



Welcome to our office. We are committed to providing high quality, comprehensive specialty care. We encourage you to ask questions. Please assist us by providing the following information.

PATIENT INFORMATION					
Patient Name (Please Print)					Date
Last	First		Middle Initial		
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Social Security Number:	-	-
Parent if Patient is a Minor					
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other (Explain)					
Home Address		City	State	Zip	
Home Telephone Number ()			Work Telephone Number ()		
Cell Phone Number ()					
Occupation			Employer's Name		
Spouse's Name					
Primary Physician's Name			Telephone Number ()		
Referring Physician's Name, (if different than PCP)			Telephone Number ()		
How did you learn about our practice?					
NOTIFY IN CASE OF EMERGENCY					
Name			Relationship		
Address		City	State	Zip	
Home phone ()		Work phone ()	Cell Phone ()		
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES					
Primary Insurance Name:			Members Name: (Insurance in name of)		
Address		City	State	Zip	
Subscriber's Name		Subscriber's Date of Birth	Subscriber's SSN#.		
Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Group Number		Insurance ID No.:	Effective date		
Secondary Insurance			Members Name: (Insurance in name of)		
Address		City	State	Zip	
Subscriber's Name		Subscriber's Date of Birth	Subscriber's SSN#		
Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Group Number		Insurance ID No.	Effective date		

Please Read Our Financial Policy Statement and Agreement on Reverse

Financial Policy Statement and Agreement

1. **AUTHORITY FOR TREATMENT:** I hereby authorize Endocrine and Diabetes Center, P.C. and/or doctors, providers and staff in charge of the patient to evaluate and perform procedures and treatment that may be deemed necessary or advisable. I hereby certify that all the information I have reported to your office including insurance coverage is correct, and authorize all payments of medical insurance benefits be paid to Endocrine and Diabetes Center, P.C. for services rendered. I understand that I am liable for the payment of all bills incurred. I agree to pay all attorneys' fees should it become necessary for the filing of a civil suit or fees associated with the use of a collection agency to collect said claims. A copy of this authorization may be used as the original. I also acknowledge that I have received and read a copy of the "Patient Information pamphlet"

Signature (parent if patient is a minor) _____ Date: _____

2. **INSURANCE AUTHORIZATION:** I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Endocrine and Diabetes Center, P.C. and /or the doctor indicated on the claim. I understand and agree that I am financially responsible for charges or any balance not paid by the insurance carrier.

Signature (parent if patient is a minor) _____ Date: _____

3. **RELEASE OF INFORMATION AND PRIVACY NOTICE:** I acknowledge that I have been presented with a copy of Privacy Notice (Health Insurance Portability and Accountability Act of 1996) explaining my rights regarding my individually identifiable health information (IIHI). I consent to the use and disclosure of my IIHI for purposes of treatment, payment or other health care operations. I hereby authorize Endocrine and Diabetes Center, P.C. to release any information pertaining to my health care, test results, billing and/ or accounting information to the following person(s) or agencies.

Myself my spouse Leave information on my answering machine

Others (specify) _____

Additional uses of my IIHI will require an authorization from me for the specific intention of disclosure.

Signature (parent if patient is a minor) _____ Date: _____

4. **MEDICARE:** I request that payment of authorized Medicare benefits for any services furnished to me, be made on my behalf to Endocrine and Diabetes Center, P.C. I authorize the release of my medical information to the Center for Medicare and Medicaid services and its agents to determine these benefits. Regulations pertaining to Medicare assignment of benefits apply.

Signature (parent if patient is a minor) _____ Date: _____



Ali M. Safa, M.D., F.A.C.P., F.A.C.E. and Associates

Privacy Policy

Effective April 14, 2003

Revised April 14, 2009

Revised May 19, 2010

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, (The Health Insurance Portability and Accountability Act of 1996) (HIPAA), mandates that we issue this new revised Privacy Notice to our patients. This notice meets all current requirements as it relates to Standards for Privacy of Individually Identifiable Health Information (IIHI); affecting our patients. You are urged to read this notice.

As part of the Privacy Standard, implemented on April 14, 2001, you are required to provide this office with a new, signed and dated, Consent Agreement. Every patient must receive our new Privacy Notice and execute a new Consent Agreement before this office may use your information for treatment, payment, or other health care operations.

Our Privacy Notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: "any information, whether oral or recorded in any medium, that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past present or future payment for the provision of health care to an individual".

Our office will use or disclose your PHI for purposes of treatment, payment and other healthcare purposes as required to provide you the best quality healthcare services that we offer to the extent permitted by your Consent Agreement or in such specific situations, by your signed and dated Authorization. It is our policy to control access to your PHI; and even in cases where access is permitted; we exercise a "minimum necessary information" restriction to that access. Which we define as the minimum necessary information needed to accomplish the intent of the request.

An Authorization is very specific with regard to the information authorized that will be disclosed or used. The individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration of the authorization. In the event of a non-healthcare related request for personal health information this office will request you to complete an Authorization Form.

You, as our patient, may revoke any Consent Agreement or Authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke either the Consent Agreement or the Authorization you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization or Consent Agreement. Any revocation will not apply to information already used or disclosed. If you had a "personal representative" initiate as Authorization you may revoke that authorization at any time.

□ Vienna Office:

301 Maple Avenue West, #120
Vienna, Virginia 22180
PHONE (703) 938-8885 FAX: (703) 242-2437

□ Woodbridge office:

2200 Opitz Blvd., #250
Woodbridge, Virginia 22191
PHONE (703) 494-5858 FAX: (703) 491-1416

You, the patient have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician or principal will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes.

In limited circumstances, The Privacy Standard permits, but does not require, covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities. These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. There are specific state laws that required the disclosure of health care information related to Hepatitis C, and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail.

