PROVIDENCE
Medical Group
Olympia Endocrinology
4800 College St. SE
Lacey, WA 98503
Phone: (360) 413.4250
Fax: (360) 413-4256

WELCOME TO OUR PRACTICE

OFFICE HOURS
7:30 am–4:30 pm Monday through Friday by appointment only. We are also closed on the major holidays so our employees can enjoy time with their families.

INSURANCES
We are currently contracted with most major insurance carriers. We ask that you bring your insurance card with you as we will take a copy for our billing department. As a courtesy, we will submit claims to other insurances provided we have all the information. Please understand insurance policies are between you and the insurer. Please check with them to assure you are covered for our services and any services that you are referred for including x-ray, CT scan, MRI, specialists, lab services, etc.

FEES
Your co-payment is due in full at the time of service; otherwise, we will need to reschedule your appointment. If you have no insurance coverage, payment is due at the time of service. If you feel a payment plan is necessary, please contact our financial aid department at 1-855-229-6466 to make arrangements PRIOR to your appointment. We accept cash, check, money orders, Visa, MasterCard, American Express and Discover. Any returned checks are subject to a $25.00 NSF fee.

MISSED APPOINTMENTS/CANCELLATIONS
Due to a high demand for endocrinology services, we must ask that any changes to your appointment be made at least 24 hours prior to your scheduled appointment. Arriving for your appointment at your scheduled time is greatly appreciated. We understand unanticipated circumstances can arise. If you are more than 5 minutes late, we reserve the right to reschedule your appt. If you no show or same day cancel your first appointment, we will contact your referring provider to re-refer you to another endocrinology clinic. As an established patient, if you no show or same day cancel two times within a 12 month period, you will be dismissed from our practice.

RELATIONSHIP WITH YOUR PHYSICIAN
Our providers are happy to provide an endocrinology consultation to you. Due to the nature of our practice, please note that we are not able to provide primary care duties at this time. However, we would be happy to coordinate our care with your primary care provider.

MEDICATIONS AND REFILLS
The types of medications prescribed for you are ones that our physicians feel would be of most benefit to your condition. Many insurance companies place limitations on what they will cover. We will do our best to work within those guidelines, but please understand your insurance company may not cover all prescribed medications.

If you need a prescription refill, call your pharmacy and ask them to fax us a refill request, or use your MyChart access. **We ask that you contact your pharmacy directly. Please allow 72 hours notice when you need a refill of your medicines.** Please allow 24-hours for written prescriptions and samples.

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MEDICAL QUESTIONS OR PROBLEMS
Our clinic uses MyChart, a secure internet based communication tool, as our **PRIMARY** means of non-urgent communication. You will be given the choice to sign up for this useful tool. However, please continue to contact the front office with any emergent issues and a message will be sent to your provider as soon as possible.

REFERRALS
Many insurance companies now require referrals for you to see specialists, to have certain tests, or to receive other forms of treatment. It is important that authorizations be in place prior to your receiving the appropriate care. Most referrals take 72 hours to process, but there are occasions where it can take longer. Also, just because we submit a referral does not mean the approval will be granted. We always suggest you check directly with your insurance company so you understand your benefits and realize which providers participate with your plan.

TELL US WHAT YOU THINK
We want to provide the highest level of service. To help ensure you receive the best possible care, we encourage you to participate in decisions regarding your care and treatment plans. We welcome your feedback about the care and service you receive. You may thank our staff and providers by completing a "thank you" form and depositing it into the metal box which is located in the lobby. If you have any questions, concerns, or comments, please let us know during your visit, or give us a call at (360)413-4250.

PHONE MESSAGES
Is it ok to leave a **DETAILED** medical message on the phone numbers you provided to us?
This would include your personal health information.

YES ☐ **NO** ☐

My signature acknowledges that I have read and understand the policies of my provider's office as stated above.

