PRIORITY
Family & Urgent Care

ENDOCRINOLOGY SPECIALTY CONSULT

1208 Guy Pickle Dr., Amory, MS 38821
Phone: 662-256-3120 Fax: 662-256-7092
Visit our website at www.priorityfc.com
Email us at info@priorityfc.com

Priority Care Endocrinology is pleased to take part in your medical care. Listed are some phone numbers and information.

Appointment Date: _____ **Time**: _____

PLEASE BE HERE 15 MINUTES BEFORE YOUR APPOINTMENT TIME

Directions to the office:

From HWY 6 coming from Nettleton

Continue onto HWY 6 into Amory, at 4-way stop, turn LEFT onto HIGHLAND DR Go 0.9 miles and turn LEFT onto GUY PICKLE DRIVE for 282 ft. We are located behind Helton Dental Clinic on the LEFT. Parking is available in front of clinic and on the side of the clinic.

From MS 25 coming from Smithville/Fulton area:

Continue on MS HWY 25 toward Amory for 7.2 miles. Turn RIGHT onto GUY PICKLE DR for 282 ft. We are located behind Helton Dental Clinic on the LEFT. Parking is available in front of the clinic and on the side of the clinic.

Prescription Refills:

Call your pharmacy first. If you need a written prescription, contact our office at 662-256-3120.

Billing Questions:

For billing questions about your doctor's bills, please call the billing department at 662-256-3120. Please make sure if you require a referral it is valid for the day of your visit.

Patient's Personal Information **Marital Status**: [ ] Single [ ] Married [ ] Divorced [ ] Widowed **Sex**: [ ]Male [ ] Female

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

Home Address: _____ Apt #: _____

City: _____ State : _____ Zip Code: _____

Home Phone: (_____) _____- _____ Cell Phone: (_____) _____- _____

Email Address: _____ Date of Birth: _____/_____/_____

Social Security#: _____ - _____ - _____

Employer Information

Occupation: _____

Employer Name: _____

Address: _____ Suite/Unit #:_____

City: _____ State: _____ Zip Code: _____

Work Phone: (_____) _____- _____

Patient's / Responsible Party Information **Relationship to Patient:** [] Self [] Spouse [] Child [] Other: _____

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____/_____/_____ Social Security#: _____ - _____ - _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____- _____ Work Phone: (_____)_____- _____ Cell Phone (_____)_____- _____

Patient's Insurance Information * Please present insurance cards to receptionist. *

Relationship to insured: [] Self [] Spouse [] Child [] Other: _____

PRIMARY Insurance Name: _____

Address: _____City: _____ State : _____ Zip Code: _____

Name of insured: _____ Date of Birth: _____/_____/_____

Policy #: _____ Group #: _____ Co-pay : $ _____

Relationship to insured : [] Self [] Spouse [] Child [] Other: _____

SECONDARY Insurance Name: _____

Address: _____City: _____ State : _____ Zip Code: _____

Name of insured: _____ Date of Birth: _____/_____/_____

Policy #: _____ Group #: _____ Co-pay : $ _____

Patient's Referral Information

Referred by**:** _____ Phone: (_____)_____- _____

Patient's Primary Medical Doctor

Name: _____ Phone: (_____)_____- _____

Patient's Other Medical Doctors

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Pharmacy Information

Name: _____

Address: _____City: _____State : _____ Zip Code: _____

Phone: (_____)_____- _____ Fax: (_____)_____- _____

Emergency Contacts

Name: _____Relationship _____

Address: _____City: _____State : _____ Zip Code: _____

Home Phone: (_____)_____- _____ Work Phone: (_____)_____- _____ Cell Phone (_____)_____- _____

Name: _____Relationship _____

Address: _____City: _____State : _____ Zip Code: _____

Home Phone: (_____)_____- _____ Work Phone: (_____)_____- _____ Cell Phone (_____)_____- _____

