CAPITOL
ENDOCRINOLOGY INC.

NEW PATIENT INFORMATION

Welcome to our office! We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally. Through our health care experience we strive to meet your medical needs and exceed your expectation with courteous, attentive, personal care.

Please find enclosed new patient forms which include a Registration form, Medical history questionnaire, Notice of privacy and financial policy. In order to save time, please fill these forms out and bring them with you to your first visit along a list of medications you take at this time including calcium, vitamins and herbs.

Please arrive 30 minutes prior to your scheduled appointment time. It is important that you remember to bring your current insurance card and driver's license at every visit. Your co-payment and / or deductible is always due at the time of your visit. If you are unable to keep your appointment, please give us 48 hours notice so we can accommodate other patients on the waiting list.

Please do not hesitate to call our office with any questions.

We look forward to meeting you.

Sincerely,

Jaiwant Rangi, MD, FACE and Staff

DIRECTIONS TO OUR OFFICE

FROM SACRAMENTO
Take Hwy 50 East towards Lake Tahoe. Exit at Cameron Park Drive. Make a left onto Cameron Park Drive. Turn right on Palmer Drive. Turn left on Ponte Morino Drive. Take the second driveway on the left into the Palmer Professional Center. We are in building # 3106, Suite C.

FROM LAKE TAHOE
Take 50 West towards Sacramento. Exit at Cameron Park Drive. Turn right on Cameron Park Drive. Turn right on Palmer Drive. Turn left on Ponte Morino Drive. Take the second driveway on the left into the Palmer Professional Center. We are in building 3106, Suite C.

CAPITOL ENDOCRINOLOGY INC.

REGISTRATION FORM

SECTION 1: PATIENT INFORMATION				
Name:	DOB:	Home Phone:		
Address:		City:	State:	Zip:
Social Security Number:	Occupation:	Employer:		
Employer Address:		City:	State:	Zip:
Local Pharmacy:	Phone:	Fax:		
Mail Order Pharmacy:	Phone:	Fax:		
Emergency Contact:	Phone:	Relationship:		
Spouse's Name:	Address:	City:	State:	Zip:
Occupation:	Employer:	Phone:		
Referring Physician:		Phone:		
SECTION 2: HEALTH INSURACNE INFORMATION				
Primary Insurance:	Subscriber ID#:	Group#:		
Subscriber's Name:	Relationship To Patient:	Contact Phone#		
Secondary Insurance:	Subscriber ID#:	Group#:		
Subscriber's Name:	Relationship To Patient:	Contact Phone#:		

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance which will be collected at the time of initial or follow up visit. I also authorize Capitol Endocrinology Inc. / Jaiwant Rangi, MD, FACE or insurance company to release any information required to process my claims. In the event you are required to proceed with any collection proceedings, I shall additionally be responsible for all reasonable fees associated with the collection of my debt and interest on the outstanding balance. I understand that it is the policy of this office to charge $25 fee for any returned / bounced checks or cancellation less than 48 hours of visit and no show. I have reviewed the detailed financial policy for Capitol Endocrinology Inc.

Patient / Guardian Signature: _____ Date: _____

CAPITOL ENDOCRINOLOGY INC.

FINANCIAL POLICY

1) We accept most insurance plans. Please call us if you have any specific questions.
2) Payment is due at the time of services unless arrangements have been made in advance by your Carrier. We accept cash, checks, money orders and most major credit cards.
3) Keep in mind that your insurance policy is basically a contract between you and your insurance company. As service to you, we will file your insurance claim if you assign benefits to your doctor in otherwords, if you agree to have your insurance company pays the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
4) We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them and you are required to pay a co-payment at the time of your visit.
5) Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.
6) Our billing company will send monthly statements to inform you of any balance due. We expect that patients due balances will be paid upon receipt of our statement. Any remaining unpaid balance will be collected at the time of your next visit. You also have the option to pay over the phone. Should there be an issue with your ability to pay, we encourage you to contact our billing service and arrange a payment plan for your balance due.
7) If necessary, unpaid past due accounts will be forwarded to an outside collection agency. All cost of this process will be your responsibility.
8) Our billing professionals will do all they can to communicate with you and your insurance company to resolve any issues. Questions Regarding billing issues can be directed to our professional billing office at 1-866-949-4565 (Toll free).
9) I understand that it is the policy of this office to charge $25 fee for any returned / bounced checks or cancellation less than 48 hours of visit /no show.
10) I have read and understand the practice's financial policy and I agree to bind by its terms. I also understand and agree that such terms may be amended by the practice from time to time.
Name of Patient: _____ Date: _____ Signature of Patient (or responsible party, if minor): _____

CAPITOL ENDOCRINOLOGY INC.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you (as a patient of our practice) may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations created as a result of the health insurance portability and accountability act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY:
Our practice is very dedicated to maintaining the privacy of your health information. Additionally, we are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we are obligated to provide you with the following important information. Use and disclose of your health information in certain special circumstances- common rule of law.

