

<b>PATIENT REGISTRATION &amp; HEALTH QUESTIONNAIRE</b>				DATE	
NAME		MARITAL STATUS		DATE OF BIRTH	
STREET ADDRESS		CITY		STATE	ZIP
PHONE (HOME)	(WORK)	(CELL)	EMPLOYER		
S.S.#	EMAIL ADDRESS		REFERRED BY		
SPOUSE'S NAME		DATE OF BIRTH	OCCUPATION/EMPLOYER		PHONE
IF UNDER 18: PARENT/GUARDIAN					PHONE
<b>INSURANCE &amp; BILLING INFORMATION</b>					
BILLING NAME (IF OTHER THAN PATIENT)				RELATION	
BILLING ADDRESS				PHONE #	
DATE OF BIRTH	S.S.#				
<b>PAYMENT REQUIRED AT TIME OF SERVICE – UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.</b>					
1) INSURANCE COMPANY		ADDRESS			
SUBSCRIBER'S NAME		I.D.#	GROUP #	S.S.#	
2) INSURANCE COMPANY		ADDRESS			
SUBSCRIBER'S NAME		I.D.#	GROUP #	S.S.#	
MEDICARE #		MEDICAID I.D. #			
OTHER COVERAGE					
<b>ASSIGNMENT OF INSURANCE BENEFITS</b>					
I hereby authorize direct payment of surgical / medical benefits to <b>MARK M. SKLAR, M.D., F.A.C.P.</b> for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.					
<b>AUTHORIZATION TO RELEASE INFORMATION</b>					
I hereby authorize <b>MARK M. SKLAR, M.D., F.A.C.P.</b> to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.					
<b>MEDICARE ● MEDICAID</b>					
I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.					
PATIENT <i>(Please Print)</i>			DATE		
PARENT/GUARDIAN <i>(Please Print)</i>			SIGNATURE		

## HEALTH QUESTIONNAIRE

### REASON FOR VISIT

### FAMILY HISTORY

(IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

- |                   |                   |                   |                      |
|-------------------|-------------------|-------------------|----------------------|
| 1. EPILEPSY       | 6. THYROID        | 11. OSTEOPOROSIS  | 16. HIGH CHOLESTEROL |
| 2. MIGRAINE       | 7. HAY FEVER      | 12. ARTHRITIS     | 17. ALCOHOLISM       |
| 3. MENTAL ILLNESS | 8. ASTHMA         | 13. HEART DISEASE | 18. CANCER           |
| 4. GLAUCOMA       | 9. ANEMIA         | 14. STROKE        | 19.                  |
| 5. DIABETES       | 10. BLEEDS EASILY | 15. HYPERTENSION  | 20.                  |

### HOSPITAL ADMISSIONS (not including pregnancies)

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING – <i>INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION</i>	ALLERGIES	VACCINE	YEAR OF LAST	TEST/EXAM	YEAR OF LAST
		TETANUS / TD		RECTAL/STOOL	
		INFLUENZA (FLU)		CHOLESTEROL	
		PNEUMONIA		EYE	
		HEPATITIS			
		TUBERCULOSIS			

### MEDICAL HISTORY

(MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

<input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Ringing in Ear <input type="checkbox"/> Ear Infections – <i>frequent</i> <input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Failing Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Double or Blurred Vision <input type="checkbox"/> Eye Infections – <i>frequent</i> <input type="checkbox"/> Nose Bleeds – <i>recurrent</i> <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Sore Throats – <i>frequent</i> <input type="checkbox"/> Hay Fever / Allergies <input type="checkbox"/> Hoarseness – <i>prolonged</i> <input type="checkbox"/> Pneumonia / Pleurisy <input type="checkbox"/> Bronchitis / Chronic Cough <input type="checkbox"/> Asthma / Wheezing <input type="checkbox"/> Shortness of Breath: <input type="checkbox"/> on exertion <input type="checkbox"/> lying flat <input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Irregular Pulse <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg Pain – <i>when walking</i> <input type="checkbox"/> Varicose Veins / Phlebitis <input type="checkbox"/> Loss of Appetite – <i>recent</i> <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic Ulcer <input type="checkbox"/> <i>Persistent</i> Nausea / Vomiting <input type="checkbox"/> Abdominal Pain - <i>chronic</i>	<input type="checkbox"/> Gall Bladder Trouble <input type="checkbox"/> Jaundice / Hepatitis <input type="checkbox"/> Change in Bowel Habits <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's / Colitis <input type="checkbox"/> Bloody or Tarry Stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Urine Infections - <i>frequent</i> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney Stones Urination – <input type="checkbox"/> Overnight > than twice <input type="checkbox"/> Painful <input type="checkbox"/> Loss of Control <input type="checkbox"/> Decrease in force / flow <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Urethral Discharge <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Weight Loss - <i>recent</i> <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremor / Hands Shaking <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Numb / Tingling Sensations <input type="checkbox"/> Headaches - <i>frequent</i>	<input type="checkbox"/> Arthritis / Rheumatism <input type="checkbox"/> Back Pain - <i>recurrent</i> <input type="checkbox"/> Bone Fracture / Joint Injury <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Foot Pain <input type="checkbox"/> Cold Numb Feet <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Sleeping - <i>difficulty</i> <input type="checkbox"/> Depression <input type="checkbox"/> Nervousness <input type="checkbox"/> Memory Loss <input type="checkbox"/> Moodiness - <i>excessive</i> <input type="checkbox"/> Mental Illness <input type="checkbox"/> Phobias <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Mumps <input type="checkbox"/> Polio <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes <input type="checkbox"/> Alcohol _____ oz. per week <input type="checkbox"/> Smoking _____ cig/day _____ # years _____ year quit <input type="checkbox"/> Coffee / Tea _____ cups per day <input type="checkbox"/> Regular Exercise	<b>MALES</b> - <input type="checkbox"/> Prostate PSA Test  <b>FEMALES</b> – <i>Please complete</i> Menstrual Flow: <input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain/Cramps Days of Flow _____ Length of Cycle _____ Date – 1 <sup>st</sup> day of last period _____ <input type="checkbox"/> Pain / Bleeding during or after sex Number of: _____ Pregnancies _____ Abortions _____ Miscarriages _____ Live Births Birth Control Method _____ B.C. Pill (Name): _____ <input type="checkbox"/> Flushing / Menopause Date of last PAP Test: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Date of Last Mammogram _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
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### NOTES

