Park Avenue Endocrinology & Nutrition PLLC

DENNIS GAGE, M.D., F.A.C.P.
CLIFTON M. JACKNESS, M.D.
GILLIAN M. GODDARD, M.D.
SHIRA B. EYTAN, M.D.

103 East 75th Street
New York, NY 10021
Office (212) 772- 7628
Fax (212) 772-7062
www.parkavendo.com

Dear Patient:

Enclosed are your registration forms. Please complete them and bring to your appointment with your **insurance card and photo ID.** Please bring your referral if required by your insurance.

Please be advised that your **appointment will be rescheduled if you do not have these items.**

Also, please note that if your insurance is Oxford Liberty, Blue Cross, Oxford Medicare, Oscar, or MagnaCare Republic, your appointment will be with Dr. Gillian M. Goddard or Dr. Shira Eytan.

For questions or concerns, please contact our office.

Sincerely,

Dennis Gage, MD Clifton M. Jackness, MD Gillian M. Goddard, MD Shira B. Eytan, MD

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PATIENT INFORMATION FORM

Date: _____

Name: _____ **Age:**_____**Date of Birth:**_____**Social Security #**_____

Address:_____

City: _____**State/Country:** _____**Zip Code:** _____

Home Phone: _____**Cell:**_____**Work:**_____

E-mail Address: _____**Referred by:**_____

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed Gender: _____

Spouse/Partner's Employer _____**Spouse/Partner's Work Ph** _____**Spouse SS#:** _____

INSURANCE INFORMATION

Primary Insurance Company: _____**ID #:** _____

Subscriber's Name: _____ **Subscriber's DOB:** _____ **Relationship to pt:** _____

Secondary Insurance _____ **ID#:** _____ **Group #:** _____

Subscriber's Name: _____ **Subscriber's DOB:** _____**Relationship to pt:** _____

GENERAL INFORMATION

Name of Employer: _____ **Occupation:** _____

Address: _____

City: _____**State/Country:** _____**Zip Code:** _____

Emergency Contact: _____**Relationship:** _____**Phone:** _____

CONSENT

I approve my physician to leave "normal" test results on my voice mail or e-mail. [ ]Yes [ ]No Phone Number: _____

I approve speaking my spouse/partner/family member for results or billing [ ]Yes [ ] No _____
Name of Contact

I have completed this form and certify that I am the patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment and that payment is due on the date service is received. I authorized release of my medical history, information, or records concerning my diagnosis and treatment by the practitioners above. I may be required to substantiate or explain insurance claims filed, and I authorize payment directly to Park Avenue Endocrinology & Nutrition, PLLC and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing. If I have Medicare coverage, I request that payment of authorized Medicare benefits be made to me or on my behalf to the practitioners above for any services furnished me by the physician or supplier. I authorize any holder of information about me to be released to the Health Care Financing Administration and as agent any information needed to determine those benefits payable for related services.

Signature of Patient or Authorized Person: _____ Date: _____

Witness: _____ Date: _____

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SUBSPECIALTY CONSENT

I _____ understand that the practitioners in this office are seeing me as a specialist only. The area specialty is Endocrinology, Metabolism and Nutrition. I attest by signing this document that I have (or will obtain) a primary care provider who is available to me for general medical care and for emergencies. Of course, we will help coordinate management of care by in advising me and treatment me in the area of this subspecialty.

If you do not currently have a primary care provider, we will assist in your referral.

Name of Primary Care Provider: _____

Signature: _____

Witness: _____ Date:_____

VITAMIN CONSENT

I _____ understand that the vitamins and nutritional supplements recommended by the health care professionals are not intended as substitutes for medical treatment. They are instead to be considered wellness products. Some supplements are contraindicated for pregnant women and therefore one should be on alert and stop these products if pregnant. Instead special supplements specifically for pregnancy will be recommended. The FDA has not recommended any of these supplements as a treatment for particular disease. Though there are enormous quantities of literature supporting the use of many of these supplements, there has also been controversy as to their overall effectiveness. I realize that these supplements are sold in this office as a convenience for patients. There is absolutely no obligation that I buy the supplements from this office.

I have read the above and understand all features of the above consent.

