Bridget Brady, MD, FACS
John P. Sabra, MD, FACS

AUSTIN THYROID SURGEONS
THYROID AND PARATHYROID SPECIALISTS

Patient Information

First Name: _____ M.I._____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Work Phone: _____Cell Phone_____

Email address: _____ Driver's License #: _____

Date of Birth: _____ Sex: [ ] F [ ] M SSN: _____ Marital Status_____

Race: ☐ American Indian or Alaska Native ☐ Hispanic or Latino ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other _____

Primary Physician Name: _____Phone: _____

Referring Physician Name: _____Phone: _____

Patient's Employer Name: _____

Emergency Contact Name: _____Phone: _____

PRIMARY INSURANCE INFORMATION ☐ **No, I will be paying the costs**

Insurance Company: _____ Phone #: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to patient: _____ Phone Number _____

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

Employer Name: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Phone #: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to patient: _____ Phone Number _____

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

Employer Name: _____

Thyroid History ☐ Not applicable

Which thyroid problems do you have? **(check all that apply)**

☐ Hypothyroidism ☐ Hyperthyroidism ☐ Goiter or enlarged thyroid

☐ Thyroid nodules ☐ Hashimoto's thyroiditis ☐ Taking thyroid hormone daily

☐ Have received radioactive iodine ☐ Thyroid surgery in the past

☐ Other _____

Parathyroid Disease: ☐ Not applicable

- How long have you known that you had high blood calcium?
  ☐ Not sure ☐ Less than a year ☐ 1-2 years ☐ 3-5 years
  ☐ 6-10 years ☐ 10-20 years ☐ More than 20 years

- Have you been diagnosed with hyperparathyroidism? ☐ Yes ☐ No, my doctor's unsure
  ☐ No, my doctors don't believe I have it ☐ No, I haven't seen a doctor for this

- Have you already had a parathyroid operation? ☐ Yes ☐ No

- Have you ever been given radioactive iodine (RAI) to kill your thyroid? ☐ Yes ☐ No

- Have you ever received radiation to your face, neck or chest for treatments of acne, cancer, infected tonsils or birthmarks? ☐ Yes ☐ No

- Have you ever had a bone mineral density scan or DEXA scan to look for osteoporosis? ☐ Yes ☐ No

- Have any of your relatives had parathyroid surgery or been diagnosed with hyperparathyroidism?
  ☐ Yes ☐ No

- Have you ever taken Lithium? ☐ Yes ☐ No

Pregnancy

Are you currently pregnant? ☐ Yes ☐ No

Please tell us if you have any of the following health issues:

Hypertension (high blood pressure) ☐ Yes ☐ No	**Fatigue (feeling tired)** ☐ Yes ☐ No
Osteopenia or osteoporosis ☐ Yes ☐ No	**Bone pain** ☐ Yes ☐ No
Kidney failure ☐ Yes ☐ No	**Kidney stones** ☐ Yes ☐ No
Feeling old and run down ☐ Yes ☐ No	**Insomnia** ☐ Yes ☐ No
Heart Palpitations (sensation of the heart beating hard or fast in your chest) ☐ Yes ☐ No	**Frequent headaches** ☐ Yes ☐ N
Atrial fibrillation or other heart rhythm abnormality	☐ Yes ☐ No
Heartburn or gastroesophageal reflux (GERD)	☐ Yes ☐ No
Excess hair loss in past few years ☐ Yes ☐ No	**Irritability or crankiness** ☐ Yes ☐ No
Stroke or cerebrovascular accident ☐ Yes ☐ No	**Leg or arm cramps** ☐ Yes ☐ No
Heart attack or myocardial infarction ☐ Yes ☐ No	**Muscle weakness** ☐ Yes ☐ No
Difficulty concentrating ☐ Yes ☐ No	**Difficulty with memory** ☐ Yes ☐ No

Other Symptoms and Conditions

Please let us know if you have any of the following conditions.

- ☐ Heart failure
- ☐ Pacemaker or defibrillator
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ History of easy bruising or bleeding
- ☐ MGUS (monoclonal gammopathy of undetermined significance)
- ☐ Multiple sclerosis (MS)
- ☐ History of gastric bypass surgery
- ☐ Other operation on the stomach or intestines
- ☐ Anemia
- ☐ Sarcoidosis
- ☐ Recent history of blood in urine (hematuria or microhematuria)

Please list any other medical conditions you have:

_____

_____

_____

Surgical History

Please list all surgical procedures you've had:

_____

_____

_____

Have you ever experienced any issues or complications from anesthesia? ☐ Yes ☐ No

Medications

Are you on blood thinners or anticoagulants? ☐ Yes (specify below) ☐ No

Are you taking Vitamin D? ☐ Yes ☐ No

Are you taking calcium supplements or medications that contain calcium, such as TUMS?