# **MARK M. SKLAR, M.D., F.A.C.P.**

3 Washington Circle, N.W. Suite 303  
Washington, DC 20037  
(202) 887-4769

## **PATIENT RESPONSIBILITY**

### **ARRIVING ON TIME**

Out of respect for our patients' schedule, our office tries hard to be on time. Therefore, we request that patients arrive on time for their appointments. If you arrive more than 10 minutes late, you will be required to reschedule your appointment.

### **NO SHOW FEE**

Our practice is very busy and we have many patients who are requesting appointments. Therefore, we find it frustrating when scheduled patients do not give us notice if they can not make their appointments. Notice given even the day before an appointment, allows us to give the time slot to another patient. As a result we instituted a **\$50.00** charge for patients who do not show for their appointments or give at least a 24 hour notice of cancellation.

### **MEDICAL RECORDS FEE**

There is a minimum \$25.00 fee for medical records.

### **PRE AUTHORIZATIONS FEE**

Preauthorization's can consume large amounts of the doctor's and his staff's time. Typically they involve waiting for and speaking with someone on the phone and in addition the process may require transmission of parts of the medical record. The time required for this process is not paid for by the insurance companies. Therefore, as compensation for the time spent by the doctor and his staff, we have instituted a **\$50.00** fee for the preauthorization process.

### **CORRESPONDENCE**

Patients wishing to have forms filled out, letters written or e-mail questions answered will be charged \$25.00 to \$100.00, depending on the time spent.

### **TELEPHONE CALLS**

Patients requiring multiple or lengthy follow up calls during a short time span will be charged for these services. The fees can range from \$25.00 to \$100.00 depending on the length of the conversations. **INSURANCE WILL NOT PAY FOR THIS SERVICE; THE PATIENT IS RESPONSIBLE FOR THIS BALANCE.**

**LAB COLLECTION FEE**

I understand that certain PPO (Aetna, United Healthcare) and all HMO health plans require their members to go to an outside specified lab for collection of blood tests and other specimens. These health plans **do not pay** for specimen collection in the office. I understand that, as a convenience, if I want lab-work to be collected in Dr. Sklar’s office and then sent to a participating lab, I will be responsible for a **\$15.00 collection fee** due at the time of the visit. There will be a fee of **\$30.00** due from patients wishing to have their blood drawn in the office when they do not see the doctor and we do not participate with their insurance companies.

**REFERRAL**

If your insurance company requires a referral for your visit with Dr. Sklar, you, as the patient, are responsible for obtaining a valid referral for **every visit**. If you do not bring a referral and wish to be seen, you are fully responsible for payment of **all** charges incurred during that visit.

**INSURANCE PAYMENT**

If we do not receive payment from your insurance company within **90 days**, you, as the patient, are responsible for paying the bill in full.

**CREDIT CARD AUTHORIZATION**

By signing this form below I authorize Dr. Sklar to charge my credit card when I call in my payment over the telephone. I understand that a receipt will be mailed to my address at my request.

**CONSENT**

By signing this form you, as the patient, authorized Dr. Sklar to file insurance claims on your behalf, receive payment from the insurance company and release medical records to the insurance company to expedite claim processing.

All of the above information is payable by the patient or patient’s representative only.

I \_\_\_\_\_ have read and agree with the information above.  
**(Print Name)**

Patient’s Signature \_\_\_\_\_

Today’s Date \_\_\_\_\_

Mark Sklar, M.D., F.A.C.P.  
Endocrinology and  
Metabolism

3 Washington Circle, Suite 303  
Washington, D.C. 20037  
Telephone: 202-887-4769  
Fax: 202-223-2552

## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Mark Sklar, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Mark Sklar M.D.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Mark Sklar, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Roberto Gunio, Privacy Officer at Mark Sklar, M.D., 3 Washington Circle, N.W., Washington, D.C. 20037.

With this consent, Mark Sklar, M.D. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. Initials: \_\_\_\_\_

With this consent, Mark Sklar, M.D. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. Initials: \_\_\_\_\_

With this consent, and with the understanding that email communications may not be secure, Mark Sklar, M.D. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, laboratory results and patient statements. Initials: \_\_\_\_\_

I have the right to request that Mark Sklar, M.D. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Mark Sklar, M.D. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Mark Sklar, M.D. may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian