Ridha Arem, M.D. P.A.
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Houston, Texas 77054
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In order to have a better understanding of your medical problems, I am requesting that you answer the following questions. Your answers should be as complete as possible since insignificant details may be very important. All information will become part of your permanent record and will be held in confidence.

Date: ____________________

PLEASE PRINT

GENERAL INFORMATION

Name (First) _________________________ (MI) _______ (Last) ____

Date of Birth: _______________ Age: ________ Sex: M ____ F ____ Marital Status: S ____ M ____ D____ W ____

Address: (Street) ____

City: ____ State: ____________________ Zip: ________________

Primary Phone: (_______) ________________________ Secondary Phone: (______) ________________________

Social Security Number: ____________- ________- ____________ DL #: ______________________ State: _______

Work: (_______) ___________________ Employer: ____

Employers Address: ____

Referring Physician (if any): ____________________________ Primary Care Physician: _______________________

If Student, School Name: ____ FT/PT _________

Pharmacy Name: ____________________________________ Pharmacy Number: __________________________

Pharmacy Fax Number: ___________________________________

Friend or relative not living with you: ___________________________________ Phone: (______) ______________

Relationship to Patient: ________________________________

Reason for consulting Endocrinologist (please explain): ____

____

____

____

How did you hear about Dr. Arem? Please check all that apply.

__ Friend/Relative __ Dr. Arem's books __ Doctor Referral __ Radio station __ Search engine/other

III. MEDICATIONS

III. MEDICATIONS	DOSAGE	DIRECTION	DURATION
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

IV. GYNECOLOGICAL HISTORY

Puberty Age ______

Menstrual Periods Days ______ Cycles ______

Pregnancies ______ Deliveries ______ MC ______

Menopause ______ No ______ Yes Years ______

Hysterectomy ______ No ______ Yes Years ______

Birth Control Pills ______

V. SURGERIES

V. SURGERIES	YEAR
______	______
______	______
______	______
______	______

VI. SOCIAL HISTORY

Occupation: ______ Alcohol: ______ No ______ Yes Quantity: ______

Marital Status: ______ Smoking: ______ No ______ Yes Duration: ______

Exercise: ______ No ______ Yes Type: ______ Other: ______

VII. FAMILY HISTORY

Mother: Alive / Deceased

Father: Alive / Deceased

Siblings: Alive / Deceased

Children: Alive / Deceased

Thyroid disease in family ______ N ______ Y

Autoimmune disorders in family ______ N ______ Y

Endocrine disorders in family ______ N ______ Y

Illnesses that tend to run in the family: ______

Patient Name: ______________________

Please check the box to indicate any symptoms you are currently experiencing.

General symptoms

- ☐ Weight gain ☐ Fatigue ☐ Cold intolerance ☐ Weight loss ☐ Hot flashes
- ☐ Heat intolerance ☐ Other: ______________________

Skin/Hair/Nails

- ☐ Dry skin ☐ Hair loss ☐ Itching ☐Hair growth ☐ Bruising
- ☐ Brittle nails ☐ Other: ______________________

Head/Eyes/Ears/Nose/Throat:

- ☐ Hoarseness ☐ Dry eyes ☐ Excessive tearing ☐ Trouble swallowing ☐ Neck pain
- ☐ Decreased hearing ☐ Sinus Problems ☐ Headaches ☐ Double vision ☐ Dizziness
- ☐ Other: ______________________

Cardiovascular/Respiratory:

- ☐ Palpitations ☐ Rapid heartbeat ☐ Chest pain ☐ High blood pressure ☐Coughing
- ☐ Shortness of breath ☐ Other: ______________________

Gastrointestinal/Genitourinary:

- ☐ Nausea ☐ Constipation ☐ Vomiting ☐ Diarrhea ☐ Urinary Infections
- ☐ Erectile dysfunction ☐ Difficulty urinating ☐ Other: ______________________

Musculoskeletal:

- ☐ Weakness ☐ Joint pain ☐ Muscle aches ☐ Other: ______________________

Psychiatric:

- ☐ Depression ☐ Nervousness ☐ Anxiety ☐Forgetfulness ☐ Trouble concentrate
- ☐Sleepiness ☐ Trouble sleeping ☐ Other: ______________________

Endocrine:

- ☐ PMS symptoms ☐ Decreased libido ☐ Irregular periods ☐Discharge of breast
- ☐ Other: ______________________

RIDHA AREM, M.D., P.A.

Endocrinology

Patient Financial Contact with Dr. Ridha Arem

Here at Dr. Arem's office, the doctor and staff are pleased to provide you with the utmost quality care. We feel your understanding of our financial policy is important to our professional relationship. Please feel free to ask if you have any questions regarding the financial policy.

Dr. Arem is strictly a fee for service physician. We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you may file for reimbursement with your insurance company. Should your insurance company require a more detailed description of service, please have them request it in wiring. Insurance is a contract between you and your insurance company. We are not a party to your contract. We will not become involved in any disputes between you and your insurance company regarding "reasonable and customary" charges, non-covered charges, pre-existing conditions or a coordination of benefits other than to supply the factual information as necessary.

