Patient Registration Form

Date: ____/____/____

Patient Name: _____ _____ _____ **Date of Birth:** ____/____/____ **Age:** _____
Last First Middle

If patient is a minor, lives with _____ Relationship _____

Gender: Male Female **Social Security #:** _____-_____-_____ **Preferred Language:** _____

Ethnicity: (Circle which applies)

Hispanic or Latino Not Hispanic or Latino Declined

Race: (Circle one or more)

American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander

White Other Declined

Address: _____
Street City State Zip

Home Phone (_____)_____ **Cell Phone: (_____)**_____

Work Phone (_____)_____ **Email:** _____

Would like access to our Patient Portal? Yes/No (If yes, please include your email)
Preferred Contact Method: Home Cell Work Email

Marital Status: Single Married Widowed Divorced Separated Other

Children: Yes No If Yes, how many? _____

Patient Employer Information (Circle all that Apply)

Employment Status: Full-Time Part-Time Not Employed Self-Employed Retired Active Military

Student Status: Full-Time Student Part-Time Student Not a Student

Employer/ and or school Name and Address:

_____ _____
Employer Name School Name

_____ _____
Street City State Zip Street City State Zip

Emergency Contact: Nearest Friend/Relative Not Living With You

Name_____ **Relationship to Patient** _____ **Phone (_____)** _____

Responsible Party: If Other than the Patient, Please Complete

Name_____ **Relationship to Patient** _____

Responsible Party's Birth date: ___/____/____ **Social Security #:** _____

Address if different than above _____
Street City State Zip

Home Phone (____)_____ **Cell Phone (____)**_____ **Work Phone (____)**_____

Referring Physician/ Medical Insurance Information

Name of Referring Physician:_____ **Phone # (____)**_____

Name of Family or Primary Care Physician:_____ **Phone # (____)**_____

Do you have medical insurance to cover your examination or treatment? Yes No

If Yes, we will take a copy of your insurance cards.
Please Note: You must have your insurance card present for all visits.

Does your insurance company require an authorization or referral for exam or treatment from a Primary Care Physician?
___Yes ___No

Primary Insurance

_____ _____ _____
Name ID# Group#

Relationship to Holder: Self Spouse Parent/Guardian

Secondary Insurance

_____ _____ _____
Name ID# Group#

Relationship to Holder: ____Self ____Spouse ____Parent/Guardian

If you are on another person's insurance policy please provide their following information:

Name _____**Social Security #** _____**Birth date** _____

If you would like to receive your statements electronically via email, please provide your email address below:

_____

Financial Responsibility Statement/ Release of Information Authorization

"I authorize the release of any medical information necessary to my insurance company and the Payment of Benefits to the Physician for services received. I also authorize the release of information to listed physicians and/ or individuals. I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and an insurance company, HMO, or other managed care entity. If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees."

X_____ Date _____
Signature of Patient or Legal Guardian

Harold T. Pretorius, M.D.
Endocrinology, Internal Medicine, & Nuclear Medicine

Date:_____

Reason for your visit today: _____

_____

_____

Patient's Current Medications:

Medication Name	Dosing	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list your preferred pharmacy (Name, Phone Number, and/or address:

_____

Health Questionnaire (Please circle all that apply to you.)

Activity Level:
Very Active Active
Sedentary Inactive

Alcohol Consumption
If yes, how many drinks per week?____

Allergies

Please list any allergies and any seasonal medications

_____

Angioplasty

Arthritis

Asthma

Bypass Surgery

Cancer
If yes, what type and what year you were diagnosed?
_____

Chest Pain

Chronic Pain
Please list location where your pain
_____

Constipation

COPD

Depression

Diabetes
Type 1 or Type 2

What is your morning fasting blood sugar average and recent HbA1c?

_____

_____

Difficulty Breathing

Dizziness

Fibromyalgia

Gallstones
Ulcers

GERD

Grave's Disease

Heart Attack/Stents

High Blood Pressure

High Cholesterol

Hirsutism

Hypo or Hyperthyroidism

Irritable Bowel Syndrome

Low Blood Pressure

Kidney Failure

Kidney Stones

Memory Loss

Osteoporosis

Pacemaker

Pancreatitis

Passing Out

PCOS

Shortness of Breath

Sjogren's Disease

Smoker
If yes, how many packs per day?____
How many years?____

Stents

Stress Test
If yes, date of most recent: _____

Stroke

Thyroiditis

Traumatic Brain Injury

*PLEASE LIST ANY SUGERIES THAT YOU HAVE HAD AND THE YEAR PERFORMED:

_____

_____

_____

List who in your <u>FAMILY HISTORY</u> (Please circle all that apply to your family history, <u>PLEASE WRITE WHO IT APPLIES TOO, IF THEY ARE DECEASED AND AT WHAT AGE)</u>

Angioplasty

Arthritis

Asthma

Bypass Surgery

Cancer
<u>If yes, what type, who, they passed away from this and at what age</u>_____
_____
_____

Chest Pain

Chronic Pain

Constipation

COPD

Depression

Diabetes Type 1 or Type 2

Dizziness

Fibromyalgia

Gallstones

GERD

Grave's Disease

Heart Attack

High Blood Pressure

High Cholesterol

Hirsutism

Hyperthyroidism

Hypothyroidism

Irritable Bowel Syndrome

Low Blood Pressure

Kidney Failure

Kidney Stones

Memory Loss

Osteoporosis

Pacemaker

Pancreatitis

Passing Out

PCOS

Sjogren's Disease

Stents

Ulcers

Stroke

Thyroiditis

"Controlled Substance" Medication Agreement

Patient Prescription Rights and Responsibilities:

To help with the goal of increasing my ability to function, I _____
Recognize that I am being treated with potent medications which are considered controlled substances by local, state, and federal agencies. Examples of such medications are narcotics, tranquillizers, muscle relaxers, sleeping medications, and weight loss medications. Other drugs not necessarily "scheduled" as controlled substances by regulatory agencies may also have a potential for habituation or abuse. I understand that no single medication prescribed by Dr. Pretorius can be considered a permanent, long term solution to chronic pain. In consultation with other physicians, such as chronic pain specialists or other specialist (for example, an orthopedic surgeon for an orthopedic condition, or a rheumatologist for an arthritic condition) with appropriate documentation, specific medications may be considered as medically necessary.

I therefore agree to abide by the following conditions:

1. I understand that it is considered a criminal offense to receive the same controlled substance from multiple physicians, and I will provide Dr. Pretorius with a list of all prescriptions that I am taking.
2. I understand that I need to use one (1) pharmacy to fill prescriptions for controlled substances.
3. I will take the medication as prescribed. If I use up the medication sooner than prescribed, I understand that it will not be replaced.
4. I understand that controlled substance medications do not qualify for early refills.
5. I am responsible for my controlled substance medication. If it is lost, stolen, or disappears for any reason, it will not be replaced.
6. I am responsible for keeping track of the amount of my medication and will plan ahead for arranging for refills in a timely manner so that I will not run out of medication.
7. I understand that if I am to receive ANY type of narcotics, I am required to submit to a random and/or yearly urine test. If I fail to comply with these terms, I understand I will no longer receive the medication(s) and may be subject to discharge from the practice.
8. I understand that there is a risk for potential dependency or psychiatric illness from weight loss treatment.
9. I understand that if I am prescribed weight loss medications and am of child bearing age and become pregnant to stop the medications due to birth defects.

A. At least a 24-hour advance notice is required for an appointment for a refill.
B. No controlled substance can or will be refilled over the telephone.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Updated 4-20-17

HIPPA Notice of Privacy Practices

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

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.
"Protected Health Information" is information about you, including demographic information that may identify you and be related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician/therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of Dr. Harold T. Pretorius and any other use required by law.
Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes that coordination or management of your health care with a third party.
For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you or to another physician/psychiatrist/therapist to which you have been referred to ensure that the provider has necessary information to diagnose and treat you.
Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services.
Health Care Operations:
We may use or disclose, as needed, your protected health information in order to support the business activities of Dr. Pretorius, M.D. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. In addition, we may confirm your up-coming appointments by telephone, unless otherwise instructed by you in writing. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or notify you of your appointment or notify you of any changes in your appointment. We may also call you by your first name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information in the following situations without your authorization:
As required by law, Public Health issues, Communicable diseases, Health oversight, abuse or neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-50.

Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to extent that your physician has taken action in reliance on the use or disclosure noticed in the authorization.

Your Rights

You have the right to inspect and copy your protected health information.
Under federal law, however, you may not inspect of copy the following records, psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you ay request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. An example of this would be if either you or another person were in al life threatening danger.

You have the right to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice form us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying us in writing and listing the privacy issue in your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provided individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with our office manager.

