Michael D. Loughner, M.D., P.C. Kenneth Tompkins, M.D.

HARVARD PARK MEDICAL PLAZA 950 E.
HARVARD AVENUE
SUITE 660
DENVER, COLORADO 80210-5051
720-399-6555
FAX –720 -399-0511

PATIENT NAME:_____ DATE OF BIRTH: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received Endocrinology Specialists of Colorado LLC's Notice of Privacy Practices.

Signature: _____ Date:_____

ENDOCRINOLOGY SPECIALISTS OF COLORADO, LLC
MEDICAL QUESTIONAIRE

Doctor L☐ T☐ Date:

Name: D.O.B.:

Medication Allergies?	Which Medications are you allergic to?	What does it do to you?
Yes☐ No☐		

Past Medical History: Please check any of the following which you have had and give approximate date.

☐	Anemia	☐	Hepatitis or Liver Problems	☐	Prostate Trouble
☐	Arthritis	☐	Infertility	☐	Rheumatic Fever
☐	Asthma	☐	Irritable Bowel	☐	Sexual Dysfunction
☐	Bleeding Disorders	☐	Kidney Stones	☐	Sexually Transmitted Diseases
☐	Blood Clots	☐	Kidney Disease	☐	Skin Disorders
☐	Blood Pressure Problems	☐	Malabsorption	☐	Stomach Ulcers
☐	Bone Fractures	☐	Mental Illness	☐	Strokes
☐	Cancer	☐	Mitral Valve Prolapse	☐	Tumors
☐	Cholesterol Problems	☐	Neurological Problems	☐	Thyroid Problems
☐	Diabetes	☐	Organ Transplant	☐	Tuberculosis
☐	Emphysema	☐	Osteoporosis	☐	Ulcerative Colitis
☐	Hearing Problems	☐	Pancreatitis	☐	Urinary Tract Infections
☐	Heart Disease or Murmurs	☐	Pneumonia	☐	Vision Problems

Please list any additional medical illness you have if not included.

Past Surgical History: Please list any surgeries you have had in the past.

Women

Menstrual History: Please complete the following with regard to your periods.

Age of onset:	Days between cycles:	Regular Y or N
Type: Heavy☐ Medium☐ Light☐	Duration:	Pain:
Birth Control:	Age of menopause:	Menopause: Natural or Surgical

Habits:

Smoking Now: Y☐ N☐	How Much?	How long?	Date you quit?
Alcohol:	How Much?	How long?	Date you quit?
Drug Use:	How Much?	How long?	What do you use?
Exercise:	How Much?	How long?	What do you do?

Family History: Please check any of the following which have occurred in your family, and indicate which family member it occurred; Mother, Father, Brother, Sister, Child, Grand Parent, Aunt, or Uncle.

☐	Anemia	☐	Emphysema	☐	Obesity
☐	Arthritis	☐	Heart Trouble	☐	Osteoporosis
☐	Bleeding Disorders	☐	Hepatitis or Liver Problems	☐	Skin Disorders
☐	Blood Pressure Problems	☐	Kidney Disease	☐	Strokes
☐	Bone Fractures	☐	Kidney Stones	☐	Stomach Ulcers
☐	Cancer	☐	Malabsorption	☐	Thyroid Problems
☐	Cholesterol Problems	☐	Mental Illness	☐	Tuberculosis
☐	Diabetes	☐	Neurological Problems	☐	Tumors

Please list any additional medical illness that has occurred in your family if not included above:

Doctor L ☐ T ☐ Date:

Name: D.O.B.:

Please list age of the following. If deaths have occurred, please list at what age and the cause.

