TREASURE VALLEY METABOLIC MEDICINE

Thank you for choosing Treasure Valley Metabolic Medicine.
We look forward to helping you meet your healthcare needs.
To help us serve you more efficiently, please fill-out, read, sign, and date in the designated areas.

Patient's First Visit Date	Nurse Practitioner's Name	Patient's New Account Number

Patient Information

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

Sex	Marital Status	Email	Home or Cell Phone
☐M *(Male)* ☐F *(Female)*	☐Married ☐Single ☐Divorced ☐Widow		

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

When was your last physician visit? *(Date/Dates)*	Physician's Name	Was this an auto accident?	Work related accident?	Date of the accident?
		☐Yes ☐No	☐Yes ☐No	

Tell Us About Your Illness / Injury / Pain	Attorney's Name

Whom may we call in case of emergency?	Relation to you?	Phone

Whom may we thank for referring you to our clinic?

☐Attorney ☐Billboard/Sign/Location ☐Doctor ☐Insurance Provider ☐Newspaper ☐Phone Book ☐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's Name)* as considered necessary and proper in diagnosing or treating his/her physical condition.

Sign

Patient and/or Guardian Signature

Patient and/or Guardian Print Name

Timestamp
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.

Sign

Patient and/or Guardian Signature | Patient and/or Guardian Print Name | Timestamp 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#	Adjuster/Case Manager
Co-Pay or %	Deductible	Amount Met	Effective Date
Secondary Insurance		Mailing Address (City, State, Zip)	Phone
Group and/or Claim #		Member Id#	Adjuster/Case Manager
Co-Pay or %	Deductible	Amount Met	Effective Date

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.

Sign

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

Sign

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

TREASURE VALLEY METABOLIC MEDICINE

Phone: 208-274-9580
951 East Plaza Drive, Suite 110 * Eagle, ID 83616

NEW PATIENT QUESTIONNAIRE

Please complete this prior to your appointment.

GENERAL INFORMATION:

Name: Language(s) spoken:

Address:

Daytime Phone #: Alternate Phone #:

Date of Birth Age: Email address (optional):

Can we contact you at this address for medical issues? ☐Yes ☐No

Ethnicity: ☐Hispanic ☐Non Hispanic

Race: ☐Caucasian ☐Black ☐Asian ☐Indian ☐Native American ☐Other:

REFERRING DOCTOR:

NAME	ADDRESS	PHONE NUMBER

Reason for visit:

☐Diabetes in Pregnancy ☐Diabetes Type 1 ☐Diabetes Type 2 ☐Prediabetes / diabetes prevention

☐Weight management ☐Other:

ALLERGIES: ☐No Known Allergies

MEDICINE	REACTION

SURGICAL HISTORY: Please list surgeries you have had, date and hospital ☐None

Surgery	Date	Location

FAMILY HISTORY - are you adopted? ☐Yes ☐No

Have any of your family members ever had any of the following?

	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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rashes/Skin Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

REVIEW OF SYSTEMS - please check if you are currently experiencing any of the following

GENERAL WELL-BEING:

☐Weight Loss
☐Weight Gain
☐Fever
☐Fatigue
☐Excessive Thirst
☐Excessive Hunger
☐Problems Sleeping
☐Heat Intolerance
☐Cold Intolerance

RESPIRATORY:

☐Coughing
☐Coughing up Blood
☐Wheezing

BLOOD SYSTEM:

☐Bleed Easily
☐Bruise Easily
☐Enlarged Lymph Nodes
☐Blood Sugars <70
☐Blood Sugars >250

CARDIOVASCULAR:

☐Shortness of Breath
☐Chest pain
☐Palpitations
☐Swelling

EARS, NOSE, THROAT, MOUTH:

☐Ulcers
☐Sinus Problems
☐Hearing Problems
☐Ringing in the Ears
☐Difficulty Swallowing

EYES:

☐Vision Changes
☐Contacts / Glasses
☐Excessive Tearing / Eye Discharge

MUSCULOSKELETAL:

☐Weakness
☐Muscle Pain

IS THERE ANYTHING SPECIFIC YOU WISH TO DISCUSS WITH YOUR PHYSICIAN THIS VISIT?

IF YOU HAVE DIABETES, complete the following questions:

At what age was your diabetes diagnosed?

Have you seen a diabetes educator? ☐Yes ☐No

Have you seen a nutritionist regarding your diabetes? ☐Yes ☐No

What type of diabetes do you have? ☐Type 1 ☐Type 2 ☐Diabetes in pregnancy ☐Do not know

Do you check your blood sugars at home? ☐Yes ☐No

If yes, what is a high reading for you?

What is a low reading for you?

Do your sugars ever go below 70? ☐Yes ☐No

If yes, is this ☐daily ☐weekly ☐monthly ☐rarely

Are you aware of when your sugars go low? ☐Yes ☐No

Have you been hospitalized for low blood sugars? ☐Yes ☐No

If yes, when and where

Do you know your A1c? ☐Yes ☐No If yes, what is it?

Have you ever been hospitalized for high blood sugars? ☐Yes ☐No

If yes, when and where

Do you have diabetes related eye problems? ☐Yes ☐No Eye Doctor:

When was your last eye exam? ☐Never

Do you have foot problems? ☐Yes ☐No Who is your Foot Doctor:

When did you last give a urine sample for your diabetes? ☐Never

Do you have diabetes related kidney problems? ☐Yes ☐No

When did you last have a cardiac assessment? ☐Never

Do you have heart diesase? ☐Yes ☐No

Are you on an insulin pump? ☐Yes ☐No Type:

Do you use a continuous glucose monitoring device? ☐Yes ☐No Type:

Males: Do you have erectile dysfunction? ☐Yes ☐No

Do you have any specific issues you would like to address with your physician regarding your diabetes?

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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 a insulin resistance? ☐Yes ☐No

Do you have a PCOS? ☐Yes ☐No

Do you have a 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

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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 Other:

☐ Specific Information Requested

The purpose of the disclosure is:

☐ Change of Insurance or Physician

☐ Continuation of Care (e.g., VA Med Ctr)

☐ 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 1 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.

Sign

Timestamp

Signature of Patient / Parent / Guardian or Authorized Representative.
(Guardian or Authorized Representative must attach documentation of such status.)

Printed name of Authorized Representative

Relationship / Capacity to patient

Address and telephone number of the authorized representative

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 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 he 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? ☐Yes ☐No

May we release your medical information to family members? ☐Yes ☐No
If yes, please list family member names:

Patient Print Name

Patient DOB

Sign

Patient Signature

Timestamp
Today's Date