Signature below is only acknowledgement that you have received the HIPPA Notice of Privacy Practices

Signature: _____

Print Name: _____

Date: _____

If over the age of 18 and you would like to allow someone else in the room with you during your visits please fill out and sign the consent below:

I, _____ agree to allow _____ to be with me during my doctor's appointment with Dr. Pretorius. I understand that all of my medical history will be discussed in front of the person named above.

Signature: _____

Written Financial Policy

Thank you for choosing Dr Harold Pretorius. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card

We offer a 3% courtesy accounting adjustment to patients who pay for their treatment with cash or credit card prior to completion of care for treatment plans of $500 or more.

Please note:

Dr Harold Pretorius requires co-payment and self pay payment for nuclear scans prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

Dr Harold Pretorius charges $30 for returned checks. ($19 bank fee; plus $11 administration fees)

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and deserve.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Who was the referring doctor to our office?

_____

Have you had any recent labs drawn within 6 months?

_____

Have you had any procedures done at any hospital or doctors office that refers to your appointment today?

_____

_____

_____

Patient Authorization Form

Phamily is a text, mobile, and web based messaging platform that helps connect health care providers, patients and their loved ones. Your health care provider has chosen to use Phamily to get updates on your health, send you reminders, answer questions, and improve access to your health care provider.

Patient Name (*Print*): _____

Patient Date of Birth: _____

Patient Mobile Phone Number: _____

Patient Email Address: _____

By signing below:

1. I represent that I am eighteen (18) years of age or older and I acknowledge that I have read and agree to be bound by the Phamily End User Terms of Use as may be updated from time to time, (http://phamily.com/patient/termsofuse).
2. I hereby authorize **Dr. Pretorius** ("Provider") and other medical professionals or staff members that the Provider has designated to access and use the Phamily services on its behalf, to communicate with me, and the Family Members identified, if any, about my medical conditions and treatment using unencrypted text messages, if I have provided a mobile phone number, and/or unencrypted email, if I have provided an email address, including those that may be considered marketing messages (e.g. flu shot reminders, etc.). I acknowledge that text messages are inherently unsecure and may be able to be accessed by third parties.
3. I understand that t*he Phamily service should only be used for routine and non-urgent matters. If you are experiencing a medical emergency or life-threatening symptom, please go to a hospital or contact 911 or your local emergency medical services agency.*

I understand and agree to participate in the Phamily service:

Signature: _____

Date: _____

OPTIONAL

Authorized Family Members:

I agree that the individual(s) listed below, if any, shall each be a "Family Member" as defined in the Phamily End User Terms of Use.

(*Optional*) Family Member Name: _____

Family Member Mobile Phone: _____

Family Member Email: _____

I hereby authorize the Provider and other medical professionals or staff members that the Provider has designated to access and use the Phamily Services on its behalf to communicate with any such Family Member with respect to my medical conditions and treatment. I acknowledge that I may revoke this designation at any time by contacting the Provider at (513) 561-3797. I also understand that in order to participate in Phamily on my behalf any such Family Member must agree to the Phamily End User Terms of Use.

Patient Signature: _____

Date: _____

Harold T. Pretorius, M.D., Ph.D., FACP
Endocrinology & Metabolism, Neuroendocrinology & Nuclear Medicine
4743 Cornell Road, Cincinnati, Ohio 45241
Phone: (513) 561-3797 FAX: (513) 561-4043

MISSED APPOINTMENT POLICY

Due to the high costs of preparing for patient appointments and the significant impact of not utilizing time reserved for the patient, the following charges will be assessed for appointments that are not kept by the patient. To cancel or reschedule an appointment in either the Ohio or Kentucky office, **at least two business days' advance notice** must be given to Dr. Pretorius' office by phone or by FAX at the above numbers.

The following fees will apply for an appointment missed without the advance notice:

Office Visits - **$25.00**

Nuclear Scans - The patient will be charged the actual cost of the tracer material isotopes ordered specifically for them. These materials cannot be returned, nor can a refund be obtained. Typical costs run from **$50.00 to $600.00** (depending on the scheduled scan) and sometimes more for highly specialized scans.

Ultrasounds - **$50.00**

Alternative Medicine Treatments - **$25.00 plus any actual costs** incurred in preparation.

Miscellaneous Appointments – (Nursing visits, training sessions, lab tests) - **$25.00**

Accommodation appointments made within the two-business-days period and not kept will incur charges for the patient as well.

Patients missing three appointments without paying the fees shall be discharged from the practice.

There is no insurance coverage for missed appointment fees.