By signing this form, I acknowledge and agree that the information provided is accurate and true.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

List the names and relationships of those you authorize us to discuss your personal health information:

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

PRIORITY
Family & Urgent Care

Consent for Treatment & Release of Health Information

Name of Patient: _____ Date: _____

1. CONSENT FOR TREATMENT: I request and voluntarily consent to the usual medical services as a patient at **Priority Care, LLC** (hereinafter referred to as "the clinic"), as well as the diagnostic laboratory (test of the blood or other bodily fluids) whether it be in house labs or send out labs, and x-ray procedures and medical treatment as well as any other treatment deemed necessary by my provider and his or her assistants. The clinic is authorized to retain, preserve, and use for scientific or teaching purposes or dispose of at its convenience, any specimens or tissue removed from my body during treatment.

2. MEDICAL CARE: During treatment at the clinic, I (the patient), will be under the professional care of a physician. I understand that no guarantees have been made as a result of examination or treatment while in the clinic.

3. COMPLIANCE WITH RULES & REGULATIONS: In consideration of treatment, I agree to abide by the rules of the clinic, including no smoking.

4. PERSONAL VALUABLES: I agree that the clinic will not be liable for the loss of or the damage to any of my personal property that I may bring to the clinic.

5. RELEASE & RESPONSIBILTY: I hereby agree, acknowledge, and understand that the clinic is not responsible for and agree that if I should leave the clinic without the consent of my provider (against medical advice), I hereby relieve my provider and the clinic of all responsibility of such action.

6. CONSENT TO DESTROY X-RAY & RADIOGRAPHOC DATA: I hereby authorize the clinic to retire or destroy my x-ray images (film and/or digital), and any other radiographic date, for (4) years after generation, if a proper report is in the medical record.

7. ASSIGNMENT OF BENEFITS: As the patient or patient's representative, I make the following assignment of benefits.
   MEDICARE/ MEDICAID: I hereby request that payment of authorized Medicare and/ or Medicaid benefits to or on my behalf for services rendered in or by the clinic, shall be made to the clinic, and I specifically assign such benefits to the clinic. I hereby certify that all information I provide, in connection with applying for benefits under Title XVIII of the Social Security Act, is true and correct, and complete in all respects. I understand that payments for services deemed not medically necessary by Medicare/ Medicaid are not authorized under the Medicare/ Medicaid program, and I may be responsible for the incurred charge(s), unless other third-party coverage is available.
   INSURANCE: I hereby assign to the clinic all rights, benefits, and interest under any insurance policy, health plan, workers' compensation, or other third-party payer for treatment received at or by the clinic. I hereby authorize payment of workers' compensation coverage directly to the clinic for expenses incurred at the clinic. I hereby authorize payment directly to the clinic of all third-party liability insurance coverage, third party payer, health plan, and individual liability. Insurance coverage for medical expenses incurred as a result od any accident, injury, or illness for which I

received treatment at the clinic. I understand that I am responsible for ensuring that all claims are submitted to my insurance company, the submission of my insurance claims by the clinic is only a courtesy, and there is no guarantee that all claims are properly submitted.

8. FINANCIAL RESPONSIBILTY: I understand that I am financially responsible to the clinic for all charges not paid by insurance. I also understand and agree that all deductibles, co-insurance, non-covered charges, and other items not paid by insurance, health plan, or other third-party payer are due and payable upon services rendered based on the best estimates available as determined by the clinic. Charges remaining on this account which are not paid by insurance health plan, or other third-party payer, are payable upon demand. Outside lab services will be billed directly to you by the lab company. I also agree that if this account is assigned to a collection agency or attorney for collection or suit, all collection fees, attorney fees, cost, and other expenses will be paid by me. I also understand, agree and authorized the clinic to verify employment status for the purpose of processing my clinic bill for payment.