Father:	Sisters:
Mother:	Children:
Brothers:	

Review of Systems: Please check if you are currently or recently experienced any of the following:

Constitutional Symptoms
- ☐ Fatigue
- ☐ Weakness
- ☐ Weight Loss or Weight Gain
- ☐ Fevers / Chills / Night Sweats

Eyes
- ☐ Eye Pain
- ☐ Glasses / Contacts
- ☐ Blurred Vision
- ☐ Loss of Vision
- ☐ Itchy or Watery Eyes
- ☐ Red Eyes
- ☐ Headaches

Ears, Nose, Mouth, Throat
- ☐ Pain in the Ears
- ☐ Decreased Hearing
- ☐ Ringing in your Ears
- ☐ Dizziness
- ☐ Infection
- ☐ Frequent Colds
- ☐ Sinus Congestion or Pain
- ☐ Nasal Drainage
- ☐ Itching or Hay fever
- ☐ Nosebleeds
- ☐ Facial Pain
- ☐ Tooth or Gum Pain
- ☐ Hoarseness
- ☐ Sore Throat

Breasts
- ☐ Lumps
- ☐ Discharge
- ☐ Pain
- ☐ Self Exams

Endocrine
- ☐ Heat or Cold Intolerance
- ☐ Excessive Sweating
- ☐ Excessive Hunger or Thirst
- ☐ Frequent Urination
- ☐ Hot Flashes

Respiratory
- ☐ Coughing or Wheezing
- ☐ Coughing up Blood
- ☐ Coughing up Phlegm
- ☐ Shortness of Breath
- ☐ Pain with Breathing

Cardiovascular
- ☐ Shortness of Breath while Lying Flat
- ☐ Number of Pillows you Sleep On
- ☐ Decreased Ability to Exercise
- ☐ Chest Pain
- ☐ Rapid Heart Rate or Pounding
- ☐ Skipped Heart Beats
- ☐ Swelling in your Feet or Ankles

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Difficulty Swallowing
- ☐ Appetite
- ☐ Bloating or Belching
- ☐ Nausea / Vomiting
- ☐ Vomiting Blood
- ☐ Constipation or Diarrhea
- ☐ Change in Bowel Habits
- ☐ Blood in the Stool
- ☐ Change in Stool Color or Size
- ☐ Food Intolerance

Hematologic/Lymphatic
- ☐ Easy Bruising
- ☐ Past Transfusions
- ☐ Swollen Glands
- ☐ Neck Pain or Stiffness

Allergic/Immunologic
- ☐ Frequent Infections
- ☐ Hay Fever
- ☐ Tetanus Shot in Last 5 Years
- ☐ Flu Shot in Last Year
- ☐ Pneumonia Shot
- ☐ Exposure to Tuberculosis

Genitourinary
- ☐ Pain or Burning on Urination
- ☐ Change in Color/Odor of Urine
- ☐ Blood in Urine
- ☐ Frequency of Urination
- ☐ Urgency of Urination
- ☐ Stop and Start Urinating
- ☐ Incontinence
- ☐ Impotence
- ☐ Decreased Libido

Musculoskeletal
- ☐ Backache
- ☐ Muscle or Joint Aches
- ☐ Muscle Weakness or Stiffness
- ☐ Muscle or Bone Pain

Neurological
- ☐ Fainting or Blackouts
- ☐ Pain / Burning in Legs or Feet
- ☐ Numbness or Tingling
- ☐ Shakes or Tremors
- ☐ Seizures

Psychiatric
- ☐ Depression
- ☐ Thoughts of Suicide
- ☐ Nervousness
- ☐ Hallucinations
- ☐ Tension
- ☐ Insomnia

Skin
- ☐ Rashes, Sores, Lumps
- ☐ Itching, Dryness
- ☐ Change in Color
- ☐ Changes in your Nails
- ☐ Changes in your Hair

Please add anything which is not listed above.

NAME: _____ L☐ T☐

Date: _____

1. **Have you had a flu shot last season?** **YES** ☐ **NO** ☐
2. **Have you had pneumonia shot in the last 5 years?** **YES** ☐ **NO** ☐
   If yes, when and where did you last have your injection? _____
   _____
   _____
3. **Have you ever had a DXA Bone Density scan?** **YES** ☐ **NO** ☐
   If yes, where and when did you have your last scan? _____
   _____
   _____
4. **Do you use tobacco?** **YES** ☐ **NO** ☐
5. **Do you drink alcohol?** **YES** ☐ **NO** ☐
6. **Do you use illicit drugs?** **YES** ☐ **NO** ☐

Please list all medications you are currently taking, including strength and frequency you are taking your medications:

Medication Name	**Strength/Dose**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your preferred Pharmacy:

Pharmacy Name	**Pharmacy Address**	**Pharmacy Phone Number**
_____	_____	_____

Please use back of page for additional medications

PATIENT INFORMATION **L ☐ T ☐** **Date:** _____

Name: _____
Last Name First Name Middle Initial

Address: _____
Street City State Zip Code

Date of Birth: _____/_____/_____ Home Phone Number: (_____)_____
Month Day Year

Work Phone Number: (_____)_____ Cell Phone Number: (_____)_____

Email Address: _____

SS#:_____-____-_____ Occupation:_____ Employer: _____

Male ☐ Married ☐ Divorced ☐ Widowed ☐
Female ☐ Single ☐ Separated ☐

Primary Care Doctor:_____ Phone: (_____)_____ Fax: (_____)_____

Address:_____

SPOUSE OR CONTACT PERSON

Name: _____ RELATIONSHIP:_____
Last Name First Name Initial

Address: _____
Street City State Zip Code

Home Phone Number:(_____)_____ Work Phone Number:(_____)_____

VOICE MESSAGE CONSENT

I authorize you to leave a message(s) for me at the following number(s):

_____ Fax:_____

CONSENT TO SHARE MEDICAL INFORMATION

I give my permission to release or exchange information regarding my medical condition and treatment between my endocrinologist, his staff, and family members/contact persons.
Yes No
If yes, please provide the following:

Name:_____, relationship: _____

Name:_____, relationship: _____

By signing this form I understand all information shared is considered confidential. I authorize payment of medical benefits to undersigned Physician or supplier for these services and all future claims. I authorize the release of any medical information necessary to process this claim and all future claims

SIGNATURE:_____ Date:_____

Endocrinology Specialists of Colorado, LLC

950 E. Harvard Avenue, Ste 660
Denver, CO 80210
Michael D. Loughner, M.D., P.C. Kenneth Tompkins, M.D.

The following is a statement of our Office Policy. **We require you to read, agree to, and sign prior to any non-emergent treatment. By signing this document you are giving Dr.'s Loughner & Tompkins permission to treat you.**

Dr.'s Loughner & Tompkins strive to provide you with the best medical care possible. In doing so, we will assist you in filing medical insurance claims in order to receive maximum benefits for you as allowed by your health insurance carrier. **Therefore, it is your responsibility to provide us with complete and accurate insurance information at the time of every visit.** If you do not have medical insurance, our staff will provide you with information regarding different payment options for our services provided.

All patients are required to complete our **Patient Information Form** before seeing the doctor. We require that all patients update Patient Information Form **every six months** so we can bill your insurance company with accurate information. It is necessary for us to have your complete **date of birth** and **social security number** in order to obtain your medical and lab information.

All doctors require an updated copy of your insurance cards and picture identification in your chart at all times. Therefore, we require all patients to provide their **current insurance cards and picture ID at every visit for verification**. If you have changed insurance companies **you must provide the updated insurance information so we can keep your records updated in order to file claims correctly.**

Co-payments must be made at time of service. No post-dated checks will be accepted. For all returned checks, there will be a $50.00 returned check fee plus bank charges. Please note: **co-payments are a contractual agreement between you and your insurance company.**

Please notify us immediately of address and telephone number changes. We cannot notify you of important medical or financial information related to your visit without the correct address and telephone numbers.

Prescriptions/Refills:
If you need a medication refill, ask your doctor for a prescription at your regular appointment. When you provide local/mail-order pharmacy information we will do our best to send your prescriptions to the pharmacy requested. **Please be clear which medications go to which pharmacy.** If for some reason you need refills in-between appointments, **call your pharmacy**. They will contact us. Your appointment must be current. **Please allow five (5) business days for refill requests.** All refill requests are addressed. We will call you if we have questions about your prescriptions. **Please be aware THE ON CALL DOCTOR CANNOT PROVIDE PRESCRIPTIONS OR REFILLS.**

OVER

Insurance Responsibility:

Please be aware, we may provide services for you that your insurance contract denies as "non-covered services." If you do not understand which services are and are not covered, it is your responsibility to contact your insurance carrier to find out. If you have questions regarding your policy, please contact your insurance company or employer. **Please determine the extent of coverage and potential for personal liability before we provide services to you.**

Late Arrival Policy:

If you are more than **fifteen (15) minutes late** for your appointment, we will reschedule your appointment for a later date.

