Welcome to **Patuxent Endocrinology Associates.**

Dr Reena Thomas, MD is a board-certified endocrinologist and has trained and worked in Endocrinology, Diabetes and Metabolism in the United States as well as in the United Kingdom.

This practice offers comprehensive specialist care for Type 1 and Type 2 diabetes mellitus, gestational diabetes, cystic fibrosis related diabetes, thyroid, parathyroid, adrenal and pituitary disorders, bone metabolism disorders (osteoporosis, osteomalacia and Paget's disease of bone), male and female hypogonadism, polycystic ovarian syndrome, metabolic disease, lipid disorders and transsexualism.

Diagnostic services:

- Ultrasound and fine needle aspiration services for thyroid nodules.
- Ultrasound for parathyroid related disorders.
- Continuous glucose monitoring for people with diabetes mellitus.

We work to keep waiting times to a

minimum. We look forward to looking after

you.

Thank you.

PATUXENT ENDOCRINOLOGY ASSOCIATES, LLC.
205 Steeple Chase Drive, Suite 307
Prince Frederick, MD 20678
Phone 443-432-3020; Fax 443-486-7178
Email: patuxentendo@myupdox.com

Full Name:____**Social Security #**____________________
Date of Birth:________________**Race:**________________**Preferred Language:**________________________
Mailing Address:____
City:____**State:**_______________**ZIP:**_________________
Phone (Home):______________ **(Work)**______________ **(Other)**______________
Marital Status:_______________**Email Address:**____________________________ **Emergency Contact Name:**_____________________________**Relationship to you:**__________
Emergency Contact Phone:___________________________**Alt Phone:**_____________________________
Primary Physician:________________________________**Referring Physician:**____________________
Pharmacy:________________________________**Pharmacy Location:**__________________________

Insurance & Billing Information

Billing Name (if other than patient)_________________________**Relationship:**_______________
Billing Address:____ **Phone #:**___________________

Payment Required at Time of Service – Unless Prior Arrangements Have Been Made

1. Insurance Company____________________________________ **Phone#:**___________________
Name of Insured:_________________________ **Relationship To Patient:**___________________________
Member DOB:_______________ **Member ID #:**_____________________ **Group #:**___________________

2. Insurance Company____________________________________ **Phone#:**___________________
Name of Insured:_________________________ **Relationship To Patient:**___________________________
Member DOB:_______________ **Member ID #:**_____________________ **Group #:**___________________

3. Insurance Company____________________________________ **Phone#:**___________________
Name of Insured:_________________________ **Relationship To Patient:**___________________________
Member DOB:_______________ **Member ID #:**_____________________ **Group #:**___________________

I _________________________________,certify that the information given by me is correct.

SIGN IN SPACE BELOW	
Patient/Guardian Name (printed):	
Patient Signature:	
Date signed:	

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INSURANCE AUTHORIZATION

I____, authorize direct payment of medical benefits to **Patuxent Endocrinology Associates**, for services rendered at the practice by Dr Reena Thomas, MD. I understand that I am financially **responsible for any balance not covered by my insurance.**

AUTHORIZATION TO RELEASE INFORMATION

I ____, authorize **Patuxent Endocrinology Associates**, to release any medical or incidental information needed for the insurance claim(s) to the insurance payor or other secondary insurance, as listed in my file.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Patuxent Endocrinology Associates, LLC.

MEDICARE/MEDICAID

I _________________________________, certify that the information given by me in applying for payment is correct. I authorize the release of all records on request. I request that payment of authorized benefits be made on my behalf.

NOTICE OF PRIVACY POLICY

I have received a copy of the Notice of *Privacy Practices*, and I have reviewed the below mentioned "new patient checklist" information.

SIGN IN SPACE BELOW	
Patient/Guardian Name (printed):	
Patient Signature:	
Date signed:	

NEW PATIENT CHECKLIST

REFERRAL – Please obtain a referral from your primary care physician. Check with your insurance to verify your benefits coverage. Request referrals to be faxed to 443-486-7178.

- ☐ **Medical Records** – Please call your primary care doctor and request them to fax a copy of your medical records to us.
- ☐ **Insurance card**- Please bring your current insurance card.
- ☐ **Medications**- Please bring ALL of your current medication bottles to your visit and/or a complete updated list.
- ☐ **Patients with Diabetes mellitus**- Please bring your blood sugar meter and blood sugar log. Please check your blood sugar 4 times a day (before each meal and bedtime) and bring in a log of the week prior to your visit.
- ☐ **Cancellation and Missed Appointments** – If you are not able to keep your appointments, please call us **at least 24 hours before your appointment** so that we can schedule other patients into your reserved time slot.
- ☐ **Cancellation of 24 hours is required for the cancellation of all appointments to avoid charges.**
- ☐ **Please note that the office is under video and audio surveillance for safety and workplace improvements.**

Patient Agreement

Patuxent Endocrinology is committed to providing you with quality and affordable health care.