9. COMMUNICATION: I authorized all clinical providers who have provided care or interpreted my test, along with any billing services and their collection agency or attorney who may work on their behalf, to contact me using pre-recorded messages, artificial voice messages, automatic telephone dialing devices. Services, or other computer-assisted technology, and/ or by email, text messaging, or any other form of communication.

10. CONSENT FOR THE RELEASE OF HEALTH INFORMATION FOR BILLING & PAYMENT PURPOSES: I hereby consent to the release of my health information (medical records, medical results and all other health information) by the clinic or any provider involved in my care for the purposes reimbursement; and certification to any insurance company, third party payer, health plan, or government agency which is necessary for the billing and payment of my account.

11. NOTICE OF PRIVACY PRACTICES: Priority Family & Urgent Care, PLLC uses Athena to electronically exchange date regarding prescriptions and related information between my providers and pharmacies. The information sent between these systems may include details of prescription drugs I am currently taking and/ or have taken in the past. This information will be utilized by Priority Family & Urgent Care, PLLC. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/ or confidential HIV related information by Athena to Priority Family & Urgent Care, PLLC. By signing below, I acknowledge that I have been informed of and/or received the clinic's Notice of Privacy Practices.

12. DISCOULSURE OF PERSONAL HEALTH INFORAMTION: Priority Family & Urgent Care, PLLC will not, without your authorization, discuss your personal health information with anyone except those allowed under the Federal and State Law or those listed below.

    Acknowledge and agreed to by:

_____

Print Patients Name & Date of Birth

_____ _____

Signature of Patient/ Personal Representative Date

I, _____have been informed that while a patient at Priority Care, PLLC that I will be under camera surveillance for my safety and protection. Surveillance is recording only; no audio is included, nor cameras are permitted in any patient rooms.

Telehealth Consent Form

By signing this form, I understand and agree with the following:

Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, medical assistants and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate on the telehealth/telemedicine service, and I agree to share my personal information with such family members, caregivers, legal representatives or guardians. The information may be used for diagnosis, therapy, follow-up and/or education.

Telehealth/Telemedicine requires transmission, via Internet or tele-communication device, of health information, which may include:

- Progress reports, assessments, or other intervention-related documents
- Bio-physiological data transmitted electronically
- Videos, pictures, text messages, audio and any digital form of data

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing and healthcare operations. By agreeing to use the telehealth/telemedicine services, I am consenting to **PRIORITY CARE** sharing of my protected health information with certain third parties as more fully described in **PRIORITY CARE** Privacy Policy. I understand, agree, and expressly consent to **PRIORITY CARE** obtaining, using, storing, and disseminating to necessary third parties, information about me, including my image, as necessary to provide the telehealth/telemedicine services.

As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Individuals other than my clinical care team or consulting providers may also be present and have access to my information for the telehealth/telemedicine session. This is so they can operate or repair the video or audio equipment used. These persons will adhere to applicable privacy and security policies.

Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient or care team.

I hereby release and hold harmless **PRIORITY CARE** and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.

I understand and agree that the health information I provide at the time of my telehealth/telemedicine service may be the only source of health information used by the medical professionals during the course of my evaluation and treatment at the time of my telehealth/telemedicine visit, and that such professionals may not have access to my full medical record or information held at PRIORITY CARE.

I understand that I will be given information about test(s), treatments(s) and procedures(s), as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telehealth/telemedicine visit.

I have the right to withhold or withdraw consent to the use of telehealth/telemedicine services at any time and revert back to traditional in-person clinic services. I understand that if I withdraw my consent for telehealth/telemedicine, it will not affect any future services or care benefits to which I am entitled.

All my questions have been answered to my satisfaction.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

Signature of Patient or Patient's Legal Representative **Date and Time**

Printed Name of Patient or Patient's Legal Representative **Relationship to the Patient**

INTERPRETER'S ATTESTATION (if applicable):
I certify that I am fluent in the language of the person providing consent. I certify that I have accurately and completely interpreted the contents of this form, and that the person giving consent has indicated their understanding of the contents.

