Scottsdale Endocrinology

Grace Zlaket-Matta, MD F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP, Kelly Hogan, PA

Date:_____

Legal Name First _____ MI _____ Last _____ Preferred Name _____

SSN _____ DOB _____ Sex: ❒Male ❒Female Sex at Birth____

Address _____ Apt # _____ City _____ State: _____ Zip: _____

Phone: Home _____ Mobile_____

Email _____ Organ Donor _____ Living Will _____

Preferred Communication: ❒Phone ❒Email ❒Text Message ❒Online Portal ❒Mail

Employment Status: ❒Student ❒Part-time ❒Full-time ❒Retired ❒Unemployed

Employer Name _____ Occupation: _____

Marital Status: ❒Single ❒Divorced ❒Separated ❒Married ❒Widowed

Preferred Language: _____

Race: ❒Asian ❒Black ❒Native-American ❒Hawaiian/Pacific Islander ❒White

Ethnicity: ❒Hispanic ❒Non-Hispanic

Primary Care Physician: _____ Phone: _____ Fax: _____

☐ **I HAVE NO PRIMARY CARE PHYSICIAN**

Referring Physician: _____ Phone: _____ Fax: _____

INSURANCE INFORMATION

Primary Insurance _____ ID _____ Group # _____

Cardholder Name _____ Relationship to Cardholder _____

Secondary Insurance _____ ID _____ Group # _____

Cardholder Name _____ Relationship to Cardholder _____

Scottsdale Endocrinology

Grace Zlaket-Matta, MD, F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP-C, Kelly Hogan, PA
9336 E Raintree Dr Ste 150 Scottsdale, AZ 85260
P: 480-219-5597 F: 480-219-5547

Notice for Prescription Refills

Please allow us **7 Business Days,** to request a REFILL on your medications. Once the refill is placed, allow up to 3 days for it to be processed by your pharmacy. We will process refills during our business hours and ONLY if you have made it to your previous SCHEDULED appointments. **It is important that you contact the pharmacy well before your prescription runs out to give us time to best help you and other patients.**

Notice for Cancellations

I understand and agree to the following courtesies regarding appointment cancellations:

1. I will cancel my appointment at least **24 hours before the appointment**
2. I agree to pay a **$50 No-Show Fee** if I do not show for any scheduled appointment, ultrasound, or biopsy or if I fail to provide a notice 24 hours before the appointment.
3. My provider will terminate or discharge my services if **I No SHOW to 3 scheduled appointments or cancel multiple times in a row.**

Termination of Services

Should your provider decide to terminate services with you, we will send you a letter. This letter will explain next steps to assist you in securing an alternative provider and receiving prescription refills for the 30 days past the date the termination letter was sent.

We will ensure you exit our practice with the proper care.

Signature _____ **Date** _____

Scottsdale Endocrinology

Grace Zlaket-Matta, MD, F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP-C, Kelly Hogan, PA
9336 E Raintree Dr Ste 150 Scottsdale, AZ 85260
P: 480-219-5597 F: 480-219-5547

Financial Responsibility

You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts, recoupments or any other patient responsibility indicated by your insurance carrier or our policies.

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: your health plan coverage has lapsed or expired at the time you receive services, your health plan determines that the services you received are not medically necessary and/or not covered by your insurance plan. We are in contract with every insurance we bill, we are required to follow their fee schedule and policies.

You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, providing signatures, and paying any co-pays or other patient responsibility amount at each visit/time of service. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished *after* the visit, we may file a claim with your insurance; and if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount at your time of service, your visit may be rescheduled. Delinquent accounts will be transferred to a collection agency when payments are not made in accordance with our policy. In the event that you default, you will be required to pay collection costs.

Please sign below that the patient understands the above policies.

Signature _____ **Date** _____

Scottsdale Endocrinology

Grace Zlaket-Matta, MD, F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP-C, Kelly Hogan, PA
9336 E Raintree Dr Ste 150 Scottsdale, AZ 85260
P: 480-219-5597 F: 480-219-5547

Authorization of Medical records

Patient Name:_____DOB:_____

The above authorizes:

Medical provider:_____

Phone:_____ Fax:_____

Purpose of release:

_____Appointment / Continuation of care other:_____

Medical records:

Specific records: _____Date:_____

Radiology Reports:_____ Date:_____

Other:_____ Date:_____

_____ _____
Patient Signature Date

******* PLEASE NO CDS'S. THANK YOU!! **********

To release medical records information concerning the above mentioned patient to Grace Zlaket-Matta,MD, Iyad Syoufi MD, Emma Reeve PA-C, Emily Geiser FNP-C. This consent will expire in 90 days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time provided I notify them in writing to that effect. I understand that any release which wasn't made prior to revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that it is subject to re-disclosure by the recipient and no longer protected by the privacy act.

