TREASURE VALLEY ENDOCRINOLOGY, P.C.
900 N. LIBERTY SUITE 201 BOISE, IDAHO 83704
PHONE (208) 367-6740, FAX (208) 367-6742

JULIE A. FOOTE, M.D.
DIPLOMATE, AMERICAN BOARD ENDOCRINOLOGY, DIABETES AND METABOLISM

TIFFANY C. HEIDT, F.N.P.
CERTIFIED, AMERICAN ACADEMY OF NURSE PRACTITIONERS

Welcome_____

Your appointment is with
- o Julie Foote, M.D.
- o Tiffany Heidt, F.N.P.

On_____ check in time_____.
If you need to cancel or reschedule your appointment we require a 24 hour notice. If no notice is given, we will NOT be able to reschedule you.

Enclosed is your New Patient Packet that provides information about our clinic, location, privacy and financial policies.

Please prepare for your visit with us by completing both sides of the enclosed

- Patient Information
- Confidential Health History
- Acknowledgement of Payment and Credit Terms Policy
- HIPPA Notice of Privacy Practices
- Prescription Refill Policy

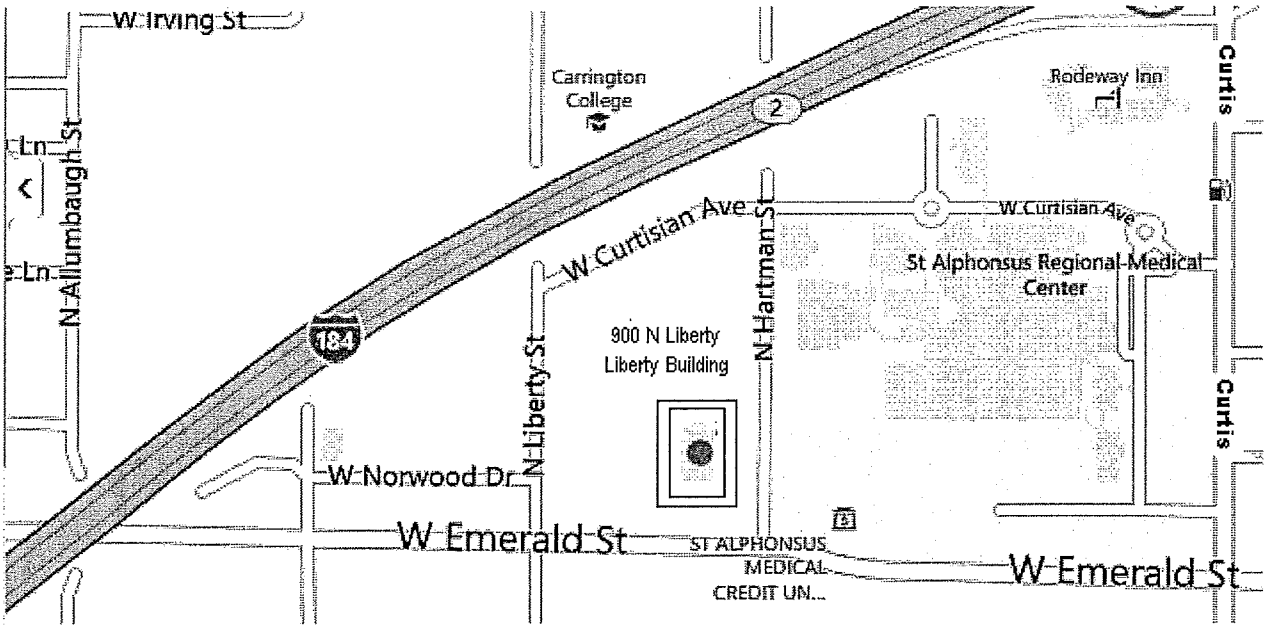
Please bring the following to your appointment.

- Completed forms
- Insurance card
- Photo ID
- Medication list
- If you are diabetic please bring your glucometer and logbook.

Call your insurance to verify coverage/deductible issues.
Thank you for choosing our office for you Endocrinology needs.

