Frederick Internal Medicine and Endocrinology Services

ENDOCRINOLOGY
Majd Hakim, M.D., FACE, ECNU
Jinhui Yuan, PA-C

65C THOMAS JOHNSON DR
FREDERICK, MD 21702
301-663-3836 Phone
301-663-0122 Fax

INTERNAL MEDICINE
Andrew Donelson, M.D.
Hemen Shah, M.D.
Hirenkumar Shah, M.D.

PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT

WELCOME TO OUR OFFICE!! Thank you for selecting our practice. In order to provide the best medical care and a great experience when you visit us please read on. If you have any other questions, feel free to call us at (301) 663-3836.

********** WHAT TO BRING WITH YOU **********

MEDICAL HISTORY FORM (*if included in this packet*) Filling this out at home will give you time to consider these questions instead of rushing to complete it while sitting in our office.

DRIVER'S LICENSE OR OTHER PICTURE ID This is to help prevent identity theft

INSURANCE CARD AND COPAY The amount of the copay is usually printed on your insurance card. You will need to pay your copay when you arrive which you can pay with cash, check, or Visa/MasterCard

INSURANCE REFERRAL If required, your primary care doctor will provide this to you. Check with your insurance company. Without it your insurance may not pay for your visit.

MEDICAL RECORDS Your other doctors will provide this for you when you ask.

BRING THYROID ULTRASOUND OR SCAN FILMS to your appointment.
If you are seeing one of our Endocrinologist, Dr. Hakim or Jinhui Yuan, PA-C we ask you to **bring the actual films for review**. Please contact the radiology department where the test was performed to schedule a pick up time.

PRESCRIPTIONS Bring the prescription bottles so your doctor knows exactly what you are currently taking and the dosage.

********** HELPFUL TIPS FROM OUR OFFICE **********

RUNNING LATE? We understand that circumstances can sometimes prevent you from arriving on time. If this happens, we will try our very best to accommodate you within the schedule. If we are unable to see you or you cannot wait, we will be happy to reschedule your appointment.

CANCELLATION If you need to cancel or reschedule an appointment please call our office at least 24 hours before your appointment. Broken appointments represent a cost to us, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

BLOOD PRESSURE CHECKS, ALLERGY INJECTIONS, FLU SHOTS You may come into our office without an appointment between 10 am and 12 pm or between 2 pm and 4 pm, on Tuesdays, Wednesdays or Thursdays. There might be a wait but the nurse will see you as soon as possible. If you cannot come during these times, please call our office so we can arrange a time that is more convenient for you.

PAYMENT If you have any questions about what insurances we accept, or about payment of your deductible or copay please call our billing office at 301-663-3836 and select prompt 2.

PRESCRIPTION REFILLS If you need to refill your medication that we have prescribed, call your pharmacy. They will contact us for you to obtain the refill authorization.

HOURS Our office is open Monday through Friday from 8:00 am to 5:00 pm. You can reach us by phone between 9 am and 4 pm. Our phones are off between 12:30 pm and 1 pm so our operators can take lunch.

ANY OTHER QUESTIONS, CALL
(301) 663-3836

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Majd Hakim, M.D., FACE, ECNU
Jinhui Yuan, PA-C
Regina Kundell, CRNP, BC-ADM

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********** DIRECTIONS **********

Direction #1 to Our Frederick Office from 270, 70 or 340, take 15 North towards Gettysburg. Take the Motter Avenue Exit. Bear to the right onto Opossumtown Pike. Go over the bridge. At the third light, turn right onto Thomas Johnson Drive. Go approximately 1 mile. Our office is located of the left side at 65 Thomas Johnson Drive. We are in the second building in Suite C.

Directions #2 to Our Frederick Office from 270, 70 or 340, take 15 North towards Gettysburg. Take the Christopher's Crossing Exit, which is directly after Motter Ave. Exit. At the top of the exit make a left at the light onto Christopher's Crossing. At the second light stay in the far left lane and make a left onto Thomas Johnson Dr. At the stop sign go straight to continue onto Thomas Johnson Dr. Turn right at the 4th building on the right (63 Thomas Johnson Dr.) We are the building directly behind them, 65 Thomas Johnson Dr. in Suite C.