No Show/ Late / Late Cancellation Policy:

Our goal is to accommodate our patients' health care needs and their schedules in a timely fashion to the best of our ability. For this reason, we require 24-hour notice for cancellations so that your appointment time may be offered to another patient. **Therefore, if you no show, arrive late, or cancel your appointment late, you will be charged a fee based on the length of time scheduled for your visit.**

Limited Space:

Due to the limited space available in our waiting area, we prefer you bring no more than one visitor to your doctor's appointment**.**

Referral Policy and Primary Care Physician:

Because regulations by today's managed care insurance plans, you must obtain a referral from your primary care physician, if required. It is your responsibility to ensure that the referral is current; otherwise you will be expected to pay in full for all services.

Dr.'s Loughner & Tompkins are specialists in the field of Endocrinology, Diabetes and Metabolism and does not function in the role of a primary care physician. **Be aware that he will not provide non-emergent medical care unrelated to your endocrine, diabetes, or metabolic condition including refills of prescription drugs not related to your Endocrine condition.**

I have read, fully understand, and agree to all terms set forth in the above Office Policy.

_____

Responsible Party (Please Print Name)

_____ _____ _____

Responsible Party Signature **Date** **Staff Initials**

REVISED 10/29/2020

HEALTH FIRST COLORADO PATIENT FINANCIAL AGREEMENT AND GUARANTEE

Patient/Client Name _____

I, the undersigned, acknowledge that not all services provided to me by Endocrinology Specialists of Colorado, LLC ("Provider") are covered or reimbursable by my insurance plan, including Colorado's medical assistance program, the Health First Colorado Medicaid Plan (the "Plan"). I acknowledge and accept that I am financially responsible for all services and items rendered on my behalf by the Provider by which a charge may be associated and which is not covered and/or not reimbursable. I agree to give the Provider complete and accurate insurance information for primary and secondary insurance coverage and all identification and benefit cards/ documents required for claim accuracy.

I accept personal responsibility for all co-payments, deductibles, non-covered services and items, and non-reimbursable services and items, as dictated by my insurance coverage, including any non-covered services and items and non-reimbursable services and items under the Plan, plus any collection costs for amounts personally owed by me for services and items provided. I have been informed that the services and items provided may not be covered or reimbursable by my insurance plan, including the Plan. I elect to proceed with service with the understanding that I may be personally responsible to pay for the non-covered and/or non-reimbursable services and items being rendered to me.

_____

Patient Signature

_____

Date

_____

Parent or Legal Guardian Signature for a Minor Patient (if applicable)

_____

Date

Endocrinology Specialists of Colorado, LLC
950 E. Harvard Avenue, Suite 660
Denver, CO 80210
PH: 720.399.6555
Fax: 720.399.0511

Michael D. Loughner, M.D., P.C. **Kenneth Tompkins, M.D.**

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you do so with appropriate notice. We consider 1 business day (with no less than 24 hours) to be appropriate notice for office appointments, and 5 business days to be appropriate notice for procedure appointments. Such notice enables another person waiting for an appointment to be scheduled in that appointment slot. With cancellations with less than 1 business days' notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 1 business days' (with no less than 24 hours') notification may be subject to a **$50.00** cancellation fee. Procedure cancellations require a 5 business day advance notice; without notification they may be subject to a **$150.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel will be considered as a **NO SHOW**. Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice and may be denied any future appointments. Patients may also be subject to the **$50.00 office appointment No Show fee or the $150.00 procedure No Show fee**.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Insurance and Medicare will not cover these fees.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (615/550-4030).

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____ **Date of Birth**_____

Patient Name (Please Print)

_____ _____

Signature of Patient or Patient Representative **Date**

CONSENT FOR TELEHEALTH SERVICES AND TREATMENT

To our patients and families:

Thank you for choosing us for your telehealth care. Patients and families are essential participants in health care, and we want you to understand your rights and responsibilities while receiving care from us. If you have any questions about this form, please ask your provider. If you are a guardian/legally-authorized representative of a patient, please read this agreement with the understanding that "I" and "me" means the patient.

