LiveNew Colorado Endocrinology

9695 S Yosemite St #285, Lone Tree, CO 80124
Tel: (303) 649-3115 Fax: (303) 649-3116

In order to care for you, we ask that you answer the following questionnaire as completely as possible.

Patient's Personal Contact Information

Name: _____ Age: _____ Date of Birth: ____/____/_____

Gender: ☐ F ☐ M Social Security Number: _____

Address: _____ City:_____ State:_____ Zip Code:_____

Home Phone (____) _____-_____; Cell Phone (____) _____-_____; Work Phone (___) ____- _____

Email: _____

Insurance Carrier: _____Subscriber Name_____

Relationship to self**:**_____ Social Security #**:** _____ DOB**:**_____

Emergency Contact:_____ Relationship**:** _____

Address**:** _____ Phone #: _____

Pharmacy:	Address/Cross Streets	Phone Number	Preferred
Local :_____	_____	_____	☐
Mail Order:_____	_____	_____	☐

Other Healthcare Providers:

Primary Care: _____Contact #:_____ Fax #_____

Specialist: _____Contact #:_____ Fax #_____

Reason for Consultation: _____

Medication Allergies:_____

Check if you are allergic to ☐ IV Contrast Dye

Current Medications with dosage and frequency:

1._____ **9.** _____

2._____ **10.** _____

3._____ **11.**_____

4._____ **12.** _____

5._____ **13.** _____

6._____ **14.** _____

7._____ **15.**_____

8._____ **16.**_____

Patient Name: _____ Date: _____

Review of Systems: In the last 2 weeks, have you experienced any of the following symptoms? Respond to each.

Constitutional

Weight Loss (unintentional)	☐Yes	☐No
Weight Gain (unintentional)	☐Yes	☐No
Appetite Changes (↑ or ↓)	☐Yes	☐No
Fatigue (profound)	☐Yes	☐No
Fever	☐Yes	☐No
Night sweats	☐Yes	☐No
Irritability	☐Yes	☐No

Eyes

Do you wear glasses or contacts (circle one if yes)	☐Yes	☐No
Dry eyes	☐Yes	☐No
Eye pain or drainage	☐Yes	☐No
Visual Changes	☐Yes	☐No

ENT/Mouth

Ear pain or drainage	☐Yes	☐No
Frequent sinus infections	☐Yes	☐No
Hearing Changes or loss	☐Yes	☐No

Cardiovascular

Chest pain or heaviness	☐Yes	☐No
Palpitations or rapid heart beat	☐Yes	☐No
Exertional shortness of breath	☐Yes	☐No
Shortness of breath when lying flat in bed	☐Yes	☐No
Swelling of feet or legs	☐Yes	☐No

Respiratory

Blood in your sputum	☐Yes	☐No
Coughing (lasting > 3 months)	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Wheezing	☐Yes	☐No

Gastrointestinal

Heartburn or Indigestion	☐Yes	☐No
Vomiting or nausea	☐Yes	☐No
Swallowing difficulty	☐Yes	☐No
Abdominal pain	☐Yes	☐No
Blood in your stool	☐Yes	☐No
Constipation	☐Yes	☐No
Diarrhea or frequent bowel movements	☐Yes	☐No

Genitourinary

Blood in your urine	☐Yes	☐No
Urinary Retention	☐Yes	☐No
Incontinence	☐Yes	☐No
Erection problems	☐Yes	☐No
Irregular menstrual cycles	☐Yes	☐No
Vaginal discharge or bleeding	☐Yes	☐No

Musculoskeletal

Broken bones	☐Yes	☐No
Joint pain or swelling	☐Yes	☐No
Muscle aches	☐Yes	☐No
Muscle weakness	☐Yes	☐No

Breasts

Masses or lumps	☐Yes	☐No
Nipple discharge	☐Yes	☐No

Neurologic

Seizures	☐Yes	☐No
Headaches	☐Yes	☐No
Slurred speech	☐Yes	☐No
Pain or burning in legs or feet	☐Yes	☐No
Numbness or tickling in legs or feet	☐Yes	☐No

Psych

Anxiety without clear explanation	☐Yes	☐No
Sadness lasting for days or weeks	☐Yes	☐No
Sleep disturbance	☐Yes	☐No