Scottsdale Endocrinology

Grace Zlaket-Matta, MD, F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP-C, Kelly Hogan, PA
9336 E Raintree Dr Ste 150 Scottsdale, AZ 85260
P: 480-219-5597 F: 480-219-5547

Authorization to Release Medical Information to Family

I authorize the release of my health information, including my medical records, conditions, and or treatment **to the following person(s) or family:**

Name _____ Relationship to patient _____Phone _____

Name _____ Relationship to patient _____Phone _____

Name _____ Relationship to patient _____Phone _____

❒ I do not authorize to disclose my health information to anyone without my written or verbal consent.

Please note that consent for provider access will expire in 90 days after the signed date above. You affirm that you have given your consent freely, voluntarily, and without coercion. You may revoke this authorization at any time provide you notify us verbally or in writing. You understand that any release which was not made prior to revocation of authorization will not constitute a breach of your rights to confidentiality.

Please sign below that the patient agrees with the above authorizations.

Signature _____ **Date** _____

Scottsdale Endocrinology

Grace Zlaket-Matta, MD, F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP-C, Kelly Hogan, PA
9336 E Raintree Dr Ste 150 Scottsdale, AZ 85260
P: 480-219-5597 F: 480-219-5547

Important Information About Patient/Family/Visitor Responsibilities

Aggressive behavior is prohibited

Scottsdale Endocrinology wants to maintain a safe, respectful, and caring clinic where we can provide good care for all patients. To help us meet these goals, we expect patients, family members, and visitors to treat others respectfully while they are here. Inappropriate behavior, or language that is rude, disruptive, hostile, intimidating, harassing, or discriminatory towards anyone in the clinic will not be tolerated and may result in the dismissal from the practice (dismissal means we will no longer provide you care and you will need to find another provider).

Examples of inappropriate behavior include:

- Yelling
- Disrespectful, insulting, intimidating, aggressive, or abusive language or swearing cussing
- Threatening or intimidating gestures
- Words or actions that get in the way of patient care and running our business
- Words or actions that upset, scare, threaten others in the waiting room
- Demanding that providers or staff do something that our policies and procedures do not allow
- Demanding that providers do something they believe is not good medicine or goes against medical training or education
- Insulting or offensive remarks about individuals' race, color, ethnicity, national origin, religion, gender, age, disability, accent/language, or sexual orientation
- Refusal to cooperate with practice policies
- Hostile or violent behavior
- Sexual remarks, gestures or physical contact
- Physical assault or attempted assault
- Behavior that may or does damage to practice property
- Failure to respect an individual's personal space
- Talking to staff/providers in a way that is too personal or not related to patient care- such as trying to contact staff/ providers on their personal time outside the clinic setting, asking staff or providers for a date or to get together in a social setting
- Written statements sent by mail, portal, email, etc. to clinicians or staff that are harassing, threatening, offensive or disrespectful

Signature: _____ Date:_____

Scottsdale Endocrinology

Grace Zlaket-Matta, MD, F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP-C, Kelly Hogan, PA
9336 E Raintree Dr Ste 150 Scottsdale, AZ 85260
P: 480-219-5597 F: 480-219-5547

The Clinician-Patient Relationship: Patient Responsibilities

The clinician-patient relationship is a partnership based on mutual trust and respect. Effective medical care requires a team effort by patients, clinicians, and practice staff. As a patient, you have the responsibility to:

- Give us correct and complete information about what brings you in today, medications, medical history, surgeries, treatments, procedures, and other health issues
- Take part of your care and ask questions about your diagnosis, treatment, recommendations/ instructions, or medications
- Do your best to follow the treatment plan you and your provider agree on
- Recognize that a healthy lifestyle can prevent or reduce illness and take responsibility for adopting healthy habits
- Pay your bill in full. If you're on a payment plan, make your payments on time
- Keep your appointment or notify us ahead of time (24 hours notice) if you need to cancel or change your appointment
- Put your cell phone, tablet or laptop away when interacting with providers and staff
- Be open and honest about your health insurance, if you have it

Complaints about our service

If you have any questions or complaints about your care, bills you receive from us, or our customer service, we want to know. Please ask to speak to the office manager.

******Guns, videotaping, recording, or photography, or prohibited in our office******

Signature: _____ Date:_____

Scottsdale Endocrinology

Grace Zlaket-Matta, MD, F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP-C, Kelly Hogan, PA
9336 E Raintree Dr Ste 150 Scottsdale, AZ 85260
P: 480-219-5597 F: 480-219-5547

Notice of Privacy Practices

Patient Name: _____

I have the option to receive this practices **Notice of Privacy Practices** written in plain language.

The notice provider in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices' legal duties with respect to my protected health information. This practice reserves the right to change the term of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's Notice of Privacy Practices on request.

I participate in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals.

Physicians in this arrangement work together to improve the quality and efficiency to deliver health care to their patients. As a participant in this arrangement, we may share you PHI with other members of this arrangement for the purpose of treatment, payment or the health care operations of this organized health care arrangement.

Signature_____Date:_____

Medication and Supplement List

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

Preferred Pharmacy Name: _____

PHARMACY ADDRESS:_____

For your safety, let the provider or medical assistant know of any changes to your medications or any new medications. It is important that you help us update your medications frequently, including any SUPPLEMENTS, as they can cause possible adverse side effects when taken. To avoid dangerous interactions, we need to know **everything** you are taking. Please include any **insulin**, as well.

Prescribed or Supplement Medication

Medication Name	**Strength** (mg, mcg, units, etc.)	**How often?**	**Form or how you take it** (tablet, pen, injection, vial, patch, etc.)

PUMP: Please circle if you use one- Omnipod Dash, Omnipod 5, iLet Bionic, Medtronic 630G, Medtronic 770G, Medtronic 780G, Tandem t:slim, Tandem Mobi, Other-_____

Continuous Glucose Monitor: Please circle if you use one- Eversense, Dexcom G6, Dexcom G7,Freestyle 2, Freestyle 3, Medtronic Guardian 3, Medtronic Guardian 4, Other-_____

MEDICAL HISTORY

Do you have or have you had any of the following?
Please check all that apply and the approximate date you were diagnosed.

DIAGNOSIS	**DATE** (month/year)
❒ Diabetes	_____
❒ High Blood Pressure	_____
❒ High Cholesterol ❒ Triglycerides	_____
❒ Heart Attack	_____
❒ Heart Failure	_____
❒ Stroke / TIA	_____
❒ Hyperthyroidism	_____
❒ Hypothyroidism	_____
❒ Thyroid Nodule	_____
❒ Thyroid Cancer	_____
❒ Osteoporosis	_____
❒ High / Low Calcium	_____
❒ Sexual Hormone Deficiency	_____
❒ Cancer	_____
❒ Kidney / Bladder Disease	_____
❒ Eating disorder	_____
❒ Depression/Anxiety	_____
❒ Other Medical Problems:	_____
❒ A-Fib	_____
❒ History of Blood clots	_____
❒ Fracture	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES

❒ No Known Drug Allergies

Please list any allergies to drugs, foods, or supplements

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

Do either of your parents, to the best of your knowledge, suffer or have suffered from any of the following conditions?

Please check all that apply and specify which parent.

DIAGNOSIS	**FAMILY MEMBER**
❒ Diabetes	_____
❒ High Blood Pressure	_____
❒ High Cholesterol ❒ Triglycerides	_____
❒ Heart Attack	_____
❒ Heart Failure	_____
❒ Stroke / TIA	_____
❒ Hyperthyroidism	_____
❒ Hypothyroidism	_____
❒ Thyroid Nodule	_____
❒ Thyroid Cancer	_____
❒ Osteoporosis	_____
❒ High / Low Calcium	_____
❒ Cancer	_____
❒ Eating disorder	_____
❒ Sexual Hormone Deficiency	_____
❒ Eating disorder	_____
❒ Other Medical Problems:	_____
❒ CKD	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please indicate here if your parents are deceased.

❒ Mother ❒ Father

❒ Unknown ❒ Adopted

PAST SURGERIES

List any surgeries you've had as well as the approximate date they took place.

SURGERY	**DATE** (month/year)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

RECENT HOSPITALIZATIONS

List any recent hospitalizations. Include the reason for the visit and the approximate date they took place.

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

PERSONAL HABITS

Do you use tobacco? ❒Yes ❒No
If so, how much and how often? _____

Are you an ex-smoker? ❒Yes ❒No
What year did you stop? _____

Do you use alcohol? ❒Yes ❒No
If so, how much per week/per month? _____

Do you use any recreational drugs? ❒Yes ❒No

DIABETIC PATIENTS ONLY

Please fill out this section if you have been diagnosed with diabetes or prediabetes.

Year diagnosed _____

List any DIABETIC medications you've tried and when you stopped:

MEDICATION	**DATE OF CESSATION**
_____	_____
_____	_____
_____	_____
_____	_____

How many times a day do you test your blood sugar?

_____

Name of insulin pump _____

Name of blood sugar meter _____

Name of test strips _____

Name of your cardiologist and your last appointment date:

_____ _____

❒ I don't have a cardiologist

Name of your eye doctor and your last appointment date:

_____ _____

❒ I don't have an eye doctor

Name of your podiatrist and your last appointment date:

_____ _____

❒ I don't have a podiatrist

Did you get a flu shot this season?

❒ Yes ❒ No