_____ _____
Patient Name, *please print* Date of birth

_____ _____
Patient Signature Today's date

Previous or current primary care physician? _____

Who referred you to this office? _____

BIRTH DATE: ___/___/___ (month day year)

PATIENT NAME: Last First Middle Full Name

SEX: ☐ M or ☐ F

MAILING ADDRESS #_____

Street Apt / Unit / Space (circle if applicable)

City State Zip

Home Phone:

Work phone:

Cell phone:

Marital Status: Single / Married / Divorced / Widowed / Other

Social Security #: ___-___-___

e-mail address: _____

If employed, employer name & job title: _____

Employer address: _____

EMPLOYMENT STATUS: ☐ Full-Time ☐ Part-Time

If you associate with a specific religion, please indicate which:

Are you RETIRED?

☐ YES or ☐ NO

Do you attend school?

☐ YES or ☐ NO

RACE *optional*

☐ American Indian/ Alaskan Native
☐ Black or African Amer.
☐ Native Hawaiian/ Other Pacific Islander
☐ White or Caucasian
☐ Other

If you require an interpreter, please indicate language:

Are you Hispanic or Latino? *optional*

☐ YES ☐ NO

Insurance Information

Insurance Information	Primary Insurance	Secondary Insurance
Insurance Company Name		
Subscriber Name:		
Subscriber's Employer:		
Relationship to Patient		
Subscriber ID#		
Group #		
Subscriber Birth Date & Sex:	Male or Female Date of Birth:	Male or Female Date of Birth:
Subscriber Address (if diff. from patient)		
Subscriber Phone # (if diff. from patient)		

This section should be completed if you have a spouse or you are the dependent/child

☐ Husband or ☐ Father of Patient (If DEP or MINOR)	☐ Wife or ☐ Mother of Patient (If DEP or MINOR)
Name (Last, First, MI):	Name (Last, First, MI):
Address:	Address:
Phone:	Phone:

The above information is true to the best of my knowledge. I understand that I am responsible for charges associated with medical services and agree to pay all bills within 30 days from the receipt of statement, unless other arrangements are made. IF INSURANCE CARD(S) ARE NOT PROVIDED AT THE TIME OF YOUR VISIT, YOU MAY BE BILLED PRIVATELY OR YOUR APPOINTMENT MAY BE RESCHEDULED.

Signature: _____ **Date:** ___/___/___

PROVIDENCE MEDICAL GROUP
OLYMPIA ENDOCRINOLOGY

AUTHORIZATION TO PAY BENEFITS (ALL INSURANCES, EXCEPT MEDICARE):

I authorize and direct said agency, attorney or insurance company to pay from the proceeds of benefits any recovery of insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand that I may be personally responsible for payment of things such as, but not necessarily limited to, deductibles and co-pays. It is understood that the signing of this form does not prohibit customary monthly billings.

_____
Patient Name, please print

_____ _____
Patient Signature Date

FOR MINOR/DEPENDENTS

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatments/services until the patients turns _____ years of age.

_____ _____
Parent Signature, if minor Date

LIFETIME AUTHORZATION FOR MEDICARE PATIENTS ONLY

I request the payment of authorized MEDICARE benefits be made either to me or on my behalf to Providence Medical Group Olympia Endocrinology for any service furnished to me by their physician. I authorize the holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature Date

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PHONE MESSAGES:

Is it ok to leave a **DETAILED** medical message on the phone numbers you provided to us? This would include your personal health information.