THE FOLLOWING CIRCUMSTANCES MAY REQUIRE US TO USE OR DISCLOSE YOUR HEALTH INFORMATION:

1) To public health authorities and health oversight agencies that are authorized to collect information.
2) Lawsuits and similar proceeding in response to a court or administrative order.
3) If required to do so by law enforcement official.
4) When necessary to reduce or prevent serious health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5) If you are a member of the U.S. or foreign military force (including veterans) and if required by the appropriate authorities.
6) To federal officials for intelligence and national security activities authorized by law.
7) To correctional institution or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8) For workers compensation and similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1) Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.
2) You can request a restriction in our use or disclosure of your health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, such as family and friends. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you.
3) You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy records. You may submit your request in writing to: Jaiwant Rangi, MD, FACE / Capitol Endocrinology Inc. / 3106 Ponte Morino Drive Palmer Professional Center/ Suite C Cameron Park/ CA 95682. Or via fax: (530) 676.7850.
4) You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the Information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Jaiwant Rangi, MD, FACE / Capitol Endocrinology Inc. / 3106 Ponte Morino Drive Palmer Professional Center / Suite C Cameron Park / CA 95682. Or via fax: (530) 676.7850.
5) Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6) Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or Secretary of department of health and human services. To file a complaint with our practice contact: Jaiwant Rangi, MD, FACE / Capitol Endocrinology Inc. / 3106 Ponte Morino Drive Palmer Professional Center, Suite C Cameron Park / CA 95682. Or via fax: (530)676.7850.
7) Rights to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for use and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policies, please contact: Jaiwant Rangi, MD, FACE / Capitol Endocrinology Inc. / 3106 Ponte Morino Drive Palmer Professional Center / Suite C Cameron Park / CA 95682. Or via fax: (530)676.7850

I hereby acknowledge that I have been presented with a copy of Capitol Endocrinology Inc. / Jaiwant Rangi, MD, FACE Notice of Privacy Practices.

Signature: _____ Date: _____

Name of Patient: _____ DOB: _____

CAPITOL
ENDOCRINOLOGY INC.

AUTHORIZATION FOR RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

I hereby authorize: _____
(Name and address of person/facility to release records)

I authorize the release of my medical records to Capitol Endocrinology Inc. / Jaiwant Rangi, MD, FACE and also authorize Dr.Rangi to release my medical records by Capitol Endocrinology Inc. / Jaiwant Rangi, MD, FACE to other physicians / Institutions for continued medical treatment and help manage my medical condition.

Jaiwant Rangi, MD, FACE
Capitol Endocrinology Inc.
3106 Ponte Morino Dr.
Cameron Park CA 95682

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: _____

This authorization is subject to written and signed revocation by the member/patient at any time. The written revocation will be effective upon receipt.

The recipient of these records may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Type of records to be disclosed: (check all that apply)

_____ Medical Information (progress notes, lab and diagnostic imaging results)

_____ Billing Records

_____ Mental Health Records

The recipient may use the health information authorized on this form for the following purposes:

_____

A copy of this authorization is just as valid as the original.

Patient Signature: _____ Date Signed: _____

CAPITOL ENDOCRINOLOGY INC.

MEDICAL HISTORY (1)

First Name:	Last Name:	Date of Visit:
DOB:	Referring Physician:	
Other Physicians:		
Reason for Visit:		

CURRENT SYMPTOMS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

CURRENT MEDICAL PROBLEMS (Please list all your medical problems here):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

LIST OF SURGERIES:

1. _____
2. _____
3. _____

LIST OF PREVIOUS HOSPITALIZATIONS:

1. _____
2. _____
3. _____

ALLERGIES: (Please write down the medications you are either allergic to or cannot tolerate and explain type of reaction, i.e. hives, wheezing, upset stomach, swelling etc.)