Diabetes/Endocrine

Increased thirst	☐Yes	☐No
Increased urination	☐Yes	☐No
Frequent low blood sugars (hypoglycemia)	☐Yes	☐No
Severe hypoglycemia (requiring help from others)	☐Yes	☐No
Unawareness of hypoglycemia	☐Yes	☐No
Waking up at night to urinate	☐Yes	☐No
Acne	☐Yes	☐No
Changes in hat/glove/shoe size	☐Yes	☐No
Enlarged thyroid (goiter)	☐Yes	☐No
Excessive sweating	☐Yes	☐No
Hair growth in unwanted areas	☐Yes	☐No
Hair loss	☐Yes	☐No
Intolerance to cold or heat (if yes, circle one)	☐Yes	☐No
Striae (purple stretch marks in skin)	☐Yes	☐No

Hematologic

Anemia	☐Yes	☐No
Easy bruising	☐Yes	☐No
Easy bleeding	☐Yes	☐No
Enlarged lymph nodes	☐Yes	☐No

Patient Name: _____ Date: _____

Past Medical History Please check all that apply (include year in which they were first diagnosed)

Diabetes ☐Yes ☐No
- Type I ☐ Type II ☐ Other_____
- Year of diagnosis_____ Age at diagnosis_____
- Last dilated eye exam _____
- Diabetic Ketoacidosis or Coma? ☐Yes ☐No
- Damage to eyes from diabetes? ☐Yes ☐No
- If yes, did you have laser therapy? ☐Yes ☐No
- Damage to kidneys from diabetes? ☐Yes ☐No
- Damage to nerves from diabetes? ☐Yes ☐No
- History of diabetic foot ulcers? ☐Yes ☐No

Eyes (circle if you have any of the following):
- Cataracts Glaucoma Macular Degeneration
- Hx Eye surgery Hx Laser therapy

Adrenal Insufficiency ☐Yes ☐No
Alzheimer ☐Yes ☐No
Anorexia or Bulimia ☐Yes ☐No
Anxiety Disorder ☐Yes ☐No
Arthritis (Osteoarthritis) ☐Yes ☐No
Asthma ☐Yes ☐No
Autoimmune Disease ☐Yes ☐No
- If yes, what type?

Bipolar Disorder ☐Yes ☐No
Blood Transfusions ☐Yes ☐No
- If yes, when?

Chronic Kidney Disease ☐Yes ☐No
Clotting Disorder ☐Yes ☐No
Congenital Heart Defects ☐Yes ☐No
Coronary Artery Disease ☐Yes ☐No
- Have you had a Heart Attack? ☐Yes ☐No
- If yes, when?

COPD (Emphysema) ☐Yes ☐No
Cystic Fibrosis ☐Yes ☐No
Depression ☐Yes ☐No
Dialysis ☐Yes ☐No
Erectile Dysfunction ☐Yes ☐No
Fibromyalgia ☐Yes ☐No
Foot Ulcers ☐Yes ☐No
GERD (reflux problems) ☐Yes ☐No
Head Injury/Concussion ☐Yes ☐No
Heart or Valve Defects ☐Yes ☐No
Hemochromatosis ☐Yes ☐No
Hepatitis ☐Yes ☐No
HIV or AIDS ☐Yes ☐No
Hyperlipidemia (high cholesterol) ☐Yes ☐No
Hypertension (high blood pressure) ☐Yes ☐No
Hypogonadism ☐Yes ☐No
Irregular Heart Rhythm ☐Yes ☐No
Liver Disease ☐Yes ☐No
Long-Term Steroid Use ☐Yes ☐No
Kidney Failure or Dysfunction ☐Yes ☐No
Kidney Stones ☐Yes ☐No
Malignancy (Cancer) ☐Yes ☐No
- If yes, where/what type?
- Did you receive chemotherapy ☐Yes ☐No
- Did you receive radiation therapy ☐Yes ☐No

Obstructive Sleep Apnea ☐Yes ☐No
Organ Transplant ☐Yes ☐No
- If yes, what organ?

