.

Patient Signature Acknowledges Receipt Date

Legal Guardian Signature Acknowledges Receipt Date

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FINANCIAL POLICY CREEDMOOR CENTRE ENDOCRINOLOGY

Office Hours: Our office is open Monday through Friday 8:00am-4:30 pm. Our last appointment is at 4:00. If you have an emergency, please dial 911, or go to the nearest emergency room.

Appointments: Patients are seen by appointment only. We realize your time is valuable and we do our best to honor your appointment time. Our practice may encounter unforeseen emergencies and delays may occur. We may at times need to make changes to your appointment date and time. We ask for your patience and understanding during these times. If you are unable to keep your appointment and need to cancel, we request that you notify us at least 24 hours in advance to avoid "missed appointment" charges. The charge will be $50.00. There will be no exceptions unless approved by Dr. Warren-Ulanch.

Insurance: We ask for your cooperation in providing us with the following:

- Your current and correct insurance information. Please provide us with a copy of your insurance card at each office visit.
- Your co-pay is expected to be paid at the time of service
- If you have an insurance plan that requires a referral, we will expect that you present this at check-in.
- If your insurance does not pay in full, we do not do payment plans. You will be expected to pay your account in full once billed. We contract our billing with MedBill. Any billing issues should be directed to MedBill. Their contact phone number is 919-435-0054.
- After 90 days, MedBill will send delinquent accounts to collections.

Deductible Plans: If you have not reached your deductible, you will be asked to pay $100 at time of service.

Self-Pay and Non-Participating Insurances: Self-pay is anyone who does not have health insurance or has an insurance which Creedmoor Centre Endocrinology is not contracted with. Insurance for these patients will be filed as a courtesy. If your non-participating insurance pays less than our usual and customary charges, you will be billed for the difference. Self-pay patients who do not have health insurance, will be required to make full payment at check-out.

Returned Checks: Returned checks are subjected to a $25.00 service fee.

Medical Records: There is no charge for Medical Record transfer if faxed from physician to physician. If you would like a copy of your medical record, the charge is $50.00. Any Life Insurance Co. or Attorney will be charged $50.00 prior to release of records. There is a charge for other documents that the physician may need to complete for you. This Charge is $75.00.

Signature of Responsible Party:_____ Date:_____

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

The undersigned hereby acknowledges that a copy of the Notice of Privacy Practices has been provided to them by Creedmoor Centre Endocrinology, PA.

I authorize Creedmoor Endocrinology's staff to leave medical, appointment and/or account information pertaining to my care by the following methods. This authorization expires one year from the date signed. **I will assume the responsibility to notify them of any changes in this information.**

If we are unable to reach you, are there any relatives or friends with whom you authorize our office to discuss your health information? Please list name(s), relationship(s), and their phone number(s) below:

Name	Relationship	Phone Number

Signature: _____ **Date:** _____

List of Providers for Medical Release of Information

I, (Patient or Legal Guardian) _____ hereby authorize:

Creedmoor Centre Endocrinology, PA
8340 Bandford Way Ste. 001
Raleigh, NC 27615
Phone: 919-845-3332 Fax: 888-714-0059

To release and forward my medical records, including machine readable medical and demographic data to the following providers:

First & Last Name Provider	Medical Specialty	Practice Name	Office Phone and Fax #
	General Pactioner or Primary Care Doctor		

8340 Bandford Way Suite 001
Raleigh, NC 27615
www.ccendocrinology.com |919 845.3332

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights: When it comes to your health information, you have certain rights.

Get an electronic or paper copy of your medical record.

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

• We will provide a copy or a summary of your health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

Your Choices: For certain health information, you can tell us your choices about what we share.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care.

• Share information in a disaster relief situation.

• Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

• Marketing purposes.

• Sale of your information.

• Most sharing of psychotherapy notes.

In the case of fundraising:

• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures: We typically use or share your health information in the following ways.

Treat you:

• We can use your health information and share it with other professionals who are treating you.

Run our organization:

• We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services:

• We can use and share your health information to bill and get payment from health plans or other entities.

Help with public health and safety issues:

• We can share health information about you for certain situations such as:
  • Preventing disease.
  • Helping with product recalls.
  • Reporting adverse reactions to medications.
  • Reporting suspected abuse, neglect, or domestic violence.
  • Preventing or reducing a serious threat to anyone's health or safety.

For more information see: **hhs.gov/ocr/privacy/ hipaa/understanding/consumers/index.html.**

Do research:

• We can use or share your information for health research.

Comply with the law:

• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:

• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:

• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:

• We can use or share health information about you: • For workers' compensation claims.
• For law enforcement purposes or with a law enforcement official.
• With health oversight agencies for activities authorized by law.
• For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:

• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Help train health care workers:

• We can use and share your health information to help us train health care professionals such as medical and nursing students, residents and fellows.

For more information see**: hhs.gov/ocr/privacy/ hipaa/understanding/consumers/noticepp.html.**

Our Responsibilities.

• We are required by law to maintain the privacy and security of your protected health information.

• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

• We must follow the duties and privacy practices described in this notice and give you a copy of it.

• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

This Notice of Privacy Practices explains how Creedmoor Centre Endocrinology, PA, its employees, medical staff, volunteers, students and trainees may use and provide your Protected Health Information (PHI) to others and describes your rights to access and control your PHI. Creedmoor Centre Endocrinology complies with applicable federal and state laws and does not discriminate on the basis of race, color, sex, age, religion, national origin or disability.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our facilities, and on our web site.

File a complaint if you feel your rights are violated:

• You can complain if you feel we have violated your rights by contacting us using the information below.

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa/complaints/

• We will not retaliate against you for filing a complaint. Privacy Officer P: (919) 845-3332 | 8340 Bandford Way, Suite 001, Raleigh, NC 27615 |