This is an Agreement between Patuxent Endocrinology Associates, ("**Practice"**), a Maryland LLC, located at 205 Steeple Chase Dr. #307, Prince Fredrick, MD 20678, and the person who signs below ("**Patient"**). By signing below, you, the Patient, indicate your consent to these terms.

1. Services. As used in this Agreement, the term Services shall mean any products or services you choose to receive from the Practice.

2. Insurance. The practice accepts Medicare, Medicaid Maryland, and CareFirst BlueCross Blue Shield insurances only. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

3. Co-payments and Balances.

Co-pay and balances - must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Failure on our part to collect co-payments and balances from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. Proof of insurance. All patients must complete their patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 30 days, the balance will automatically be billed to you.

8. Nonpayment. If your account is over 30 days past due, you will receive a letter stating that you must pay for your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. Missed appointments. Our policy is to charge for missed appointments not canceled 24 hours prior to the appointment. If the 24-hour notice is not received by the practice, a $100 will be added to your account. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

We reserve the right to end the physician-patient relationship in case of multiple missed initial or follow up appointments.

Our practice is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area.

10. Insufficient funds. If any check is returned due to insufficient funds, there will be an additional $100.00 fee. Once a check is returned the patient will no longer be able to use checks as a form of payment.

11. Acceptance of Patients. The practice reserves the right to accept or decline patients based upon its capability to handle appropriately the patient's needs. We may decline new patients because the provider's panel of patients are full, or because the patient requires medical care not within the practice's licensed health care practitioners' scope of services.

12. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of Maryland and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice address in Maryland.

I have read and understand the patient agreement and agree to abide by its guidelines:

Patient Printed Name ____

Patient (or Guardian) Signature ____

Date __________________________

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Patuxent Endocrinology Associates Prescription

Refill Procedure

Patients should call their Pharmacy when they need a refill for the medications prescribed by Dr. Thomas. Please avoid calling the office for refills.

Prescription refills must be requested from the pharmacy. Patients who want to transfer prescriptions to a new pharmacy must allow 2-3 days for new prescriptions to be written and sent into the new pharmacy.

Prescription refills take at least 24 hours to process.

Please call and request medication refills several days before running out of medications, to allow for this processing time.

The fastest and most convenient way to request prescription refills is during your office visit, which will allow us to transmit prescriptions to the pharmacy when the doctor is seeing you in the office.

I hereby acknowledge that I have been made aware of Patuxent Endocrinology Associates Prescription Refill Procedure.

If you have not received your prescription within 72 hours (business days), please call the office and let us know.

Name: ______________________________ Date: __________

Signature: ____

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Patient Portal – an effective means of communication

Patuxent Endocrinology would like to invite you to sign up for the patient portal.

Please copy and post the Link into your internet browser and log in to your patient portal:

https://myupdox.com/portal/patuxentendo/html/index.html

Why use a patient portal:

1. Secure email messaging – regarding any questions you have in between your office appointments.
2. Setting up appointments.
3. Discussion of lab results or imaging results ordered at your office visit.

Process:

1. Write out your email on your demographic form and speak to the front staff about setting up your patient portal.
2. Once you have done this, you will receive a communication from our practice – click on the link and set up your username and password.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:		**Date of Birth:**	
Previous Name:		**Social Security#**	
I request and authorize (Primary care doctor or referring physician			

To release healthcare information of the patient named above to:

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This request and authorization applies to

☐ **All healthcare information**

1. **Doctors notes from the last 2 visits.**
2. **Lab test results – 6-12 months.**
3. **Diagnostic reports – ultrasound, X-rays, CT scan, MRI scans, Biopsy.**

SIGN IN THE SPACE BELOW

Patient Signature:		**Date signed**	

THIS AUTHORIZATION EXPIRES 12 MONTHS AFTER IT IS SIGNED

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<u>OFFICE LOCATION</u>

FOX RUN PROFESSIONAL CENTER,
(BEHIND TACO BELL)
SUITE 307
205 STEEPLE CHASE DRIVE,
PRINCE FREDERICK, MD 20678.
TEL: 443-432-3020; FAX:443-486-7178