1. _____
2. _____
3. _____

CURRENT MEDICATIONS

Name of Drug:	MG/Dose or Units of Insulin:	No. of Pills:	How Often:

FAMILY HISTORY

RELATIONSHIP	MEDICAL PROBLEM	STATUS	AGE
Father		Living / Deceased	
Mother			
Brother / Sister			

SOCIAL HISTORY

Occupation:	Marital Status:
Are You Sexually Active? ☐ Yes ☐ No	Are You Pregnant? ☐ Yes ☐ No ☐ Not Sure
Date of Last Menstrual Period:	Age At Menopause:
Do You Smoke? ☐ Yes ☐ No ☐ Quit	If Yes, Now Much? (# Of Packs/Day):
Age When Started: Age When Quit:	If Quick, How Much Did You Smoke Per Day?
Do You Drink Alcohol? ☐ Yes ☐ No If Yes, How Much & How Often?	
Exercise Regularly? ☐ Yes ☐ No If yes, what kind of exercise and how often?	

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MEDICAL HISTORY (2)

REVIEW OF SYSTEMS:

(Please check if you have experienced any of the following symptoms in the last **6 months**)

GENERAL		MUSCULOSKELETAL	
Fatigue	☐No ☐Yes	Have you lost height	☐No ☐Yes
Loss of appetite	☐No ☐Yes	Any fractures in adult	☐No ☐Yes
Weight Loss	☐No ☐Yes	Muscle weakness	☐No ☐Yes
Weight Gain	☐No ☐Yes	Back pain	☐No ☐Yes
ENDOCRINE		NEUROLOGIC	
Excessive thirst	☐No ☐Yes	Burning	☐No ☐Yes
Excessive urination	☐No ☐Yes	Numbness	☐No ☐Yes
Breast discharge	☐No ☐Yes	Migraine	☐No ☐Yes
Increase in shoe size/ring size	☐No ☐Yes	SKIN	
		Hair Loss	☐No ☐Yes
ENT / THYROID		Rash	☐No ☐Yes
Hoarseness of voice	☐No ☐Yes	Acne	☐No ☐Yes
Swelling in the neck	☐No ☐Yes	EYES	
Difficulty in swallowing	☐No ☐Yes	Bulging eyes	☐No ☐Yes
Difficulty in breathing	☐No ☐Yes	Loss of vision	☐No ☐Yes
Chocking Sensation	☐No ☐Yes	Laser treatment in past	☐No ☐Yes
CARDIOVASCULAR AND CHEST		Double vision	
Cough	☐No ☐Yes	PSYCHIATRIC	
Difficulty breathing	☐No ☐Yes	Depression	☐No ☐Yes
Chest pain	☐No ☐Yes	Anxiety	☐No ☐Yes
Palpitations	☐No ☐Yes	Difficulty falling asleep	☐No ☐Yes
GI SYSTEM		BLOOD	
Nausea / Vomiting	☐No ☐Yes	Bleeding tendency	☐No ☐Yes
Heartburn	☐No ☐Yes	Easy bruising	☐No ☐Yes
Stomach pain	☐No ☐Yes	Heavy periods	☐No ☐Yes
Diarrhea	☐No ☐Yes		
Constipation	☐No ☐Yes		

PLEASE ANSWER THE FOLLOWING QUESTIONS IF YOU HAVE DIABETES	
What year was diabetes diagnosed?	
What type of diabetes do you have?	
Are you on Insulin injections or pump?	
When did you start Insulin?	
Who was your previous endocrinologist?	
When did you last see an eye doctor?	
Do you have retinopathy?	☐No ☐Yes
Laser treatment in the past?	☐No ☐Yes
When did you last see a podiatrist?	
Do you have neuropathy?	☐No ☐Yes
Any numbness or tingling?	☐No ☐Yes
Do you have any foot ulcers?	☐No ☐Yes
Do you have any amputations?	☐No ☐Yes
Do you have heart disease?	☐No ☐Yes
Did you ever have a stroke?	☐No ☐Yes
Do you have any kidney problems?	☐No ☐Yes
Did you ever take diabetes education classes?	☐No ☐Yes
Did you follow any special diet?	☐No ☐Yes

NOTES

_____
_____
_____
_____
_____
_____
_____
_____

CONSENT TO TREAT: I hereby authorize and consent to the performance of examinations, diagnostic procedures and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment and / or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

Patient's Signature: _____

Date: _____