Osteopenia/Osteoporosis ☐Yes ☐No
Pancreatitis ☐Yes ☐No
Peripheral Artery Disease ☐Yes ☐No
Pituitary Tumor/ Dysfunction ☐Yes ☐No
Polycystic Ovary Syndrome ☐Yes ☐No
Rheumatoid Arthritis ☐Yes ☐No
Sarcoidosis ☐Yes ☐No
Schizophrenia ☐Yes ☐No
Seizure Disorder ☐Yes ☐No
Sickle Cell ☐Yes ☐No
Skin Disorders ☐Yes ☐No
Stroke/ TIA ☐Yes ☐No
Thyroid Disease:
- Hyperthyroidism ☐Yes ☐No
- Hypothyroidism ☐Yes ☐No

Thyroid Nodules ☐Yes ☐No
Thyroid Cancer ☐Yes ☐No
Other: _____

Patient Name: _____ Date: _____

Past Surgical History (please list surgical procedure/date):

1._____ **6.** _____

2._____ **7.** _____

3._____ **8.** _____

4._____ **9.** _____

5._____ **10.**_____

Have you had any of the following vaccinations? Check all that apply and specify when last received

.☐ Influenza _____ ; ☐ Pneumonia _____; ☐ Tetanus _____

Social History: Are you: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Widow

Do you have any children: ☐ Yes ☐ No If yes, how many: ____ Biological ____ Adopted or Step-Children

What is your current profession: _____

Tobacco Use: ☐ None Quite Date: _____

☐ Pipe/Cigar ☐Cigarettes Packs/Day: _____ Number of years smoked: _____

☐ Smokeless Tobacco ☐ Electronic or E-Cigarettes ☐ Secondhand smoke exposure

Alcohol Use: ☐ None ☐ Daily ☐ Occasional ☐ In Recovery Amount per week:_____

Drug Use: ☐ None ☐ Past Use ☐ Current Use

☐ Marijuana ☐ Amphetamines ☐ Cocaine ☐ Designer/Club Drugs

Route: ☐ Smoke ☐ Inject ☐ Ingest ☐ Topical

Obstetric/Gynecological history

If you are female, have you ever been pregnant? ☐Yes ☐No If yes, please describe

Number of pregnancies? _____ Number of live births? _____ Number of miscarriages or abortions? _____

Age of onset of menstrual cycles? _____ Age of onset of menopause? _____ ☐N/A

Are your periods regular? ☐Yes ☐No If no, please describe_____

Date of your last menstrual period _____

Have you ever taken birth control pills, or used birth control patches or implants? ☐Yes ☐No

If yes, what did you take and or how long? _____

Have you ever been on hormone replacement therapy? ☐Yes ☐No

If yes, what did you take and or how long? _____

Have you ever had your tubes tied? ☐Yes ☐No If yes, when? _____

Have you ever had your uterus removed (hysterectomy)? ☐Yes ☐No

If yes, why? _____; when? _____; were your ovaries removed? ☐Yes ☐No

Patient Name: _____ Date: _____

Family Medical History:

Please mark those relatives with diabetes

RELATIVE	DIABETES
Mother	
Maternal Grandmother	
Maternal Grandfather	

RELATIVE	DIABETES
Father	
Paternal Grandmother	
Paternal Grandfather	

If you have any siblings please tell us how many, and if any of them have diabetes:

RELATIVE	# with diabetes	# without diabetes
Maternal Aunts & Uncles		
Paternal Aunts & Uncles		

If you have any siblings please tell us how many, and if any of them have diabetes:

RELATIVE	# with diabetes	# without diabetes
Sisters		
Brothers		

If you have any biological children please tell us how many, and if any of them have diabetes:

RELATIVE	# with diabetes	# without diabetes
Daughters		
Sons		

Do any of your family members have the following disorders (if yes, please mark those who do):

Cancers ☐Yes ☐No If yes, who & what type_____
_____

Chronic Kidney Disease ☐Yes ☐No If yes, who _____

Congestive Heart Failure ☐Yes ☐No If yes, who _____

Genetic Disorders ☐Yes ☐No If yes, who/what type_____

Heart Attacks before age 55 ☐Yes ☐No If yes, who _____

Hemochromatosis ☐Yes ☐No If yes, who _____

High Blood Pressure ☐Yes ☐No If yes, who _____

High Cholesterol ☐Yes ☐No If yes, who _____

Hormonal Disorders ☐Yes ☐No If yes, who/what type _____

Kidney Disease ☐Yes ☐No If yes, who _____

Lupus (SLE) ☐Yes ☐No If yes, who _____

Osteoporosis ☐Yes ☐No If yes, who _____

Pituitary Disorder ☐Yes ☐No If yes, who _____

Rheumatoid Arthritis ☐Yes ☐No If yes, who _____

Stroke ☐Yes ☐No If yes, who _____

Thyroid Conditions ☐Yes ☐No If yes, who _____
_____

Other conditions ☐Yes ☐No If yes, who & what type _____

SUMMARY NOTICE OF PRIVACY PRACTICES

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains Patient rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. You may obtain a copy by asking the front desk or Privacy Officer. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