Julie Foote, M.D. Tiffany Heidt, F.N.P.

***Map on back*



Directions:

From I-84

Take I-84 connector towards City Center.

Take the Curtis Road exit, and turn right onto Curtis road.

Take a right on Emerald, then right on Liberty.

Liberty Medical Park building will be on your right.

We are on the second floor, Suite 201.

From Downtown:

Take I-84 connector west.

Take Curtis road exit, and turn left on Curtis road.

Take a right on Emerald, then right on Liberty street.

Liberty Medical Park building will be on your right.

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Patient's Full Legal Name is required **Please use the name on your government issued photo ID** ☐	Date of Birth Age
First Middle Last	Social Security # Gender
Preferred language	Race
Mailing Address	Ethnicity Country of origin
City State Zip Code	Primary Physician Phone #
Home Phone Cell Phone	Referring Physician Phone#
Preferred Pharmacy & Location	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower
Responsible Party	**Spouse** (parents name if minor)
Employer	Employer
Occupation	Occupation
Work Phone #	Work Phone #
Primary Insurance	**Secondary Insurance**
Group #	Group #
Policy #	Policy#
Policy Holder	Policy Holder

***Emergency Contact**:(Nearest Friend or Relative)_____

Relationship to Patient:_____Phone_____

ASSIGNMENT AND RELEASE I, the undersigned, have Insurance coverage with_____ and assign directly to Dr. Foote, Treasure Valley Endocrinology all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____Date_____

Signature of Insured/Guardian

Medicare Authorization I request that payment of authorized Medicare benefits be made on my behalf to Dr. Foote for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorization release of medical information necessary to pay the claim. If "other health Insurance "Is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determined of the Medicare Carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

_____Date_____

Beneficiary Signature

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PROTECTED HEALTH INFORMATION RELEASE

Patient Name_____**D.O.B**_____
Patient Phone_____

❑ Only release information to me personally.

❑You have my permission to leave information on my answering machine regarding my medical care and test results.

❑ You have my permission to discuss my medical care and test results with the person(s) listed below.

Name_____Phone:_____
Relationship_____

Name_____Phone:_____
Relationship_____

Name_____Phone:_____
Relationship_____

Patient
Signature:_____Date:_____

CONFIDENTIAL HEALTH HISTORY - TREASURE VALLEY ENDOCRINOLOGY

Name: _____ Date of Visit to TVENDO:_____

SIGN YOUR NAME HERE: _____

Birth date: _____ Age:_____

Primary Care Provider:

Reason for visit today:

Referring Provider:

MEDICATIONS: LIST NAME/DOSAGE/FREQUENCY Please include over the counter/supplements.

_____

_____

_____

_____

_____

ALLERGIES: NONE (CIRCLE) OR LIST: _____

MEDICAL HISTORY Circle all that you have had in the past.

Anemia	Chemical dependency	Heart disease	Multiple Sclerosis	OTHER:
Anorexia	Diabetes	Hepatitis	Pacemaker	
Arthritis	Epilepsy	Hernia	Prostate problem	
Asthma	Emphysema	High Cholesterol	Psychiatric care/list diagnosis:	
Bleeding prob	Gallstones	Kidney disease	_____	
Breast lump	Goiter	Liver disease	Suicide attempt	
Bulimia	Gout	Lung disease	Stroke	
Cancer /type/site _____		Migraine	High Blood pressure	
Cataract	Glaucoma	Miscarriage	Stomach Ulcer	
	Gluten Sensitivity	Blood Clot	Thyroid problem	

LIST ALL SURGERIES, HOSPITALIZATIONS, or SERIOUS ILLNESS

Year Hospital REASON OR PROCEDURE OUTCOME

_____

_____

_____

_____

_____

_____

WOMEN: **NUMBER OF PREGNANCIES:** _____ **LIVE BIRTHS**_____ **MISCARRIAGES** _____

GESTATIONAL DIABETES? Yes (circle) PREGNANCY RELATED HIGH BLOOD PRESSURE? Yes (circle)

EVER HAD A BLOOD TRANSFUSION? YES NO DATE:

OCCUPATION _____ or RETIRED (circle)

HABITS (circle) ALCOHOL What and how often? _____

TOBACCO

EXERCISE What and how often? _____

SIGN YOUR NAME HERE: _____ DATE:

FAMILY HISTORY

	Illness	Age/Age at Death	Cause of Death
Father			
Mother			
Siblings (list)			

UNKNOWN/ADOPTED (circle)

DISEASE IN FAMILY (circle) &Relationship to you:

Arthritis (type) _____
Cancer (type) _____
Diabetes
Heart disease
High Blood Pressure
Stroke
Kidney disease
Thyroid disorder _____
Blood clots or clotting disorder
Osteoporosis/back/hip fracture

SYMPTOM REVIEW CIRCLE if you have had these in the last three months:

Chills	Poor appetite	Blurred Vision	Eye lid problem
Depression	Bloating	Difficult swallowing	Bruising
Dizziness	Bowel change	Choking	Rash
Fainting	Constipation	Hoarseness	Hives
Fever	Diarrhea	Hearing loss	Mole change
Forgetfulness	Excess hunger	Ear ringing	Skin sores
Falls	Indigestion	Nosebleeds	Hair loss
Broken bone	Nausea	Nasal drip	
Headache	Vomiting	Tingling	
Insomnia	Abdominal pain	Muscle cramp	Frequent urination
Weight loss	Heartburn	Muscle pain/ where _____	Painful urination
Weight gain	Acid reflux	Joint pain/where _____	Erection problem
Excess thirst		Height loss/how much?	Bladder leaking
Nervousness	Cough	_____	Breast lump
Sweats/flushing	Chest pain	Growth hands/feet	Irregular periods
Sleep apnea	Rapid heart beat	Dental problems	Heavy periods
Abnormal breathing during sleep	Irregular heart beat	Numbness	Abnormal PAP
	Shortness of breath		Nipple discharge
Snoring	Swelling feet/ankles		Hot flashes

HEALTH SCREENING Last Rectal exam/PSA (men)?
Last Mammogram/Pelvic exam (women)?

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Thank you for choosing Dr. Julie Foote and Tiffany Heidt, FNP for your endocrinology concerns. They are happy to participate with your priA1a.1'Y doctor or family physician in your medical care.

Dr. Foote is board certified in Endocrinology, Diabetes and Metabolism. She specializes in glandular diseases and in disorders of metabolism. These include diabetes, thyroid diseases, osteoporosis, and problems with the reproductive organs. She also specializes in disorders of calcium and cholesterol metabolism, and of the adrenal and pituitary glands.

Tiffany Heidt, FNP is certified by the American Academy of Nurse Practitioners and specializes in thyroid disorders and diabetes.

Neither Dr, Foote nor Ms. Heidt provides primary care services. Please ask for referral to a primary care provider if you require one,

GENERAL INFORMATION-On your first visit, either Dr, Foote or Ms. Heidt will take medical history and perform a thorough physical exam. Your available medical records and x-rays in the areas of concern will be reviewed. The evaluation will take approximately one hour. You may take your routine medications and eat prior to your appointment an information sheet and health history is enclosed which you are asked to complete and bring with you, A copy of your insurance card(s) and a government issued ID will be needed. Please bring a list of your medications and supplements. Please have your referring doctor send us your test results and please call to verify they have been received prior to your appointment.

DIABETES: Recent lab tests, glycohemoglobin (AIC), cholesterol, and urine tests. Bring meter, sensor, logbook to every appointment. LibreView Practice ID to Share Data is 08462058. If you can upload your data prior to your appointment, it is always appreciated.

THYROD DISEASE: recent lab tests, scans, ultrasounds, pathology. Iodine treatment reports.

PITUITARY DISORDER: Reports of CT scan or MRI of the brain, lab tests, pathology/operative reports, reports of radiation treatments, Bring MRI images on disk.

OSTEOPOROSIS: reports of Bone x-rays, one density "DEXA" reports, lab tests, and a list of vitamins/supplements taken,

CANCER: Last progress note from your doctor, List of medications, including medications given in the last two years (Some cancer drugs affect the Endocrine System.)

