900 N. LIBERTY STE #201
BOISE, IDAHO 83704
PHONE: (208)506-7111 FAX :(208)506-7112

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

_____Julie Foote, M.D
_____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, financial and prescription policies.

Please prepare for your visit with us by completing BOTH sides of the enclosed paperwork and checking to make sure all pages requiring a signature have been signed.

Please bring the following to your appointment

- All the completed New Patient Packet
- Insurance card(s)
- Photo ID
- Medication list
- If you are diabetic, please bring your glucometer/logbook. If you have a CGM that can share data with our clinic, please have your device ready and let the front desk know what type of device you have.

Please call your insurance to verity coverage/deductible issues. Thank you for choosing our office for your Endocrinology needs.

MAP ON BACK

Saint Alphonsus Regional Medical Center Campus Directory

DESTINATION	ENTRANCE
Admitting	Main
Ambulatory Clinic	S2
Anticoagulation/Coumadin Clinic (999 N. Curtis Road)	S3
Breast Care Center	W5
Cancer Care Center	N1
Conference Center	Main
Diabetes Care & Education (1000 N. Curtis Road)	1000
Day Surgery	N7
EKG	Main
Emergency Room	S1
Endoscopy/GI	S2
Family Center	W4
Family Maternity Center/NICU (*Labor & Delivery*)	N4
Financial Services	S2
Lab	S2
Lost & Found	S2
Med Now Pharmacy	S3
Medical Imaging (X-Ray)	S2
Medical Records	Main
Neonatal Intensive Care Unit (NICU)	N4
Outpatient Diagnostics (Lab, X-Ray & Medical Imaging)	S2
Outpatient Echocardiogram	Main
Outpatient EEG	Main & S2
Pain Management & Spine Medicine (Outpatient; 6th Floor South Tower)	S2
Pre-Surgical Screening	Main
Pulmonary Diagnostics	N3
Security	S2
Sleep Disorders Center (Basement)	N3
Surgery Center	Main
Vascular Lab	Main
Wound Healing & Hyperbaric Medicine	S6

April 2015

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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/Pronoun	Email Address
Mailing Address	Ethnicity/Race 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	Emergency Contact
Occupation and Phone #	Emergency Contact #
Primary Insurance	Secondary Insurance
Group #	Group #
Policy #	Policy#
Policy Holder	Policy Holder

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.

Beneficiary Signature and Date____

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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 TOBACCO What and how often? ______________________

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
Depression
Dizziness
Fainting
Fever
Forgetfulness
Falls
Broken bone
Headache
Insomnia
Weight loss
Weight gain
Excess thirst
Nervousness
Sweats/flushing
Sleep apnea
Abnormal breathing during sleep
Snoring

Poor appetite
Bloating
Bowel change
Constipation
Diarrhea
Excess hunger
Indigestion
Nausea
Vomiting
Abdominal pain
Heartburn
Acid reflux

Cough
Chest pain
Rapid heart beat
Irregular heart beat
Shortness of breath
Swelling feet/ankles

Blurred Vision
Difficult swallowing
Choking
Hoarseness
Hearing loss
Ear ringing
Nosebleeds
Nasal drip
Tingling
Muscle cramp
Muscle pain/ where ________
Joint pain/where ________
Height loss/how much? ________
Growth hands/feet
Dental problems
Numbness

Eye lid problem
Bruising
Rash
Hives
Mole change
Skin sores
Hair loss

Frequent urination
Painful urination
Erection problem
Bladder leaking
Breast lump
Irregular periods
Heavy periods
Abnormal PAP
Nipple discharge
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 primary 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, menopause, 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 a referral to a primary care provider if you require one.

GENERAL INFORMATION

On your first visit, either Dr. Foote or Ms. Heidt will take a 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 are enclosed which you are asked to complete and bring with you. A copy of your insurance card and a government issued ID will be needed.

Please bring a list of your medications. Depending on your condition, the following specific information will also be needed at your appointment. For all x-rays, please bring the actual films as well as the reports. Please ask your referring doctor to send us your tests results. Please call us to verify that your test results were received prior to your appointment.

Diabetes:	Recent lab tests – glycohemoglobin, cholesterol, and urine tests. Bring meter, sensor, logbook to very appointment. We will be able to share data with if you are using Libre View. Our practice ID is tvendocrine. Dexcom code is: tvendocrine
Thyroid disease:	Recent lab tests, scans, ultrasounds, chest x-rays, pathology and operative reports. Iodine treatment reports.
Pituitary disorder:	CT scan or MRI of the brain, lab tests, pathology and operative reports, reports of radiation treatments.
Growth disorder:	Growth charts or previous height and weight records, hand x-ray, lab tests.
Osteoporosis:	Bone x-rays, bone density reports, lab tests, and type of vitamins taken.
Cancer:	Last progress note from your doctor, list of medications, including all meds taken 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, and have previous Endocrine records faxed to 208-506-7112

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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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 NOTICE CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information and to notify affected individuals following a breach of unsecured health information.

1. Uses and disclosure we may make without written authorization. We may use or disclose your health information for certain purposes withouyt your written authorization, including the following :

Treatment. We may use or disclose your information for purposes of treating you. For example, we may provide, coordinate or manage healthcare and related services by one or more providers.

Payment. We may use and disclose your information in order to obtain payment for services provided to you. For example, we may disclose information to your health insurer to confirm coverage, obtain pre-authorization or payment for treatment.

Health Care Operations. We may use and disclose your information to operate your business. For example, we may use information to ensure quality customer service.

Release of Information to Family/Friends. Unless clearly instructed to the contrary.

Other Uses or Disclosures. We may use or disclose your information for certgain other purposes allowed by 45 CRF 164.512.

2. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

3. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations or accounts. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.
- You may obtain a paper copy of this Notice upon request.

4. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area. You may obtain a copy of the Notice from our receptionist or Privacy Officer.

5. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer, Miren Arozamena. All complaints must be in writing. We will not retaliate against you for filing a complaint.

______________________________ _______________

Patient or Representative Signature Date

______________________________ _______________

Printed Patient Name Date of Birth

Relationship to Patient (if other than patient: _______________

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Prescription Refill Policy

You, the patient, are responsible for knowing when medications will need renewal or refilling. Many prescriptions now require prior authorization meaning extra time and paperwork between the office, the pharmacy and your insurance company.

Prescription refills and authorizations are approved between 8:00 am- 3:00 pm Monday - Thursday, and 8:00 am - 12pm on Fridays. No routine prescriptions will be filled on Friday afternoons, weekends or holidays. You are obliged to have been seen in the office by your provider within 12 months of any prescription refill request. You are asked to adhere to guidelines for lab monitoring as requested by your provider.

All requests must be sent to us from your pharmacy. The procedure is as follows:
1. Call your pharmacy with your refill request.
2. Pharmacy will send electronic or faxed request to our office for provider approval.
3. Allow 4 business days for ROUTINE refills. Allow <u>two weeks</u> for medications or supplies needing <u>prior authorization</u>. Please plan ahead in order to be assured that you will not have a lapse in your prescriptions.

I HAVE READ AND UNDERSTAND THIS REFILL POLICY:

PRINTED NAME: ____________________________________

SIGNATURE: ______________________________________