From Thurmont or Emmitsburg: Directly from route 15 (south) you will take the Hayward Road Exit. At the yield sign bear to the right and continue on Hayward Road. Take your first left onto Thomas Johnson Drive. Our office is located on the right side at 65 Thomas Johnson Drive. We are the second building in suite C.

PATIENT INFORMATION FORM (Please Print)

PATIENTS NAME: _____
(LAST) (FIRST) (M.I.)

BIRTH DATE: ___/___/___ AGE: _____ SEX: _____ SOCIAL SECURITY #(SSN): _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

PATIENTS EMPLOYER: _____ POSITION: _____

EMPLOYER ADDRESS: _____

IF PATIENT IS A MINOR, PARENT OR GUARDIAN'S NAME: _

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT: _____

PRIMARY INSURANCE COMPANY NAME: _____
SUBSCRIBER'S NAME: _
SUBSCRIBER'S BIRTH DATE: _ SUBSCRIBER'S SSN: _
INSURANCE COMPANY ADDRESS: _____
COPAY: _____ POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE COMPANY NAME: _____
SUBSCRIBER'S NAME: _
SUBSCRIBER'S BIRTH DATE: _ SUBSCRIBER'S SSN: _
INSURANCE COMPANY ADDRESS: _____
COPAY: _____ POLICY NUMBER: _____ GROUP NUMBER: _____

NEXT OF KIN: _____ PHONE NUMBER _____
ADDRESS: _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE NUMBER: _____

IF YOU ARE SEEING DR. HAKIM OR JINHUI YUAN, PA-C, PLEASE LIST YOUR PRIMARY CARE DOCTOR:
_____ PHONE NUMBER: _____

I AUTHORIZE THE ABOVE MEDICAL PRACTICE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL FEES FROM SERVICES PROVIDED, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS AND ANY COSTS INCURRED BY THE PHYSICIAN(S) IN ORDER TO COLLECT SUCH FEES.

SIGNED: _____ DATE: _____
PATIENT (OR PARENT'S SIGNATURE IF PATIENT IS A MINOR)

ENDOCRINE & METABOLIC HEALTH HISTORY (please print)

A. PERSONAL INFORMATION

Name:	Gender: M / F Today's Date:
Date of Birth: Age:	Marital Status: □M □D □W □S
Referring Physician:	Primary Physician:
Other Physicians:	
Occupation:	

B. REASON FOR CONSULTATION

Please indicate the reason for your visit or your concerns or questions:

1._____

2._____

C. GENERAL MEDICAL INFORMATION

CONDITION	YES	Runs in Family	CONDITION	YES	Runs in Family
High Blood Pressure:	□	□	Liver Disorder:	□	□
High Cholesterol:	□	□	Gall Bladder Disorder:	□	□
High Triglycerides:	□	□	Diverticulitis:	□	□
Diabetes Mellitus:	□	□	Other Abnormal/Intestinal Disorders:	□	□
Heart Attack:	□	□	Kidney Stones:	□	□
Angina/Coronary Disorder:	□	□	Urinary Infection:	□	□
Other Heart Disorders:	□	□	Other Kidney/Bladder Disorders:	□	□
Stroke/TIA:	□	□	Arthritis:	□	□
Seizures/Convulsions/Epilepsy:	□	□	Back Disorder:	□	□
Migraine Headaches:	□	□	Neck Disorder:	□	□
Other Neurological Disorders:	□	□	Menstrual Irregularities:	□	□
Emphysema/Bronchitis:	□	□	Gout:	□	□
Pneumonia:	□	□	Anemia:	□	□
Asthma:	□	□	Cancer:	□	□
Peptic Ulcer Disease:	□	□	Phlebitis (Inflamed Leg Veins):	□	□
Other Lung Disorders:	□	□	Breast Problems:	□	□
Reflux Esophagitis/Hiatal Hernia:	□	□	Prostate Problems:	□	□
Overweight/Obesity:	□	□	Glaucoma:	□	□
Sleep Apnea:	□	□	Other Eye Disorders:	□	□
Allergic Disorders:	□	□	Rashes or Other Skin Disorders:	□	□

Please give any details if any conditions are marked "Yes":

Name: _____ Date of Birth: _____

ENDOCRINE CONDITIONS IN YOU OR YOUR RELATIVES:

CONDITION	YES	Runs in Family	CONDITION	YES	Runs in Family
Pituitary:	☐	☐	Pancreas:	☐	☐
Thyroid:	☐	☐	Ovaries:	☐	☐
Adrenal Glands:	☐	☐	Testes:	☐	☐
Parathyroid Glands:	☐	☐			
Please give any details if any conditions are marked "Yes":					

D. MEDICATIONS: List current medications and dosage, including over the counter medications and supplements:

Medication	Dose	Frequency	Medication	Dose	Frequency

E. PAST SURGERIES: (Please mention all major and minor surgeries or procedures.)

☐ Thyroid Surgery ☐ Hysterectomy (Uterus Surgery) ☐ Back surgery

☐ C-section ☐ Appendectomy (Appendix Surgery) ☐ Tonsillectomy

☐ Hernia surgery ☐ Mastectomy (Breast Surgery) /Breast biopsy ☐ Gastric bypass/gastric sleeve

☐ Joint surgery ☐ Coronary bypass ☐ Gall Bladder Surgery:

☐ Other: _____

F. ALLERGIES:

Allergy to any drug (s) _____

X-Ray Dye_____Food _____

G. SOCIAL HISTORY:

( ) tobacco: amount:_____( ) alcohol: amount:_____( ) regular exercise

( ) Ionizing radiation exposure to head or neck ( ) excessive intake of Iodine-containing foods

Name: _____ Date of Birth: _____

H. RECENT SYMPTOM LIST: Have you had problems with any of the following?

General: ( ) fatigue ( ) unintentional weight loss ( ) intentional weight loss ( ) weight gain ( ) fever ( ) chills ( ) excessive sweating ( ) excessive thirst ( ) feeling excessively cold ( ) feeling excessively hot ( ) increase in appetite ( ) decrease in appetite ( ) change in ring size ( ) change in shoe size

Neurological & Psychological: ( ) depressed mood ( ) anxiety attacks ( ) excessive nervousness ( ) irritability ( ) blackout spells or loss of consciousness ( ) dizziness ( ) forgetfulness ( ) difficulty concentrating ( ) headaches ( ) poor sleep ( ) sleep too much ( ) numbness or tingling in hands and/or feet ( ) tremors ( ) seizures

Head/Neck: ( ) visible lump in front of neck ( ) trouble swallowing ( ) pain swallowing ( ) persistent hoarseness ( ) voice change ( ) neck pain ( ) sinus problems ( ) dry mouth ( ) sore throat ( ) swollen glands in neck ( ) neck fullness ( ) choking sensation ( ) pressure in the neck

Eyes: ( ) bulging eyes ( ) dry eyes ( ) eye irritation ( ) double vision ( ) tunnel vision ( ) blurred vision ( ) loss of vision ( ) loss of peripheral vision

Skin: ( ) dry skin ( ) itching ( ) dry or brittle hair ( ) hair loss or balding ( ) weak or cracking nails ( ) easy bruising or bleeding ( ) yellowish skin ( ) rash ( ) increased hair growth: ( ) face ( ) chest ( ) breast ( ) abdomen

Heart/Lung: ( ) palpitations ( ) swelling in feet or ankles ( ) chest pain ( ) shortness of breath ( ) cough ( ) wheezing

Gastro: ( ) diarrhea ( ) constipation ( ) frequent bowel movements ( ) abdominal pain ( ) nausea ( ) vomiting ( ) heartburn ( ) change in bowel movements

Muscles/Joints: ( ) muscle weakness ( ) muscle aches and pains ( ) swollen joints ( ) joint aches ( ) joint stiffness

G/U: ( ) difficulty urinating ( ) excessive urination ( ) getting up to urinate at night

WOMEN ONLY:

Pre menopause: ( ) infrequent menses ( ) more frequent menses ( ) no menstrual cycle ( ) heavy menses ( ) light menses ( ) hot flashes ( ) low sexual desire ( ) irregular menstrual cycle ( ) change in menstrual cycle

How old were you when you had your first menstrual cycle? _____
What was the date of your last menstrual cycle? _____
What method of contraception (if any) are you using? _____