1. Consent for Treatment: I consent to telehealth care performed by my physician and all other associated health care providers at Endocrinology Specialists of Colorado ("ESC") (the "Providers"). This includes examinations, diagnostic testing, treatment, and other health care services deemed medically necessary in the Providers' professional judgment. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I also understand that I have the option to refuse the delivery of health care services by telehealth at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled. If I am pregnant, this consent also applies to my fetus.

2. Consent for Telehealth Services: Telehealth involves transmission of video, photographs, and/or details of my medical record such as x-rays and test results (collectively, "Data"). I understand that:

    - I will be informed of any other people who are present at the Providers' end of the telehealth encounter, and have the right to exclude anyone.
    - Except as modified or waived by Executive Order or other action taken by Federal or State authorities, all confidentiality protections required by law or regulation will apply to my care.
    - I have the right to refuse or stop participation in telehealth services at any time and request alternate services such as an in-person appointment. However, I understand that equivalent in-person services might not be available at the same location or time as telehealth services.
    - If I do not want to receive health care services by telehealth, it will not affect my right to future care or treatment, or any insurance/ program benefits to which I would otherwise be entitled.
    - If an emergency occurs during a telehealth encounter at a hospital or clinic, health care personnel at my location will manage the emergency. If an emergency occurs during a telehealth encounter when I am at a non-health-care site, I should call 911 and stay on the video connection (if applicable) until help arrives.

3. Records and Release of Information: Transmitted Data may become part of my medical record. Data will not be transmitted to people outside my health care team except as described below, and/or if I provide additional written consent.

    - I will have access to all of the information in my medical record resulting from the telehealth services that I would have for a similar in-person visit, as provided by federal and state law.
    - The Providers may use or disclose my health information for treatment, continuity of care, payment, or internal operations, or when required by law or regulation in certain unique situations.
    - All releases of information are subject to the same laws and regulations as in-person care. If I am participating in a human subject research protocol, my medical information may also be released as described in the research consent form(s).

4. Payment Agreement/ Assignment of Benefits: I agree to be responsible for any co-payments, deductibles, or other charges from the Providers and their providers that are not covered or paid by insurance or other third party payors – except as prohibited by any state or federal law, or any agreement

between my insurance company and theProviders or Endocrinology Specialists of Colorado. I authorize the Providers and Endocrinology Specialists of Colorado to file any claims for payment of any portion of the patient bills, and assign all rights and benefits payable for health care services to the provider or organization furnishing the services. I agree, subject to state and federal law, to pay all costs, attorney fees, expenses, delinquent charges, and interest in the event the Providers and/or Endocrinology Specialists of Colorado have to take action to collect the same because of my failure to pay all incurred charges in full. It is my responsibility to know what providers and telehealth services are covered under my insurance plan. I understand that I may be billed and agree to pay all bills submitted by the Providers, Endocrinology Specialists of Colorado, and/or other providers involved with the provision of telehealth services.

5. Consent to be Contacted (Telephone Consumer Protection Act): By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for the Providers, Endocrinology Specialists of Colorado, and/or other providers involved with the provision of telehealth services to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s)), or to collect any amounts I may owe, the Providers, Endocrinology Specialists of Colorado, and/or other providers involved with the provision of telehealth services may contact me at the telephone number(s) provided which could result in charges to me. I expressly consent that methods of contact may include SMS text messages, phone calls, including automated technology such as an auto-dialing device, pre- recorded messages, and artificial voice messages as applicable. This consent applies to all services and billing associated with my account(s) and is not a condition of purchasing services.

If I initial here, I DO NOT consent to being contacted by SMS (short message service) text message and automatically-dialed appointment reminders.

_____ **(Initial here if you do not consent to SMS messages)**

By signing this form, I acknowledge that I have read this information and agree to treatment by telehealth.

_____
Printed Patient Name

_____
Provider obtaining telephone
or video-conferenced consent

_____
Patient or Parent/ Legally Authorized
Representative Signature

Date: _____

_____
Printed Name & Relationship to Patient

Date: _____

A witness is only required if consent is obtained by telephone or video-conferencing:

_____ _____
Name & title of witness to consent Date