All of these disclosures could occur previously under former laws and regulations however; The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgments to decide whether to disclose any information, reflecting our own policies and ethical principals.

On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a "chain of trust" contract and monitor our business associates' contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard. Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

Effective October 19, 2005, Board of Medicine regulations (18VAC85-20-26) now require physicians practices to maintain an adult patient's record for a minimum of six years following the last patient encounter. The regulations provided an exception to this retention requirement for records that have previously been transferred to another physician or provided to patient. Records of a minor child, including immunizations, must be maintained until the child reaches the age 18, with a minimum time for records retention of six years from the last patient encounter regardless of the age of the child

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IHHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

In the event of a breach of security involving the patient's protected health information, Endocrine and Diabetes Center will follow the recommendations outlined by the American Medical Association.

If you have any questions about this information discussed above please contact the privacy officer directly in the office where you are seen.

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Name _____ Age _____ Date of Birth _____

Please Circle Appropriate Answer

• CONSTITUTIONAL SYMPTOMS

- Good general health No Yes
Recent weight change (explain)..... No Yes
Fever No Yes
Fatigue..... No Yes
Headaches No Yes
Insomnia..... No Yes

• EYES

- Eye disease or injury No Yes
Wear glasses/contact lenses No Yes
Blurred or double vision No Yes
Glaucoma No Yes
Changes in visual field..... No Yes

• EARS/NOSE/MOUTH/THROAT

- Hearing loss or ringing..... No Yes
Chronic sinus problem or rhinitis No Yes
Nose bleeds No Yes
Hoarseness or difficulty speaking No Yes
Bleeding gums No Yes
Sore throat..... No Yes
Swollen glands in neck No Yes

• CARDIOVASCULAR

- Heart trouble No Yes
Chest pain..... No Yes
Palpitation No Yes
Shortness of breath with walking or lying flat No Yes
Swelling of feet, ankles or hands No Yes
Cold extremities No Yes

• RESPIRATORY

- Chronic or frequent coughs..... No Yes
Spitting up blood..... No Yes
Shortness of breath..... No Yes
Asthma or wheezing No Yes
Snoring No Yes

• GASTROINTESTINAL

- Loss of appetite No Yes
Change in bowel movements No Yes
Nausea or vomiting No Yes
Frequent diarrhea No Yes
Painful bowel movements or constipation..... No Yes
Rectal bleeding or blood in stool No Yes
Abdominal pain or heartburn No Yes
Peptic ulcer (stomach or duodenal)..... No Yes

• GENITOURINARY

- Frequent urination No Yes
Burning or painful urination No Yes
Blood in urine No Yes
Change in force of strain when urinating..... No Yes
Incontinence or dribbling No Yes
Kidney stones..... No Yes
Female - painful periods No Yes
Female - irregular periods..... No Yes
Female - vaginal discharge No Yes
Female - # pregnancies _____ # miscarriages _____
Female - date of last pap smear _____

• MUSCULOSKELETAL

- Joint pain No Yes
Joint stiffness or swelling..... No Yes
Weakness of muscles or joints No Yes
Muscle pain or cramps No Yes
Back pain No Yes
Difficulty in walking No Yes

• INTEGUMENTARY (skin, breast)

- Rash or itching No Yes
Change in skin color No Yes
Change in hair or nails No Yes
Varicose veins No Yes
Breast pain No Yes
Breast lump No Yes
Breast discharge No Yes

• NEUROLOGICAL

- Frequent or recurring headaches No Yes
Light headed or dizzy..... No Yes
Convulsions or seizures No Yes
Numbness or tingling sensations No Yes
Tremors No Yes
Paralysis No Yes
Stroke No Yes
Head injury..... No Yes

• PSYCHIATRIC

- Memory loss or confusion No Yes
Nervousness No Yes
Depression..... No Yes

• ENDOCRINE

- Hormone problem (explain)..... No Yes
Thyroid disease No Yes
Diabetes..... No Yes
Excessive thirst or urination..... No Yes
Heat or cold intolerance..... No Yes
Skin becoming dryer..... No Yes
Change in hat or glove size No Yes

• HEMATOLOGIC/LYMPHATIC

- Bleeding or bruising tendency No Yes
Anemia No Yes
Phlebitis..... No Yes
Past transfusion No Yes
Enlarged glands..... No Yes

• ALLERGIC/IMMUNOLOGIC

- Known drug allergies _____

Known food allergies _____

Reviewed By: _____



Endocrine & Diabetes Center

Ali M. Safa, M.D., F.A.C.P., F.A.C.E.

Mary Jean Bozzelli, MSN, CFNP

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize (Name of healthcare provider or organization): _____

(Street) (City) (State) (ZIP Code)
to disclose health information from the medical record(s) of:

Patient Name: _____

Address: _____
(Street) (City) (State) (ZIP Code)

Date of Birth: _____ Approximate date(s) of treatment: _____

Please release Information to: Endocrine and Diabetes Center, P.C. at the following address:

- 301 Maple Avenue West, Suite 120 Vienna, VA 22180
- 2200 Opitz Boulevard, Suite 250, Woodbridge, VA 22191

Information requested:

_____ ALL MEDICAL RECORD _____ Operative reports _____ Pathology report _____ Discharge summary

_____ LABORATORY FINDINGS _____ RADIOLOGY REPORTS _____ NUCLEAR MEDICINE

_____ OTHER: _____

I permit this confidential information be released for the following purpose:

_____ continuing medical care

_____ Confirmatory consultation

_____ Other: Specify Reason: _____

Print Patient's Name: _____

Signature of Patient: _____ Date: _____

Signature of Legally Authorized Person: _____ Date: _____

Signature of witness: _____ Date: _____

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