Signature: _____ Witness: _____ Date:_____

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ADVANCE BENEFICIARY NOTICE

Patient Name _____ Medicare or Insurance ID (HICN) _____

Note: You need to make a choice about receiving these health care items or services.

We expect that Medicare and all other Insurance Companies may not pay for the item(s) or service(s) that are described below. Medicare and all other Insurance Companies do not pay for all of your health care costs. Medicare and all other Insurance companies only pay for covered items and services when Medicare or Insurance Company rules are met. The fact that Medicare or other Insurance Companies may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it in your personalized treatment plan.

Right now, in your case, Medicare and other Insurance may not pay for items or services: 1) CV Profiler, 2) BMR O2 measurement 3) Lab-HgA1c, Female Panel, Thyroid Panel, Chemistry, and CBC, 3) Echocardiogram 4) Nerve Conduction Study, 5) Bone Density, 6) Ansar, 7) Sudo-Scan, 8) Vestibular, 9) H.pylori

Because insurance states: 1) These tests are not considered medically necessary; 2) The frequency the test is performed is considered excessive; 3) The test is considered "experimental"

Please note: All tests are FDA APPROVED.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully. Ask us to explain if you don't understand why Medicare or other Insurance Companies may not pay. Ask us how much these items or services will cost you in case you have to pay for them yourself or through other insurance.

I understand that Medicare or other Insurance will not decide whether to pay unless I receive these items or services. Please submit my claim of Medicare or my other insurance. I understand that you may bill me for items or services and I may have to pay the bill while Medicare or my insurance company is making its decision. If Medicare or other Insurance does pay, you will refund to me any payments I made to you that are due to you. If Medicare or other Insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through other insurance that I have. I understand that I can appeal Medicare's decision.

Signature: _____ Date: _____

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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

We understand that information about you and your health is personal, and we are committed to protected the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your health information for the purposes described below. Please read the information below carefully before signing this form.

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

Disclose Information to and/or Obtain Information from

Name: _____
Name of Physician/Facility/Individual

Please give a reason as to why this information is to be disclosed

[ ] At the request of the individual [ ] Other _____

Information to be used or disclosed:

[ ] Medical Records

I understand the information to be released or disclosed may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release of disclosure of this type of information. I understand that I have the right to revoke this authorization at any time. I hereby authorize the use or disclosure of my health information as described in this form.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Name and Relationship of Legally Authorized Representative to Patient Witness Signature/Print

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PRIVACY NOTICE

Dennis Gage, MD, FACP/Clifton M. Jackness, MD/Gillian M. Goddard, MD/Shira Eytan, MD understand your privacy is important. You have received this notice in accordance with applicable state and federal laws because you are a current or potential patient. This notice will help you understand what types of nonpublic personal information—information about you that is not publicly available—we may collect, how we use it and how we protect your privacy.

- We collect nonpublic personal information to process and administer our patients' business.
- We have policies and procedures in place to protect nonpublic personal information about our patients or their families.
- We do not sell nonpublic personal information about our patients or their families to third parties.
- We do not disclose any nonpublic personal information about our patients or their families to anyone, except as permitted by law.
- We disclose your private health information routinely to insurance companies, other providers, and others for purposes of treatment, payment and healthcare operations.
- For all other purposes, we will either obtain your authorization or remove all information that could identify you as an individual.
- Our Privacy Policy applies to both current and former patients.

Questions and Answers that detail Dennis Gage, MD, FACP/Clifton M. Jackness, MD/Gillian M. Goddard, MD/Shira Eytan MD Privacy Policy

