TREASURE VALLEY METABOLIC MEDICINE

Patient Name:

REFERRING PROVIDER:

NAME	ADDRESS	PHONE NUMBER

Reason for visit: Circle
Diabetes in Pregnancy Diabetes Type 1 Type 2 Prediabetes Diabetes prevention
Weight management Other:

ALLERGIES: Circle or complete No Known Allergies

MEDICINE	REACTION

SURGICAL HISTORY: Circle or complete None

Surgery	Date	Location

MEDICATIONS: Circle or complete None

Name	Dose	Frequency	Prescriber
TOBACCO USE: Circle			

Yes	No	Quit (How many years smoked)

ALCOHOL USE: Circle

Yes (amount per week/month)	No	Quit (Date)

FAMILY HISTORY - are you adopted? Yes No

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Negative Hx	Other
Arthritis-Rheum										
Arthritis-Osteoporosis										
Asthma										
Cancer										
Diabetes										
Heart Failure										
High Cholesterol										
Hypertension										
Migraines										
Seizures										
Stroke										
Thyroid Disease										

Other:

REVIEW OF SYSTEMS: Circle

General Well-Being:	**Endocrine**:	**Cardiovascular**:
Weight loss	Excessive thirst	Chest pain
Weight gain	Increased urination	Palpitations
Fever	**Respiratory**:	Cardiovascular disease
Fatigue	Cough	**Musculoskeletal**:
Problems sleeping	Shortness of breath	Muscle weakness
Endocrine:	Wheezing	Joint pain/Back pain
Heat intolerance	**Eyes**:	**Neurological**:
Cold intolerance	Blurry vision	Numbness, tingling or burning
Fatigue	Double vision	Balance problems

IS THERE ANYTHING SPECIFIC you WISH TO DISCUSS WITH YOUR PROVIDER THIS VISIT?

If you have DIABETES: Circle Type 1 Type 2

What age was your diabetes diagnosed? ____
Have you seen a diabetes educator/dietitian? Yes , when _____ No
Do you check your blood sugars? Yes No
Meter/CGM _____
Pump _____
If yes, what is a high reading for you? _____

What is a low reading? _____
Do your blood sugars ever go below 70? Yes No
If yes, is this Daily Weekly Monthly?
Are you aware when your blood sugars go low? Yes No
Have you been hospitalized for low blood sugars? Yes No
Have you been hospitalized for high blood sugars? Yes No
Last A1C? ____ Date: _____
Do you have diabetes related eye problems? Yes No
When was your last eye exam? _____ Provider: _____
Do you have foot/nail problems? Yes No Foot provider: _____
When did you last give a urine sample for your diabetes? _____
When was your last lab work? _____
Do you have diabetes related kidney problems? Yes, Provider _____ No
When was your last cardiac assessment? _____ Provider _____
Males: Do you have erectile dysfunction? Yes, Provider _____ No

If WEIGHT MANAGEMENT,

Do you follow a specific diet plan? Yes No _____
Do you have any dietary restrictions? Yes No _____
Weight history _____
Goal Weight _____
Have you had any weight management surgeries? Yes No _____
Medications you have tried for weight management _____
Other things you have tried for weight management _____
Do you have insulin resistance? Yes no
Do you have PCOS? Yes no
Do you have hypothyroidism? Yes no
Do you have hypercortisolism/Cushings? Yes no
Do you have Pre-Diabetes (A1C 5.7-6.4%) yes no
Do you have Diabetes Type 2 (A1C >6.5%) yes no
Do you have another type of metabolic syndrome? Yes No _____
Have you had your insulin levels tested? Yes no
Have you had your thyroid levels tested? Yes no
Do you have any mental health diagnoses? Yes No _____
Have you been diagnosed with any chronic medical conditions? Yes No _____
Do you engage in regular exercise? Yes No _____
When was the last time you had bloodwork? _____
Do you have a family history of obesity/overweight? Yes No

Females:
Menstrual Cycles
Heavy bleeding: Yes No Painful cycles: Yes No Irregular: Yes No Regular: Yes No Low libido: Yes No
Men:
Erectile dysfunction: Yes No Low libido: Yes N

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Patient Information

Patient Name *(Last, First Middle Initial)*	SSN *(Social Security Number)*	DOB *(Date Of Birth)*

Sex ☐M*(Male)* ☐F*(Female)*	Email	Home or Cell Phone

Street Address *(Mailing Address)*	City, State, Zip

Who is your primary care provider?

Whom may we thank for referring you to our clinic?

