# MICHAEL D. LOUGHNER, M.D., P.C.

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 Dr. Loughner'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 | | Respiratory | | Genitourinary | |
|---|---|---|---|---|---|
| | Fatigue | | Coughing or Wheezing | | Pain or Burning on Urination |
| | Weakness | | Coughing up Blood | | Change in Color/Odor of Urine |
| | Weight Loss or Weight Gain | | Coughing up Phlegm | | Blood in Urine |
| | Fevers / Chills / Night Sweats | | Shortness of Breath | | Frequency of Urination |
| Eyes | | | Pain with Breathing | | Urgency of Urination |
| | Eye Pain | Cardiovascular | | | Stop and Start Urinating |
| | Glasses / Contacts | | Shortness of Breath while Lying Flat | | Incontinence |
| | Blurred Vision | | Number of Pillows you Sleep On | | Impotence |
| | Loss of Vision | | Decreased Ability to Exercise | | Decreased Libido |
| | Itchy or Watery Eyes | | Chest Pain | Musculoskeletal | |
| | Red Eyes | | Rapid Heart Rate or Pounding | | Backache |
| | Headaches | | Skipped Heart Beats | | Muscle or Joint Aches |
| Ears, Nose, Mouth, Throat | | | Swelling in your Feet or Ankles | | Muscle Weakness or Stiffness |
| | Pain in the Ears | Gastrointestinal | | | Muscle or Bone Pain |
| | Decreased Hearing | | Abdominal Pain | Neurological | |
| | Ringing in your Ears | | Difficulty Swallowing | | Fainting or Blackouts |
| | Dizziness | | Appetite | | Pain / Burning in Legs or Feet |
| | Infection | | Bloating or Belching | | Numbness or Tingling |
| | Frequent Colds | | Nausea / Vomiting | | Shakes or Tremors |
| | Sinus Congestion or Pain | | Vomiting Blood | | Seizures |
| | Nasal Drainage | | Constipation or Diarrhea | Psychiatric | |
| | Itching or Hay fever | | Change in Bowel Habits | | Depression |
| | Nosebleeds | | Blood in the Stool | | Thoughts of Suicide |
| | Facial Pain | | Change in Stool Color or Size | | Nervousness |
| | Tooth or Gum Pain | | Food Intolerance | | Hallucinations |
| | Hoarseness | Hematologic/Lymphatic | | | Tension |
| | Sore Throat | | Easy Bruising | | Insomnia |
| Breasts | | | Past Transfusions | Skin | |
| | Lumps | | Swollen Glands | | Rashes, Sores, Lumps |
| | Discharge | | Neck Pain or Stiffness | | Itching, Dryness |
| | Pain | Allergic/Immunologic | | | Change in Color |
| | Self Exams | | Frequent Infections | | Changes in your Nails |
| Endocrine | | | Hay Fever | | Changes in your Hair |
| | Heat or Cold Intolerance | | Tetanus Shot in Last 5 Years | | |
| | Excessive Sweating | | Flu Shot in Last Year | | |
| | Excessive Hunger or Thirst | | Pneumonia Shot | | |
| | Frequent Urination | | Exposure to Tuberculosis | | |
| | Hot Flashes | | | | |

Please add anything which is not listed above.

# 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**

**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**

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**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:(______)___________________

SS#:_____-____-_______ Date of Birth: _____/______/_______ Occupation:______________________

Employer: _________________________

**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:_______________________________

NAME: ________________________________  L  T

*Please answer one set of questions once a year.*

**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**

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**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**
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   ____________________________________________________________________________
   ______________________________________________________________
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   ____________________________________________________________________________
   ______________________________________________________________
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5. **Do you drink alcohol?** **YES** **NO**
6. **Do you use illicit drugs?** **YES** **NO**

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**Date: ___________________**

1. **Have you had a flu shot last season?** **YES** **NO**
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   ____________________________________________________________________________
   ______________________________________________________________
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   **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**

NAME: ___________________________________ L ☐ T ☐

Please list all medications you are currently taking:

# 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 the Providers or University of Colorado Medicine (Faculty Practice Plan ("CU Medicine")). I authorize the Providers and CU Medicine 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 CU Medicine 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, CU Medicine, 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, CU Medicine, 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, CU Medicine, 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

Date: ____________________________

_________________________________
Patient or Parent/ Legally Authorized Representative Signature

_________________________________
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