Our pledge to protect your privacy:

LiveNew, The Bariatric & Metabolic Center of Colorado and Colorado Endocrinology is committed to protecting the privacy of your medical information. Your care and treatment is recorded in a medical record. So that we can best meet your medical needs, we share your medical record with the providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

Patient Rights - You have the following rights regarding your medical information:

- to request to inspect and obtain a copy of your medical records, subject to certain limited exceptions;
- to request to add an addendum to or correct your medical record;
- to request an accounting of LiveNew, The Bariatric & Metabolic Center of Colorado and Colorado Endocrinology disclosures of your medical information;
- to request restrictions on certain uses or disclosures of your medical information; to request that we communicate with you in a certain way or at a certain location; and to receive a copy of the full version of our Notice of Privacy Practices.

We may use and disclose medical information about you for the following purposes:

- to provide you with medical treatment and services;
- to bill and receive payment for the treatment and services you receive;
- for functions necessary to run LiveNew, The Bariatric & Metabolic Center of Colorado and Colorado Endocrinology and assure that our Patients receive quality care;
- to provide basic contact information (no medical information is provided) to our development office for purposes of fundraising for LiveNew, The Bariatric & Metabolic Center of Colorado and Colorado Endocrinology; to support our standing as a federally qualified health center; and as required or permitted by law.

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES

Revised June 23, 2018

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. LiveNew, The Bariatric & Metabolic Center of Colorado and Colorado Endocrinology provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____	_____	_____
Name of Patient (print)	Signature of Patient	Date
_____	_____	_____
Signature of Patient Representative (Required if Patient is a minor or an adult who is unable to sign this form)	Relationship to Patient	Date

I understand that my health care and the payment for my health care will not be affected if I do not sign this_____(initial)

COMMUNICATION PREFERENCES:

In caring for our patients, it may be necessary for LiveNew, The Bariatric & Metabolic Center of Colorado and Colorado Endocrinology staff to contact you by phone. When we are not able to speak to you directly, we like to leave messages when possible. In order to protect your privacy, it is LiveNew, The Bariatric & Metabolic Center of Colorado and Colorado Endocrinology's policy to not leave messages with anyone except the patient or legal guardian, nor leave specific information on an answering machine/voicemail system unless we have your written permission to do so.

Home phone number: _____ Mobile phone number: _____

- ☐ Yes, I want you to leave a voice mail. Home Mobile (Please circle)
- ☐ No, I do not want you to leave a voice mail.

LiveNew, The Bariatric & Metabolic Center of Colorado and Colorado Endocrinology may disclose your medical information such as exams, labs/radiology results, appointments and your insurance or billing information to the following people:

_____			_____		
Name	Relationship	Phone Number	Name	Relationship	Phone Number
_____			_____		
Name	Relationship	Phone Number	Name	Relationship	Phone Number

- ☐ No, I do not want you to discuss my medical care with anyone other than me.
- ☐ Yes, I request removal from lists that initiate promotional or marketing communications _____ (initial)

Bariatric and Metabolic Center of Colorado

LiveNew Colorado

Colorado Endocrinology

At LiveNew, we strive to provide our patients with the best care possible. We endeavor to foster a safe environment of mutual respect for patients and staff. Please review and sign the office policy below, prior to initiation of medical care. By signing this document, you are giving us your permission to treat you.

As specialty consultants, we are always happy to listen, but we do not provide primary care services and do not give non-emergent medical care outside the scope of our field of practice.