☐ Billboard/Sign/Location ☐ Medical Provider ☐ Insurance Provider ☐ Newspaper/Magazine ☐ Radio

☐ Return Patient ☐ Television ☐ Website ☐ Family Or Friend ☐ Other: _____

Responsible Party

Responsible Party Name or Business Name	Relationship to Patient	Phone

Street Address *(Mailing Address)*	City, State, Zip

Insured Party's SSN *(Social Security Number)*	Insured Party's DOB *(Date Of Birth)*	Other Information

Responsible Party Employer

Employer's Name	Employer's Phone

Employer's Address	City, State, Zip

Patient Or Spouse Employer

Employer's Name	Employer's Phone

Employer's Address	City, State, Zip

Consent For Care And Treatment

I, the undersigned, do hereby agree and give my consent for TVMM, LLC to furnish medical care and treatment to _____

_____ _____

Patient and/or Guardian Signature Patient and/or Guardian Print Name Today's Date

Benefit Assignment/Release Of Information

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to TVMM, LLC. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient and/or Guardian Signature | Patient and/or Guardian Print Name | Today's Date

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full, from you. Any unpaid balance after the first 30 calendar days of treatment accrues 1.5% interest each month thereafter. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes and internal usual and customary fee schedule, you will be responsible for the remaining difference.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to TVMM, LLC.

The above does not apply for those patients that are treated under Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that my account if paid within 90 days of my discharge will be interest free, after 90 days my account will be subject to a 12% interest (APR). If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Insurance Information

Primary Insurance	Mailing Address *(City, State, Zip)*	Phone
Group and/or Claim #	Member Id #	
Secondary Insurance	Mailing Address *(City, State, Zip)*	Phone
Group and/or Claim #	Member Id #	

Patient's Responsibility

Ded To Meet	Co-Pay/Co-ins	Arrangement

NOTE: Estimated coverage information is provided as a courtesy to our patient, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me. I understand my full responsibility for the payment of my account.

Patient and/or Guardian Signature | Patient and/or Guardian Print Name | Today's Date

Authorized TVMM Representative's Signature | Authorized TVMM Rep's Printed Name | Today's Date

TREASURE VALLEY METABOLIC MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:		DOB:	
Phone (H):		Phone (W):	
Address:		City/State/Zip:	

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes all healthcare facilities to make record disclosure.

Dates and type of information to disclose:

- ☐ 2 years prior from last date seen
- ☐ Dates: _____
- ☐ Specific information requested: _____

The purpose of the disclosure is:

- ☐ Change of insurance or provider
- ☐ Continuation of care
- ☐ Referral
- ☐ Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To:	Treasure Valley Metabolic Medicine		
Address:	951 E Plaza Drive, suite 110		
City/State/Zip:	Eagle, ID 83616		
Fax:	208-274-9581	Phone:	208-274-9580

- ☐ Please mail records
- ☐ Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: If I fail to specify an expiration date, event, or condition, this authorization will expire I year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization; I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provider in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ Date _____

Signature of Patient / Parent / Guardian or Authorized Representative.

(Guardian or Authorized Representative must attach documentation of such status.)

TREASURE VALLEY METABOLIC MEDICINE

This document is Effective September 16th, 2019

Statement of HIPPA Compliance

HIPPA (Health Insurance Portability and Accountability Act) was signed into law on August 21, 1996. Public Law 104-191. This was designed to provide insurance portability, to improve the efficiency of health care by standardizing the exchange of administrative and financial data. It will also protect the privacy, confidentiality, and security of health care information. It affects all areas of the health care industry.

Treasure Valley Metabolic Medicine (TVMM) upholds the HIPPA objectives and is proactively enhancing our existing HIPPA compliance.

TVMM has committed to track and provide coordination, education, and communication for all HIPPA activities. This is for monitoring and verifying that all HIPPA efforts for readiness are proceeding successfully within out organization.

Our software programs have been reviewed in order to determine how to best assist our clinics and customers with their HIPPA readiness issues.

The complete text of the proposed and finalized rules, along with comments, is available at:
http:\\aspe.hhs.gove/adminsimp

If you have any further questions regarding TVMM's processes or HIPPA readiness issues, please the Front Office Coordinator.

When making your inquiry, please mention that you are requesting additional information,

May we leave detailed voicemails on your phone with medical information? (Circle) Yes No

May we release your medical information to family members? (Circle) Yes No

Patient Print Name _____ Patient DOB _____

Patient Signature _____ Today's Date _____