Signature of Interpreter **Date and Time**

COMPREHENSIVE HISTORY AND PHYSICAL ENDOCRINOLOGY EVALUATION (FEMALE)

NAME_____, _____ _____DATE BORN_____/_____/_____Age_____
(Last) (First) (Initial)

On the two lines below, please describe the problem for which you are seeing the doctor:

_____

_____

History of the present illness (HPI)

(PLEASE DO NOT WRITE IN THIS BOX)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Prescription medications, antacids, aspirin, supplements, vitamins, health products, or laxatives you are now taking**:**

Name of Medicine	Dose strength	When taken	To treat what	Year begun	Prescribed by

FAMILY HEALTH HISTORY:
(Such as heart disease, high blood pressure, stroke, cancer, diabetes, thyroid disease, mental illness)

Relationship to you	AGE IF STILL LIVING	IF NOT ALIVE, AGE PERSON DIED	DISEASES PERSON HAS OR HAD AND CAUSE OF DEATH IF DECEASED
Mother			
Father			
Brother			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			
Sister			

PERSONAL AND SOCIAL HISTORY:

Where were you born? _____With whom do you live now?_____

Children (give sex and age in years)_____

Circle one: Married Divorced Widowed Remarried Never Married

Present weight: _____pounds The most you ever weighed (not pregnant):_____pounds

Has your weight changed in the past year? Gained _____pounds Lost _____pounds

Reason for weight gain or loss: _____

Your height: _____inches If you have lost height, how much? _____inches

Average number of hours you sleep each day ____hours

If you have trouble sleeping, what is the problem? _____

How many hours of exercise or heavy work do you do each week? ____hours

Amount and type of alcohol used each week:_____

Have you used "recreational" drugs (marihuana, heroin, crack). What?_____

If you have problems with your sexual function, what is the problem? _____

If you have used tobacco, what?_____ How much?_____

For how long? _____ years If you have quit, what year did you quit? _____

Highest education level you completed (circle one) GED High school College Graduate school

If you are on a restricted diet, what do you restrict?_____

If you drink caffeine beverages (coffee, cola, tea), how many ounces a day? _____ounces

What are your hobbies, recreational activities?_____

What is your current job?_____Your past jobs_____

If you served in the military service, give branch_____and years _____-_____

Religion (Catholic, Protestant, Jewish…)_____ Religious?_____

PAST MEDICAL HISTORY:

How healthy are you now (circle one): GOOD FAIR POOR

List drugs you are allergic to:_____

Year of last: Tetanus booster ____ Pneumococcal Vaccine ____ Flu Vaccine ____Hep B Vaccine ____ Covid Vaccine_____

Check if you had rheumatic fever____ Malaria____ Other serious infections _____

PAST HOSPITAL ADMISSIONS & SURGERIES:

Year admitted	Cause of illness		Year admitted	Cause of illness

REVIEW OF THE SYSTEMS:

EYES, EARS, NOSE, THROAT (CHECK THOSE YOU HAVE)

Loss of hearing ____

Earache or drainage ____

Loss of balance or vertigo ____

Lightheadedness ____

Hoarseness ____

Loss of sense of smell ____

Sinus trouble ____

Constant or frequent nasal stuffiness ____

Loss of ability to taste food ____

Repeated nose bleeding ____

Chronic dryness of the mouth ____

Wear glasses or contacts ____

Blurred vision and glasses don't help____

Double vision ____

Glaucoma ____

Sense of something in the eyes all the time____

Year last saw dentist: _____ Name of dentist:

Dr._____

Year last saw eye doctor: _____ Name of eye doctor:

Dr. _____

LUNGS and HEART (CHECK THOSE YOU HAVE)

Short of breath even with little effort ____

Heart murmur ____

Wake up at night very short of breath ____

Exposed to tuberculosis____ Year _____ Treatment given?