YES ☐ **NO** ☐

Emergency Contact Information

Name: _____ Relationship: _____

Phone Number(s): _____ ☐ Home ☐ Work ☐ Mobile

Phone Number(s): _____ ☐ Home ☐ Work ☐ Mobile

Patient Name: _____ Date of Birth: ___/___/___

Patient Signature: _____ Date: ___/___/___

Directions to Providence Medical Group

Olympia Endocrinology
4800 College St. SE
Lacey, WA 98503
Ph: 360.413.4250
Fax: 360-413-4256

I-5 Southbound:

Take exit 109 for Martin Way toward College St/Sleater-Kinney Rd N
Turn right onto Martin Way E
Use the left 2 lanes to turn left onto College St SE
At the traffic circle, continue straight to stay on College St SE
Destination will be on your left

I-5 Northbound:

Take exit 108 for Sleater-Kinney Road toward College Street
Keep left at the fork, follow signs for College St
Continue onto 3rd Ave SE
Turn right onto College St SE
At the traffic circle, continue straight to stay on College St SE
Destination will be on your left

PMG OLYMPIA ENDOCRINOLOGY HISTORY FORM

What medical concerns bring you to our office? _____

When did the problem begin? _____ Can you rate the pain (1-10)? _____

What is the most important health issue to you (whether or not it applies to an endocrine visit)? _____

_____

Past Medical Issues, Hospitalization or Surgeries? (Please list them, including dates of occurrence)

_____

_____

_____

_____

Specific Medical History: (Circle if they apply to you)

Allergies	Anemia	Arthritis	Asthma
Prostate Problems	Bleeding disorder	Cholesterol disorder	Depression
Diabetes	Thyroid disorder	Heart disease	Stroke
HIV/Hepatitis	Hypertension	Lung Disease	Kidney disorder

Cancer (specify type) _____

Social History:

Marital Status: Single Married Separated Divorced Widowed Other

Alcohol use: Never Rarely Moderate Daily

Tobacco use: Never Quit Currently smoke? packs/day Year you quit? _____

What do you do for a living? If retired/unemployed, what was your main profession?

_____

Family History:

Father: Age Living / Deceased~ Cause of death or medical problems? _____

Mother: Age Living / Deceased~ Cause of death or medical problems? _____

Any close relatives with diabetes? What type or age diagnosed? _____

Any relatives with thyroid problems? What type? _____

Any relatives with any of these: adrenal tumor, pituitary tumor, calcium problem? _____

Any other physicians involved in your care? _____

Patient Signature: _____ **Today's Date:** _____

Print Patient Name: _____ **Date of Birth:** _____

ENDOCRINE SYSTEM REVIEW

Circle the items in each category that presently cause you problems or discomfort

General/Constitutional
Recent Weight Change(up/down)
Fever
Fatigue
Headache

Integumentary (skin/hair)
Changes in skin dryness
Nipple discharge

Eyes
Blurred/double vision
Loss of peripheral vision

Ears/Nose/Throat/Mouth
Chronic sinus problems
Difficulty swallowing

Respiratory
Chronic or frequent cough
Shortness of breath
Asthma or wheezing

Cardiovascular
Heart murmur
Chest pain
Palpitation
Swelling of feet, ankles or hands

Gastrointestinal
Loss of appetite
Nausea or vomiting
Abdominal pain

Genitourinary/Reproductive
Kidney stones
Sexual difficulty
Female – pain with periods
Irregular periods
Total pregnancies_____

# of deliveries_____

# of miscarriages_____

Men: biological children_____

Method of birth
control_____

Musculoskeletal
Joint Stiffness
Muscle pain/cramps

Neurological
Light headed/dizzy
Tremors
Tingling/Burning in limbs

Psychiatric
Depression or depressed feeling
Anxiety

Endocrine
Excessive thirst/urination
Change in hat or glove size

Hematological/Lymphatic
Easy bleeding or bruising
Anemia
Enlarged lymph/glands

PATIENT NAME:_____

SIGNATURE:_____

DATE:_____

PROVIDENCE MEDICAL GROUP OLYMPIA ENDOCRINOLOGY

Please note that it is very important that this paperwork is completed in its entirety. Your provider needs this information in order to properly assist in treatment of your medical condition.

Medication	Dosage	Frequency

Preferred pharmacy name and street address: _____

Do you prefer 30 or 90 day supply of your medications? _____

Medication Allergies

Patient Name: _____ **Date of Birth:** _____