Post menopause: ( ) hot flashes ( ) low sexual desire ( ) vaginal dryness

Breasts: ( ) breast tenderness ( ) fluid leakage from breast ( ) breast lump

MEN ONLY:

( ) impotence ( ) low sexual desire ( ) difficulty with erections ( ) prostate problems ( ) testicular lumps ( ) pain in testicles

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PHONE: 301-663-3836 FAX: 301-663-0122

HIPAA NOTICE OF PRIVACY PRACTICES

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 THE EXTENT THAT YOUR PHYSICIAN OR THE PHYSICIAN'S PRACTICE HAS TAKEN AN ACTION IN RELIANCE ON THE USE OR DISCLOSURE INDICATED IN THE AUTHORIZATION.

6. YOUR RIGHTS: THE FOLLOWING IS A STATEMENT OF YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION. UNDER FEDERAL LAW, HOWEVER, YOU MAY NOT INSPECT OR COPY THE FOLLOWING RECORDS: PSYCHOTHERAPY NOTES; INFORMATION COMPILED IN REASONABLE ANTICIPATION OF, OR USE IN, A CIVIL, CRIMINAL, OR ADMINISTRATIVE ACTION OR PROCESS; 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 PURPOSES OF TREATMENT, PAYMENT OR HEALTHCARE 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 RESTRICION TO APPLY.

YOUR PROVIDER IS NOT REQUIRED TO AGREE TO A RESTRICTION THAT YOU MAY REQUEST. IF THE PROVIDER 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. YOU THEN HAVE THE RIGHT TO USE ANOTHER HEALTHCARE PROFESSIONAL.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATION FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US, UPON REQUEST, EVEN IF YOU HAVE AGREE TO ACCEPT THIS NOTICE ALTERNATIVELY (i.e. ELECTRONICALLY).

YOU MAY HAVE THE RIGHT TO HAVE YOUR PROVIDER 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, OF 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.

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HIPAA NOTICE OF PRIVACY PRACTICES

7. COMPLAINTS: YOU MAY COMPLAIN TO US OR TO 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 OUR HIPAA COMPLIANCE OFFICER. 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 PROVIDE 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 ASK TO SPEAK WITH OUR HIPAA COMPLIANCE OFFICER IN PERSON OR BY PHONE AT OUR MAIN PHONE NUMBER 301-663-3836.

SIGNATURE BELOW IS ONLY TO ACKNOWLEDGE THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES.

REVISED 06/27/2018

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Patient Name: _____ Date of Birth: _____
(Please print)

Acknowledgment of Receipt of Privacy Notice

I have been offered a copy of the HIPAA Privacy Policy. I understand my rights according to this policy and that HIPAA law grants this practice authorization to use and disclose my medical records for treatment/care and payment operations.

Communication Authorization

My provider may contact me at the phone numbers list below regarding my diagnosis, results, treatment and care, or payment. I may request any other means of communication (such as e-mail or mail) or I may deny a particular means of communication in writing.

Home Number: _____ Cell Number: _____ Work Number: _____

I authorize my provider to share medical or billing information with the following people:

Name	Relationship	Phone
Name	Relationship	Phone

I understand that I have a right to 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 HIPAA Privacy Officer. I understand that 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.

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 copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: FREDERICK INTERNAL MEDICINE AND ENDOCRINOLOGY SERVICES HIPAA PRIVACY OFFICER LESA WALLACE.

_____ _____
Signature of Patient or Authorized Representative Date

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FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. You can pay with cash, personal checks, VISA, and MasterCard. There is a service charge for returned checks. If you do not have insurance and will not be able to pay in full at the time of your visit, call our office to make payment arrangement prior to your visit.

INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. We will send you a statement for any balance due after your insurance has paid us.

CANCELLATION POLICY:

Please note we have a 24 hour cancellation policy. Patients that do not cancel within 24 hours or do not show for their appointment may be charged a fee of $30.00. **New patients** may be charged a fee of $75.00. Biopsy appointments may be charged a fee of $100.00

MEDICAL FORMS:

A fee may be applied for medical forms that need to be completed by your provider.

REFUNDS:

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

I have read and understand the **FIMES** Financial Policy. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Patient Name: _____
(Please print)

Patient's Signature: _____ Date: _____