- What types of nonpublic personal information does the physician collect?
  - Information provided to us, such as on applications or other forms.
  - Information about transactions with affiliates, our third parties, or us.
  - Information from others, such as credit reporting agencies, employers and federal and state agencies.
  - The types of nonpublic personal information we collect varies according to the products or services provided and may include, for example, account balances, insurance premiums, marital status, and health history.
- What do we do to protect nonpublic personal information?
  - We restrict access to those employees, agents, representatives or third parties who need to know the information to provide products and services to our patients or their families.
  - We have policies and procedures that give direction to our employees, and agents and representatives acting in our behalf, regarding how to protect and use nonpublic personal information.
  - We maintain physical, electronic and procedural safeguards to protect nonpublic personal information.
- With whom do we share nonpublic personal information, and why?
  - We do not share nonpublic personal information about our patients or their families with anyone including other affiliated companies or third parties, except as permitted by law.
  - We may disclose, as allowed by law, all types of nonpublic personal information we collect when needed, to affiliated companies, agents, employees, representatives, and third parties that market our services and products and administer service customer accounts on our behalf.
  - Examples of the types of companies and individuals to whom we may disclose nonpublic personal information include attorneys, trustees, third party administrators, insurance agents, insurance companies, insurance support organizations, reporting agencies, registered broker/dealers, auditors and regulators.
  - We do not share personally identifiable health information unless the customer or the applicable law authorizes further sharing.
- Does our privacy policy apply to its agents and representatives?
  - To the extent by law, to its agents and representatives when they are acting on our behalf.
  - Please note: There may be instances when these same agents and representatives may not be acting on behalf of Dennis Gage, MD FACP/Clifton Jackness, MD/Gillian Goddard, MD/Shira Eytan, MD in which case they may collect nonpublic personal information on their own behalf or on behalf of another. In these instances, Dennis Gage MD FACP /Clifton Jackness, MD/Gillian Goddard, MD, Shira Eytan, MD would not apply.
- Does our privacy policy change?
  - We reserve the right to change any of our privacy policies and related procedures at any time, in accordance with applicable federal and state laws. You will receive appropriate notice if our privacy policy changes. Please also note that as provided in Dennis Gage, MD FACP/Clifton Jackness, MD/Gillian Goddard, MD/Shira Eytan, MD Notice of Privacy Practices, we reserve the right to change the privacy practices that are described in such notice. I may obtain a revised notice of privacy practices by contacting the office and requesting a revised copy by mail or asking for one at my next appointment.

Signature of Patient or Authorized Representative: _____ Date: _____

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NAME: _____

MEDICAL HISTORY

Allergies to Medications, X-Ray Dyes, Food, or Other Substances [ ] No [ ] Yes
(If yes, please list name of medicine and type of reaction):

_____ _____ _____

Medications and Doses (Prescription, Over-the Counter, Vitamins, Herbs):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Medical History & Review of Systems (Please circle current or past problems):

1. High Blood pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheaded ness
10. Frequent Urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gallbladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back pain
40. Skin diseases
41. Blood disorders
42. Venereal disease
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. _____
50. _____

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Gynecologic and Obstetric History:

Age at onset of periods: _____ Frequency: _____ Length of period:_____
Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding: [ ] No [ ] Yes (Please describe):_____

Leakage of urine: [ ] No [ ] Yes (Please describe):_____

Pelvic pain: [ ] No [ ] Yes (Please describe):_____

Abnormal discharge: [ ] No [ ] Yes (Please describe):_____

History of abnormal Pap smear [ ] No [ ] Yes (Please describe):_____

Surgeries/Operations (Please include approximate dates):

_____

Hospitalizations other than for surgery (Please include approximate dates):

_____

Immunization history—have you had:

Hepatitis B? [ ] No [ ] Yes when? _____
Pneumonia shot [ ] No [ ] Yes when? _____
Flu shot [ ] No [ ] Yes when? _____
Tetanus shot [ ] No [ ] Yes when? _____

When was your last:

Pap smear? _____ Breast exam? _____ Stool check for blood _____
Mammogram _____ Cholesterol check _____ Prostate exam _____

Family History
(Has any member of your family including parents, grandparents, siblings ever had the following)?

Illness	Which family members?	Living/Deceased	Approx. age diagnosed
Cancer (type)	_____	_____	_____
High blood pressure	_____	_____	_____
Heart Disease	_____	_____	_____
Diabetes	_____	_____	_____
Strokes	_____	_____	_____
Mental disease (anxiety, depression) _____		_____	_____
Drug or alcohol	_____	_____	_____
Glaucoma	_____	_____	_____
Bleeding disease	_____	_____	_____
Thyroid disease	_____	_____	_____
Other: _____	_____	_____	_____