_____

Positive skin test for tuberculosis ____

Pain, discomfort, or tightness in chest ____

High blood pressure ____

Pain or lumps in breasts____

Breast biopsies ____

Persistent cough ____

Cough up blood ____

Cough up phlegm or sputum ____

Asthma ____

Palpitations or racing of the pulse ____

Repeated episodes of bronchitis ____

Drenching night sweats ____

Swelling of the legs or ankles ____

Severe pain in the calves while walking or running ____

Had an electrocardiogram (EKG) ____ Year of last one_____

Had a chest x-ray ____ Year of last one _____

Had a mammogram ____ Year of last one _____

Had an exercise or stress test ____ Year done _____

STOMACH, INTESTINES & LIVER (CHECK THOSE YOU HAVE)

Severe problem with stomach gas, bloating, or passing gas ____

Heartburn ____

Use antacids regularly ____

Frequent nausea ____

Have frequent or unexplained vomiting ____

Vomit blood ____

Stomach or abdominal pain ____

Bloody bowel movements ____

Loose bowels most of the time ____

Constipation most of the time ____

Hemorrhoids ____

Rectal pain or bleeding ____

Colon polyps ____

Ulcers ____

Had hepatitis or yellow jaundice ____

Had an Xray of the stomach ____

Had an endoscopy (a lighted tube exam) of stomach ____

Had a CAT scan or MRI of the abdomen ____

Had an X-ray or ultrasound of gallbladder ____

Had a lighted tube exam of the colon (sigmoidoscopy or colonoscopy)____

Had a barium enema Xray of the colon ____

KIDNEYS & BLADDER (CHECK THOSE YOU HAVE)

Had a kidney ultrasound or IVP ____

Get up at night just to urinate____ How many times a night? ____

Unable to control bladder and have accidents ____

Weaker and slower urine stream ____

Blood in urine ____

Kidney stone ____

Urinary, kidney or bladder infections ____

Venereal disease ____

Burning or pain during urination ____

Protein in urine ____

Constant feeling of a need to urinate ____

Trouble or hesitancy in getting urine flow going _____

MUSCLES, JOINTS & SKELETON (CHECK THOSE YOU HAVE)

Had fractures of bones____

Severe or unusual muscle cramps ____

Stiff joints____

Painful muscles ____

Swollen joints ____

Pain or stiffness in spine ____

Regular or repeated treatment for back ____ Treatment is by _____

NERVOUS AND PSYCHIATRIC (CHECK THOSE YOU HAVE)

Nervous breakdown ____

Psychiatric treatment ____ Treated by _____

Unusual weakness of muscles ____

Sick headaches ____

Numbness of part of body ____ Which part?_____

Paralysis in or loss of use of part of body ____ Which part?_____

Stroke ____

Pass out, fainting or loss of consciousness ____

Seizures or convulsions ____

Unusual shaking or trembling ____

Depressed ____

Easily annoyed or irritable____

Disturbed greatly by family___ By work ____ By other things ____

Considering suicide____ By what means?_____

Attempted suicide ____By what means?_____

Memory failing____

ENDOCRINE (CHECK THOSE YOU HAVE)

Big problem with heat or hot weather ____

Big problem with cold or cold weather ____

Excessive perspiration ____

Trouble swallowing ___

Goiter or enlarged thyroid gland ____

Nodule on thyroid gland ___

Tender thyroid or pain in the front of your neck ____

Excessive appetite ____

Poor appetite ____

Exhaustion or fatigue most of the time ____

Reduced libido or a poor sex drive____

Breast discharge ____

Change in voice ____

Excessive body or facial hair ____

Problem with acne____

OTHER PROBLEMS (CHECK THOSE YOU HAVE)

Pain in feet ____

Phlebitis____

Pulmonary embolus ____

Bleeder ____

Rash now or often ____

Chronic itching ____

Growth in the skin ____

Had or now have cancer ____Type?_____

Radiation therapy ____For?_____

Anemic ____

Swollen lymph glands ____