☐ Yes ☐ No

Please list all of your current medications:

_____

_____

_____

Allergies

Please list all drug allergies and the reactions you have

☐ **I have no allergies**

Medication Name	Reaction

Smoking / Tobacco Use

Do you have a history of smoking or use of tobacco products? ☐ Yes ☐ No
Do you currently smoke? ☐ Yes ☐ No

Family Medical History ☐ Adopted

Mother: Deceased: ☐ Yes ☐ No Current Age: _____

Current Illnesses: _____

Father: Deceased: ☐ Yes ☐ No Current Age: _____

Current Illnesses: _____

Please tell us if there are any other conditions that run in your family and who:

_____

_____

_____

Communication After or Before Business Hours

Our physicians at times contact patients outside of our normal business hours (8am-4:30pm).

Is it okay for them to call you outside of these normal business hours (could be as early as 6am or as late as 10pm? **Check and initial**

☐ Yes, use my home phone number. _____(initials)

☐ Yes, use my cell phone number. _____(initials)

☐ No, please don't contact me as early as 6am but okay to call me as late as 10pm._____(initials)

☐ No, please don't contact me as late as 10 pm but okay to call me as early as 6am._____(initials)

☐ No, please don't contact me outside of the normal business hours. _____(initials)

Cost and Billing

There are two type of fees for our practice.

1. Online Medical Opinion Consultation Fee
    a. $950.00 fee
    b. This fee is highly unlikely covered by any insurance company.
    c. Patient is responsible for this out-of-pocket fee.
    d. Payment is due on date of online consultation prior to your assigned time.

Agreement for Self-Payment of Medical Services

By signing below, you understand and agree the medical opinion consultation is a noncovered service and you agree to be responsible and pay for the full amount of the fee. Additionally, because the online medical opinion consultation is a noncovered service, we will not submit any claims to your health insurance policy for this online medical opinion consultation.

I have read the Agreement for Self-Payment of Medical Services. I understand and agree to this Agreement.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient if Legal Guardian

_____ _____
Witness Date

2. Surgical Cost for Physician Fees
    a. This fee is usually covered by your insurance if we are contracted with your insurance company.
    b. Austin Thyroid Surgeons is contracted with nearly all major insurance companies.
    c. We will submit our physician charges for the surgery to the insurance company on your behalf.
    d. Details will be discussed when you have been deemed a surgical candidate.

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Patient Authorizations

Our primary mission is to provide you with quality, cost effective, medical care. It is important that we have a good understanding with our patients regarding financial responsibility. We hope this summary will be helpful in explaining your responsibility and the expectations in maintaining a positive Austin Thyroid Surgeons and patient relationship. We encourage you to ask questions if you do not understand any area.

Please understand that financial responsibility for medical services rest between you and your health plan for surgery payment. While we are pleased to be of service by filing your medical insurance for you for our physician charges for surgery, we are not responsible for any limitations in coverage that may be included in your plan.

- Online Medical Consultation Fee, not covered by insurance, is due before your assigned time.
- Applicable deductibles and/or co-insurance are due prior to your surgery date.
- If you are uninsured, or if the services being provided are not covered by your insurance, you will be expected to provide payment in full at the time they are rendered.
- If you receive a payment from your insurance in error, you are responsible for paying Austin Thyroid Surgeons in full for that amount.

1. Authorization to Release Information

I hereby authorize Austin Thyroid Surgeons to: (1) release any information necessary to insurance carriers regarding my illness and treatments for surgery payment; (2) process insurance claims generated in the course of examination and treatment for surgeon's fees; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

2. Assignment of Insurance Benefits/Patient Financial Responsibility

I hereby authorize direct payment of my insurance benefits for surgery payment to Austin Thyroid Surgeons for services rendered to my dependents or me by Austin Thyroid Surgeons providers or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any balance due that Austin Thyroid Surgeons is unable to collect from my insurance carrier for whatever reason.

3. Medicare/Insurance Benefits

I request that payment from Medicare or any other insurance carrier, be made on my behalf to Austin Thyroid Surgeons I authorize the release of any of my or my dependent's records that these programs may request. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and its agents or insurance company any information needed to determine these benefits payable for related services.

4. Lab/ X-Ray/ Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services. I also understand that I am financially responsible for any balance due for these services if they are not reimbursed by my insurance for whatever reason.

5. Consent to Obtain Patient Medication History

I give my permission to allow Austin Thyroid Surgeons to obtain my medication history from my pharmacy, insurance carrier, and other healthcare providers. *This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression*

6. Consent to Treatment

I hereby consent to evaluation, testing, and treatment as directed by my physicians at Austin Thyroid Surgeons.

_____	_____	_____
Signature of Patient or Legal Guardian	Relationship to Patient if Legal Guardian	Date

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND RECORD OF DISCLOSURE

The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I understand that as part of my health care, Austin Thyroid Surgeons originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, as well as plans my future care or treatment.

I understand that as part of Austin Thyroid Surgeons treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I certify that I understand the privacy risks of the mail, phone calls, texts messages and email. I hereby authorize a representative or my physician to mail, call, text or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Austin Thyroid Surgeons in writing.