Insurance Responsibility: Our office will assist in filing all the medical insurance claims related to your care in our office. It is the patient's responsibility to provide correct and complete insurance information at the time of visit. We do require an up-dated copy of your insurance cards and a government issued picture identification in your chart at each visit. Please notify us immediately with address or telephone number changes. For accuracy, you will be asked to verify your health insurance, de-mographics at each visit. If you do not have health insurance, our staff will provide information regarding the payment options available for the services provided. At the time of your visit, we may provide you services that your insurance contract denies as "non-covered" services. If you do not understand which services are covered and which are not covered, please contact your insurance directly and determine the extent of coverage and potential personal liability before we provide services to you.

Co-payments: These are a contractual agreement between the patient and their insurance company. Co-payments must be made at the time of service.

Refund Policy: Payments made to LiveNew for services rendered or for no-show fees will not be refunded. Payments made to LiveNew for clinical services that were never rendered (unless now-show fees apply) or for overpayments will be refunded if a request has been made within 90 days of the transaction. LiveNew is not responsible for any payments made to financing companies. All such queries must be directed to the financing entity.

Prescriptions/Refills: Please request refills with your provider during the regular clinic visit. Notify us of your preferred phar-macy. If you change pharmacies, update us with the correct information. Be clear on which medications should go to which Pharmacy. If prescriptions are needed between visits, call your pharmacy, so they can send an electronic request. **Please allow 3 business days for the refill to be completed.** Be aware, the on call doctor does not provide routine prescription refills.

Lab testing: Your insurance determines which lab facility is covered for testing. **Please make sure you get your labs done at the facility of your choice and per your coverage plan, 7-10 days prior to your appointment**. This will allow a more meaningful conversation with your physician.

No show/Late cancellation policy: If you are more than 15 minutes late, your appointment may need to be rescheduled. If it is necessary to cancel your appointment we ask that you notify us as soon as possible, as there are patients waiting for appoint-ments. A $50 fee will be charged for clinic visit no shows or cancellations less than 24 hours. A fee of $100 will be charged for no shows/late cancellations for thyroid ultrasounds, thyroid biopsies, endoscopic procedures and all other procedures.

Finally, we strive to provider an environment of respect, safety and care for our patients. In turn, we ask that you treat our staff with respect. Cursing and yelling at staff will result in discharge from the clinic.

I have read this policy fully, and agree with the terms set forth above.

_____	_____	_____
Responsible Party (Print name)	Signature	Date

LiveNew

Patient Authorization to Disclose Protected Health Information
#001 rev. 10/17

Patient Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 of Social Security Number
Address	**City, State, Zip Code**	**Telephone Number**

I hereby authorize the LiveNew facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency, or patient named.

Release from: LiveNew Colorado
Facility Name
9695 S. Yosemite St. Suite 265
Address
Lone Tree, CO, 80124
City, State, Zip Code

Release to: _____
Facility Name
_____
Address
_____
City, State, Zip Code

Treatment Date(s): _____
Purpose: ☐ Further Medical Care ☐Workers' Comp
☐ Personal Use ☐ Insurance ☐Legal
☐ Marketing/Fundraising
☐ Other: _____

Type of Disclosure Authorized & Delivery Instructions:
☐ **Provide copies of records to organization/agency/individual**
☐ **Mail records directly to address above**
☐ **Call to pick-up records:** _____
☒ **Fax records to:** _____

Pertinent Protected Health Information Allowed to be Included:
☐ Discharge summary ☐ Radiology ☐ Special Studies ☒ Entire Medical Record
☐ History & Physical/Consult ☐ Outpt Record ☐ Medication Records
☐ Operative Report ☐ Progress Notes ☐ Psych Health Records
☐ Labs ☐ Physician Orders ☐ Other (specify): _____

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management / Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.

I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event, will expire 90 days from the date hereof, unless a different date is specified here: _____

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

For Marketing/Fundraising Purposes Only, if Applicable: I understand that LiveNew ☐ will ☐ will not receive remuneration, either direct or indirect, as a result of the marketing that I hereby authorize.

SIGNATURE: _____ **DATE:** _____
Patient (Parent or Legal Guardian)

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law.
Relationship (if other than patient): _____ ☐ Power of Attorney ☐ Death Certificate
Name of individual signing on behalf of patient: _____
Verification: ☐ Driver's License # _____ ☐ Other Appropriate ID #: _____

OFFICE USE ONLY: Attach copies of required identification.
Number of pages released: _____ Completion date: _____ Delivery method: _____
Name of individual who received request: _____ Date received: _____
Patient Medical Record Number / Account Number: _____/_____