*If your history is complicated, please provide a written timeline of your Endocrine Care.

PAYMENT AND CREDIT TERMS POLICY

PAYMENT AT TIME OF SERVICE

Full Payment for services is due at the time of your appointment. If you have not yet met your deductible, your full payment is due. Notice thereof will be sent to your insurance to apply to your deductible. Policy allows 30 days for your insurance to make payment. If the insurance payment is delayed and your account is over 30 days old, our office expects payment. Payment of your bill can be done by cash, check or credit card.

INSURANCE ISSUES

IT IS YOUR RESPONSIBILITY TO RESEARCH YOUR DEDUCTIBLE AND COPAYMENT AMOUNTS PRIOR TO YOUR APPOINTMENT. IF DR. FOOTE OR TIFFANY HEIDT, FNP ARE NOT IN YOUR NETWORK, YOU MAY BE REQUIRED TO PAY A HIGHER AMOUNT THAN AN "IN NETWORK" FEE. Questions about your co-payment amounts and insurance network issues should be handled directly with your insurance company. Payment plans are not available for your first visit. After your first visit, if you are having financial difficulty, payment plans are available. Please notify the office regarding changes of insurance. Please verify that you have a written referral prior to your appointment, if this is required by your insurance. If you do not have a written referral, and it is required, your insurance may not pay for your visit.

PREMIER BILLING

Premier Billing Solutions provides billing services for Treasure Valley Endocrinology PC. Premier bills your insurance as a courtesy to you, to make this aspect of your care as easy as possible. When indicated, they will also bill secondary insurance carriers. Please let them know in a timely manner if you have questions about your bill. Policy requires that monthly payments be no less than $35.00 a month or 30% of the balance, whichever is greater. Accounts past due by 30 days are considered delinquent. Finance charges will be implemented 60 days after the date of service. Accounts 90 days past due are sent to collections. Care may be terminated at this office for patients whose accounts are sent to collections.

APPOINTMENT CANCELLATION

If you need to cancel your appointment, please notify us 24 hours in advance. This will enable other patients to schedule an appointment. We must charge for missed routine appointments which are not canceled the previous day.

OTHER SERVICES

Fees are charged for the following services:

- release of records to another physician, insurance companies, etc.
- report preparation
- letter preparation.

PATIENT SIGNATURE: _____

I have read the above and understand these charges and policies.

We look forward to helping you with your medical needs.

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HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use or disclose as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, Quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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.

As of 2/3/2009 This office has chosen to participate in the Idaho Health Data Exchange (IHDE). If you do not want to participate in the IHDE, you can opt out of participation. To do so you must complete the Patient Opt-Out Form and submit the form to IHDE.

Your Rights
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 proceeding, 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 purposed as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician 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 communications 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 agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician 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 in writing of any changes. You then have the right to object or withdraw as provided in this notice.

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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

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 speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature:_____Date:_____

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JULIE A. FOOTE, M.D.

DIPLOMATE, AWERICAN BOARD ENDOCRINOLOGY, DIABETES AND Metabolism
DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE

TIFFANY C. HEIDT, F.N.P.

CERTIFIED, AMERICAN ACADEMY OF NURSE PRACTITIONERS

Prescription Refill Policy

You, the patient, are responsible for knowing when medications will need renewal or refilling. Prescription refills and authorizations are approved between 8:00 am-3:00 pm Monday-Thursday, 8:00 am -12 pm on Friday. No routine prescriptions will be filled on Friday afternoons, weekends or holidays.

All refill requests must be sent to us by your pharmacy. Your pharmacy will send the request to our office for approval. Procedure is as follows:

1. Call your pharmacy with your request.
2. Pharmacy will send electronic or fax a request to our office for provider signature.
3. You need to allow 3 business days for refills.

Pharmacy turnaround will vary so please allow 1-2 weeks for refills.
I have read and understand the refill policy.

Print Name _____

Signature _____ Date _____