Patient/Guardian Signature: _____Date: _____

Patient/Guardian Printed Name: _____Patient DOB: _____

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

**If you would like to authorize for us to send your records to a physician, a separate Release of Information Authorization form will need to be completed. See attached form after page 9.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

I certify that I have received and read a copy of the Patient Information Privacy Policy.

Signature of Patient/Legal Guardian _____Date _____

(To be completed if patient refuses to sign acknowledgement)

Date_____ Name of person providing notice _____

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General Information

Our goal: Our goal is to provide you excellent endocrine surgery services to meet your healthcare needs. The information provided on this sheet answers our most frequently asked questions. These guidelines are in place to ensure the prompt handling of issues that surround healthcare today. Please review them thoroughly. Should you have any problems or issues, please contact the office at (512) 887-3187.

Prescriptions: Pharmacy Refills – Contact your pharmacy directly to obtain a prescription refill. Allow 48-72 hours for the approval process unless it is during weekends and holidays, then more time is required. Mail Order Refills – Please be sure to provide the form required by your mail order pharmacy to ensure it will be sent to the proper pharmacy.

Referrals/Surgery Authorizations: If one of our physicians refers you to another physician or facility for treatment, we contact your insurance company to obtain authorization for that care if necessary. It can take up to 7-10 days business days to get an approval; however, that time may vary depending on your insurance company. Do not make an appointment until our office has notified you that your approval has been received. For surgery authorizations (when required), we will contact your insurance company to obtain authorization approval and will notify the surgical facility upon receiving the authorization. If insurance company does not authorize the surgery prior to the surgery date, we may need to reschedule your surgery for a later date dependent on when/if your insurance company authorizes the surgery. We will keep you informed of the status prior to surgery date.

Lab and Other Test Results: If the physician has not scheduled a follow up appointment, results will be received and relayed by telephone within 7-14 business days of your appointment, do keep in mind that some tests might take longer. If you have a follow up appointment please keep it to discuss the results. Urgent matters, if received sooner will be relayed by telephone upon receipt. Please do call the office if you have not received notification of your results after 14 days of your appointment.

Appointments: Your online consultation appointment time is reserved especially for you. To ensure all available appointment times are utilized, it is imperative that our office is notified at least 24 hours in advance when a scheduled appointment cannot be kept. Please help us serve you and all our patients best by keeping your scheduled appointment. If it is necessary to reschedule your appointment, please give at least a 24-hour notice. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Austin Thyroid Surgeons reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments that are not cancelled with at least a 24-hour advanced notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

After Hours, Weekend and Holiday Coverage: There is always a physician available for Austin Thyroid Surgeons. For healthcare concerns that need to be addressed when our office is closed, please contact our office at (512) 887-3187 for instructions on how to reach our physician prior to the weekend or holiday closure.

Financial Responsibility: Payment is due prior your time of service. For surgery payment, per contract with your insurance company, we are required to collect your co-payment, deductible and/or co-insurance prior to the time of your visit; we are not allowed to bill for your co-payment. We are happy to provide the service of filing your insurance claim; however, you are responsible for any co-payment, deductible or coinsurance required by your insurance. Austin Thyroid Surgeons accepts check, cash and all major credit cards for payment.

FMLA Paperwork: Our office charges a $25.00 fee to fill out FMLA forms. This charge is not reimbursed by your insurance. By signing you understand that you are financially responsible for FMLA paperwork. Payment can either be made at the time forms are dropped off or picked up.

I have read and understand the above information. I understand a copy of this sheet may be given to me at any time upon request.

Signature of Patient or Legal Guardian	Relationship to Patient if Legal Guardian	Date

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d), effective June 2013 Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

PATIENT'S NAME: _____DATE OF BIRTH: _____

ADDRESS: _____ City/State/Zip: _____

PHONE: _____ EMAIL ADDRESS: _____

I AUTHORIZE THE FOLLOWING PRACTICE TO DISCLOSE MY/THE PATIENT'S PROTECTED HEALTH INFORMATION:

Practice Name: **Austin Thyroid Surgeons, PA**

- 3107 Oak Creek Drive, Ste 120, Austin, TX 78727
- 5301B Davis Lane, Suite 200, Austin, TX 78749

Phone: 512.887.3187
Fax: 512.887.3197

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: _____

Address: _____City, State, Zip: _____

Phone: _____ Fax: _____

REASON FOR DISCLOSURE: (*check that apply***)**
☐ Treatment/Continuing Medical Care ☐ Relative/Family Member ☐ Friend ☐ Other: _____

WHAT INFORMATION CAN BE DISCLOSED (*check that apply*):
☐ Office Visit Notes ☐ Labs ☐ Pathology ☐ Radiology ☐ Operative Reports/Hospital Records

☐ *ALL* health information (requesting transfer of all medical records) ☐ Other _____

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE: _____ Printed Name: _____

Name & Relationship if Signed by Individual's Legally Authorized Representative: _____

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means. The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)).

Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.