Please initial all 3 statements:

_____ I have read and understand that I am fully responsible for payment of all services provided by Dr. Arem's office at the time of services.

_____ I have been informed that Dr. Arem is not contracted with any insurance plan and that he renders services exclusively as an out-of-network physician.

_____ I am aware that it is my responsibility to file any claim from this office directly with my insurance company.

Medicare Waiver: Dr. Arem is not a participating provider with Medicare and has opted-out of the Medicare Program. Since Dr. Arem has not contracted to accept assignment for Medicare insurance, and has opted out of Medicare, neither he nor I shall file any claims from this office with Medicare, or with any participating Medicare supplemental insurance program, for current of future medical care. I have been informed by Dr. Ridha Arem's office that I have the right to obtain Medicare covered items and services from a physician/practitioner who has not opted out of Medicare.

Dr. Arem's current opted out status is valid July 1, 2015 until June 30, 2017 and will be renewed for two years (July 1, 2017 until June 30, 2019). At that time, Dr. Arem will file another two-year renewal of the opted out status. For those nor currently Medicare patients, note this waiver will become effective on the first day of your Medicare coverage.

Tricare/Champus Patients: I, as a Tricare/Champus patient, am aware there is a 115$ balance billing limitation for all medical charges. I understand that services rendered by Dr. Arem could exceed the 115% balance billing limitation. I am willing to waive my rights under the Tricare/Champus Department of Defense Appropriations Act and agree to be responsible for the difference between the billed charge and the Tricare maximum allowable charge.

I do _____ I do not _____ currently have Medicare/Medicare Supplement Insurance (please check one)

I do _____ I do not _____ currently have Tricare/Champus Insurance (please check one)

Please initial both statements:

_______ I understand that Dr. Arem is not a participating provider with Medicare and has opted out of the Medicare program.

_______ I agree not to file any claims from this office with Medicare, or with any participating Medicare Supplemental Insurance Program.

All patients: I choose for Dr. Ridha Arem to treat my medical conditions with the agreement that I am willing to pay for all my charges and will be fully responsible for my financial medical obligations with Dr. Arem, for all present and future care. Any questions I may have had were answered and explained to me in full. I have read and understand this document in its entirety and here by agree to the terms stated in the document.

Please Sign Below

______________________________	______________________________
Patient's Guardian's Signature	**Date**
______________________________	______________________________
Print Patient's Name	**Print Guardian's Name**

Ridha Arem, M.D., PA

Authorization for Communication

Patient Name: ______________________________

By signing below, I authorize Ridha Arem, M.D., PA to release my medical and billing information to:

Relationship			**Name of Designated Person**
Spouse	☐ Yes	☐ No	______________________
Children	☐ Yes	☐ No	______________________
Parents	☐ Yes	☐ No	______________________
Caregivers	☐ Yes	☐ No	______________________
Others	☐ Yes	☐ No	______________________

Patient Signature ______________________________

Date ______________________

We ask if you have any changes in this request that you please inform the receptionist.

Ridha Arem, M.D., PA, may leave appointment information on my voicemail:

Home:	☐ Yes	☐ No
Work:	☐ Yes	☐ No
Relative	☐ Yes	☐ No

Patient Signature: ______________________________

I authorize the following to pick up prescriptions, x-rays, etc...

Relationship: ______________________________

Name: ______________________________

Patient Signature: ______________________________

Date: ______________________________

I understand that Ridha Arem, M.D., P.A. will ask for identification of the person picking up patient medical information or products.

NOTICE OF PRIVACY PRACTICES ACKOWLEDGEMENT & HEALTH CARE AUTHORIZATION FORM

Patient's Name: ______________________________ Patient's SS#: ______________________ DOB: __________

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Conduct normal healthcare operations such as quality assessments and facilitate payments of your claims by your insurance company and you

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

SIGNATURE OF PATIENT: ____

Name and signature of personal representative: ____

SPECIFIC AUTHORIZATIONS

THE PATIENT INDENTIGIED ABOVE AUTORIZES (Ridha Arem, M.D., hereafter referred to as "provider") TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATIO IN ACCORDANCE WITH THE FOLLOWING:

- I give permission to provider to use my address and phone number to contact me with appointment reminders and missed appointment notification. If provider contacts me by phone, I give the provider permission to leave a phone message on my answering machine or voicemail.
- I give provider permission to treat me in an open room where other patients may also be being treated. I am aware that other persons in that room or the provider's office may overhear some of my protected health information during the course of care. Should I need to speak with my provider or doctor at any time in private, my provider or the doctor will provide a room for these conversations.

The Authorization is indefinite as long as Dr. Arem is my physician.

I also understand I have the right to revoke this AUTHORIZATION, in writing, at any time. The revocation is not effective until it is received by the provider's Privacy Official.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, provider will not refuse to provide treatment.

SIGNATURE OF PATIENT: ____ **DATE:** ____________

Even though our office does not file insurance, we are ***required*** to have your insurance information on file in the event that we need to refer you to other facilities.

Name of Patient: ____________________

Date of Birth: ____________________

Name of Insurance: ____________________

ID #: ____________________

Group #: ____________________

Name of Insured Person: ____________________

Insurance Phone Number: ____________________

________ Please check here if you do not have insurance