# 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
833-979-0962 Fax

**INTERNAL MEDICINE**
Dr Andrew Donelson
Dr Hemen Shah
Dr. Hirenkumar Shah
Caitlin Prince, CRNP

## *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.

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## ********** 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 3 or 4.

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

**ANY OTHER QUESTIONS, CALL**
**(301) 663-3836**

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## ********** DIRECTIONS **********

**Directions 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.

**From Thurmont or Emmitsburg:** Directly from route 15 (south) you will take Exit 18, Monocacy Blvd/Christophers Crossing. At the light you will turn right onto Christophers Crossing. Take your first left onto Thomas Johnson Drive. You will continue until you come to a stop sign (old Hayward Rd). Cross over Hayward Rd and continue on Thomas Johnson Drive. Your destination will be 0.3 miles on the right, located at 65 Thomas Johnson Drive. We are the second building in suite C.

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: _____

NAME: _____ 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)

NAME: _____

AGE: _____

SOME OF THE QUESTIONS MAY NOT APPLY TO YOU. PLEASE LEAVE THEM BLANK. IF YOU DO NOT UNDERSTAND ANY QUESTION, PLEASE MARK THEM WITH AN 'A'.

REASON FOR YOUR VISIT OR YOUR CONCERNS OR QUESTIONS:

1. _____

2. _____

3. _____

PAST OR PRESENT MEDICAL PROBLEMS (ANY TIME IN LIFE)

| DISEASE | YES OR NO | DISEASE | YES OR NO | DISEASE | YES OR NO |
|---|---|---|---|---|---|
| SINUS INFECTION | | ASTHMA | | HAY FEVER | |
| PHEUMONIA | | BRONCHITIS | | EMPHYSEMA | |
| CORONARY ARTERY DIS | | HIGH BLOOD PRESSURE | | STROKE OR MINI | |
| HEART MURMUR | | HEART ATTACK | | HEART FAILURE | |
| BLOOD CLOTS(LEG/LUNG) | | MITRAL VALVE PROLAPSE | | IRREGULAR HEART BEATS | |
| HIATAL HERNIA | | ANEMIA | | STOMACH ULCERS | |
| HEMORRHOIDS | | ACID REFLUX | | DIVERTICULOSIS | |
| DIABETES | | BOWEL OR COLON POLYP | | HEPATITIS / LIVER DISEASE | |
| HIGH CHOLESTEROL | | GALLSTONES | | KIDNEY STONES | |
| SKIN CANCER / MOLES | | FREQUENT URINE INFECTION | | THYROID DISEASE | |
| CATARACTS | | SEXUALLY TRANSMITTED DIS | | FRACTURED BONES | |
| DEMENTIA | | OSTEOPOROSIS | | ARTHRITIS | |
| PANIC ATTACKS | | GLAUCOMA | | HEARING PROBLEMS | |
| DEPRESSION | | ANXIETY DISORDER | | ANY CANCER | |
| ANY OTHER PROBLEMS: | | | | | |

PAST SURGERIES: (PLEASE MENTION ALL MAJOR AND MINOR SURGERIES OR PROCEDURES. EX. BREAST BIOPSY, BACK OR JOINT SURGERY, HYSTERECTOMY, TONSILS REMOVED, APPENDIX REMOVED, ETC.)

1._____ 2._____ 3. _____

4._____ 5._____ 6. _____

7._____ 8._____ 9. _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION AT ANY TIME? IF YES, WHEN?_____WHY? _____

IMMUNIZATIONS: (WHEN DID YOU HAVE THE LAST SHOT? IF YOU DO NOT REMEMBER, PLEASE WRITE 'UNKNOWN'. IF YOU HAVE NEVER HAD IT, PLEASE WRITE 'NEVER'.)

| | | | |
|---|---|---|---|
| TETANUS: | years ago | FLU: | years ago |
| PNEUMONIA: | years ago | MMR: | years ago |
| HEPATITIS B: | years ago | PPD: | years ago |

ARE YOU AT ANY RISK OF TICK BITES? YES NO

HAVE YOU HAD TICK BITES AT ANY TIME IN THE PAST? YES NO

ALLERGIES: (FOOD OR DRUGS, PLEASE MENTION TYPE OF REACTION TO EACH ALLERGY)

_____

MEDICINES: (PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING)

*Please bring all current Medication Bottles to your visit*

Name:_____Date of Birth: _____

**HEALTH MAINTENANCE**: (PLEASE MENTION WHEN YOUR LAST EXAM OR TEST WAS DONE)

**MALE**:

SIGMOIDOSCOPY/COLONOSCOPY (AFTER 50 YEARS OF AGE) _____YEARS AGO
CHOLESTEROL LEVEL CHECKED (AFTER 25 YEARS OF AGE) _____YEARS AGO
PROSTATE EXAM WITH FINGER (AFTER 50 YEARS OF AGE) _____YEARS AGO
PSA SCREENING (TESTING FOR PROSTATE CANCER, AFTER 50 YEARS OF AGE) _____YEARS AGO

**FEMALE**:

SIGMOIDOSCOPY/COLONOSCOPY (AFTER 50 YEARS OF AGE) _____YEARS AGO
CHOLESTEROL LEVEL CHECKED (AFTER 25 YEARS OF AGE) _____YEARS AGO
PELVIC EXAM (AFTER 20 YEARS OF AGE) _____YEARS AGO
BREAST EXAM BY DOCTOR (AFTER 30 YEARS OF AGE) _____YEARS AGO
PAP SMEAR (AFTER 20 YEARS OF AGE) _____YEARS AGO
MAMMOGRAM (AFTER 40 YEARS OF AGE) _____YEARS AGO
BONE DENSITY SCAN (AFTER MENOPAUSE) _____YEARS AGO

**OBSTETRICS AND GYNOCOLOGY HISTORY**: (IF THE QUESTION DOES NOT APPLY TO YOU, PLEASE LEAVE IT BLANK)

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____
DID YOU HAVE ANY ABORTIONS OR MISCARRIAGES? _____
AT WHAT AGE DID YOU HAVE YOUR FIRST PERIOD? _____
DO YOU USE BIRTH CONTROL PILLS? _____
ARE YOUR PERIODS REGULAR? _____
ARE YOUR PERIODS VERY PAINFUL? _____
ARE YOUR PERIODS HEAVY? _____
DO YOU HAVE HOT FLASHES? _____

**FAMILY HISTORY**: (MAINLY PARENTS, GRANDPARENTS, SIBLINGS AND CHILDREN)

PLEASE MENTION ANY MEDICAL PROBLEMS YOUR FAMILY MEMBERS PRESENTLY HAVE OR HAVE HAD IN THE PAST. ALSO MENTION IF SOMEONE HAS DIED AND THE CAUSE OF THEIR DEATH (IF KNOWN).

GRANDFATHER:_____GRANDMOTHER:_____
FATHER:_____MOTHER:_____
BROTHER:_____SISTER:_____
CHILDREN: _____

| DISEASE | WHO? | DISEASE | WHO? | DISEASE | WHO? |
|---|---|---|---|---|---|
| ASTHMA | | CAD | | HEART ATTACK | |
| STROKE | | HIGH BLOOD PRESSURE | | HIGH COLESTEROL | |
| DIABETES | | THYROID DISEASE | | OSTEOPOROSIS | |
| DEPRESSION | | PSYCH. HISTORY | | TUBERCOLOSIS | |
| ANEMIA | | COLON/BOWEL CANCER | | SKIN CANCER | |
| PROSTATE CANCER | | BREAST CANCER | | UTERINE CANCER | |
| OVARY CANCER | | LUNG CANCER | | ANY OTHER CANCER: | |

ANY OTHER HISTORY: _____

**SOCIAL HISTORY**:

ARE YOU SINGLE?_____MARRIED?_____DIVORCED?_____WIDOWED?_____
HOW MANY CHILDREN DO YOU HAVE? _____
DO ANY LIVE NEARBY? (PLEASE WRITE HIS/HER NAME) _____
DO YOU CURRENTLY WORK?____IF YES, WHAT KIND OF WORK DO YOU DO? _____
HAVE YOU EVER SMOKED?_____IF YES, HOW MUCH DO/DID YOU SMOKE, AND HOW LONG? _____
DO YOU SMOKE NOW? _____
DO YOU USE TOBACCO IN ANY OTHER FORM? (EXAMPLE: CHEWING TOBACCO, CIGARS, ETC.) _____
HAVE YOU EVER USED HEROIN, COCAINE OR MARIUANA LIKE DRUGS? _____
DO YOU CURRENTLY USE ALCOHOL? IF YES, HOW MUCH? _____

DO YOU FOLLOW A SPECIAL DIET? _____

DO YOU EXERCISE: IF YES, WHAT KIND AND HOW FREQUENTLY? _____

HAVE YOU EVER BEEN PHYSICALLY OR EMOTIONALLY ABUSED? _____

DO YOU HAVE A LIVING WILL? _____

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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: _____

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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