Syed Hussain, M.D., FACE
Institute of Diabetes Hormone and Metabolism
902 Preskitt Road Suite 100 Decatur, Tx 76234
3412 N Tarrant Parkway, Suite 520 Fort Worth, Texas 76177
Phone: 940-626-2470 Fax 940-626-2471

Thyroid

Office Use Only: ***Room: _____Nurse: _____***

H: _____ W: _____B/P: _____ HR: _____

Patient Name: _____ Date of Birth: _____

Primary Care Provider: _____

Main Concerns: _____

_____

_____

Have you ever had any of the following?

- ☐ **High blood pressure**
- ☐ **High cholesterol**
- ☐ **Heart problems**
- ☐ **Stroke**
- ☐ **Liver problems**
- ☐ **Sleep apnea**
- ☐ **lung disease, emphysema or asthma**
- ☐ **Depression**
- ☐ **Thyroid problems**
- ☐ **Anemia**
- ☐ **Kidney problems**
- ☐ **Cancer**

Please list the year you received these **Immunizations**.
Tetanus _____/Flu Vaccine: _____/ Pneumonia prevention: _____/ Covid-19 Vaccine: ____

Tobacco Use:

- ☐ Non-Smoker
- ☐ Ex-Smoker
- ☐ Current Smoker, how many cigarettes per day? _____
- ☐ Electronic Cigarette Smoker
- ☐ Chews Tobacco
- ☐ Never Smoker

Alcohol Use:
How often do you have a drink containing alcohol?

- ☐ Never
- ☐ Monthly or less
- ☐ How many standard drinks containing alcohol do you have on a typical day? _____

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✓ **~Please check the following Family History~**

✓	Diabetes	Thyroid Disorders	Heart Disease	Hypertension	High Cholesterol	Obesity
Mother						
Father						
Siblings						
Children						
Grandparents						
Uncle/Aunt						

Thyroid History:

1. Have you had recent thyroid blood work drawn? □ Yes □ No
   If yes: When? _____ Physician/Location: _____
2. Have you ever had a thyroid ultrasound? □ Yes □ No
   If yes: When? _____ Physician/Location: _____
3. Have you ever had a thyroid biopsy? □ Yes □ No
   If yes: When? _____ Physician/Location: _____
4. Have you ever had surgery on your neck? □ Yes □ No
   If yes, was your thyroid evaluated at that time? □ Yes □ No
   If yes: When? _____ Physician/Location: _____
5. Have you ever had radiation treatment to your head and/or neck? □ Yes □ No
   If yes: When? _____ Physician/Location: _____

List any Thyroid Medications you have taken previously:

Name:	Strength:	Date Range:	Reason Stopped:

(Check yes or no) Do you have any of the following?
Enlarged thyroid: □ Yes □ No
Thyroid nodule(s): □ Yes □ No
Underactive thyroid: □ Yes □ No
Overactive thyroid: □ Yes □ No
Thyroid cancer: □ Yes □ No

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Family History of Thyroid Disease

✓	Goiter	Overactive Thyroid	Underactive Thyroid	Thyroid Surgery	Thyroid Cancer
Mother					
Father					
Siblings					
Children					
Grandparents					
Uncle/Aunt					

***Current* Health Concerns**

(Please check any symptoms you are having.)

- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Difficulty Sleeping
- ☐ Diarrhea
- ☐ Snoring
- ☐ Constipation
- ☐ Hoarseness
- ☐ Trouble Swallowing
- ☐ Difficulty Hearing
- ☐ Headaches
- ☐ Lightheadedness
- ☐ Passing Out
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Depression
- ☐ Anxiety
- ☐ Thoughts of harming yourself
- ☐ Problems with sexual function

MEDICATIONS

☐ Gave list to front desk

- ❖ Specify insulin as Vials/Pens
- ❖ PLEASE LIST ALL SUPPLEMENTS/VITAMINS

Medication:	Dose Example: 30mg/5ml/10 units	How often:

List Medication Allergies:

_____

☐ NKDA

Your Pharmacy: _____ Location: _____

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Thyroid Questionnaire

1. Fatigue? □ Yes □ No
2. Weight change in the past year? □ Yes □ No Gained (lbs): _____ Lost (lbs):_____
3. Has your appetite changed? □ Yes □ No

a. If yes: □ Eating more per meal □ Eating less per meal □ Eating more often □ Eating less often

b. Other (please explain): _____

4. Are you more sensitive to *cold* than usual? □ Yes □ No
5. Are you more sensitive to *heat* than usual? □ Yes □ No
6. Sweating problems? □ Yes □ No How long? _____
7. □ Heart Racing □ Skipping Beats □ Pounding out of chest
8. Do you ever feel shaky? □ Yes □ No

□ Jittery □Tremors □ Tingling

9. Moodiness/irritability □ Yes □ No How long? _____
10. Issues with memory or concentration? □ Yes □ No How long? _____
11. Change in bowel function?

a. If yes: □ Constipation □ Diarrhea □ Going more often □ Going less often

b. Other (please explain): _____

12. Change in muscle strength? □ Yes □ No How long? _____
13. Changes in skin? □ Yes □ No
14. Changes in hair? □ Yes □ No

a. If yes: □ Oily □ Dry □ Straighter □ Curlier □ Growing more □ Growing less □ Bald patches

15. Changes in eyes or vision? □ Yes □ No How long? _____

a. If yes: □ Dryness □ Burning □ Itching □ Puffiness □ Redness □ Pain □ Eyelid twitching □Hair Loss

□ Double vision □ Blurry □ Cloudy □ Bright lights □ Dark spots □ Focus □ Light sensitivity

List any Serious or Chronic Illness and Major Surgeries and Year

□ Gave list to front desk.

_____
_____
_____
_____
_____
_____

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DEMOGRAPHIC INFORMATION

First: _____Middle: _____ Last: _____

MAILING ADDRESS: _____

CITY: _____STATE/ZIP: _____

AGE: _____

DATE OF BIRTH: _____SEX: _____

SOCIAL SECURITY #: _____

Email: _____ (access your records, send direct messages to the staff.)

Circle BEST method of contact:
Home Phone#: _____ Work Phone: _____Cell Phone: _____

*PARENT/LEGAL GUARDIAN NAME (if patient is a minor): _____
RELATIONSHIP TO PATIENT: _____
PHONE# Home: _____Work: _____Cell: _____

Children: □ Yes □ No If yes, how many: _____

PATIENT'S EMPLOYER: _____
Occupation: _____

PATIENT'S MARITAL STATUS (Circle ONE):

SINGLE	DIVORCED
MARRIED	SEPARATED
WIDOWED	

Guarantor Information:
NAME: _____
DATE OF BIRTH: _____
SPOUSE'S EMPLOYER: _____
CONTACT PHONE: _____

~ HEALTH INSURANCE INFORMATION~ /□ Gave insurance to front desk.

Primary Insurance: _____Member#: _____Group#: _____
Secondary Insurance: _____ Member #: _____Group#: _____

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Authorization to Disclose Health Information

Emergency Contact: _____Relationship to patient: _____

Contact Phone number _____

Please identify the person who is to receive medical health information.

Name _____ Relationship to Patient _____

DOB __/__/___ Phone number: _____

Please Identify what health information may be released:
By initialing the following items, you are authorizing Institute of Diabetes, Hormone, and Metabolism to release the following specific types of information to the person listed above:

_____ General medical information
_____ Lab & Radiology Results
_____ Medication approvals and changes
_____ Other health information: _____

Limitations, if any (you may limit by provider, date span, service type, etc.)

_____

_____

_____

_____ Date: _____
Signature of patient or Legally Authorized Representative

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Text Message Consent Form

We can now send you appointment confirmation messages
and communicate general health information by text.
If you wish to receive these text messages, we require your consent.
Please read the disclaimer below then complete and sign below.

1] I consent to the Institute of Diabetes Hormones and Metabolism contacting me by text message for the purpose of receiving appointment reminders.

2] I acknowledge that appointment reminders by text are an additional, but not guaranteed service. The responsibility of attending or cancelling appointments still rests with the patient. I understand that if I am not able to not keep an appointment, I will phone the office to cancel.

3] Text messages are generated using a secured service, but I understand that they are transmitted over a public network onto a personal telephone. We cannot guarantee the security of your device.

4] All patients have the right to change their mind and terminate this service.
If you no longer wish to receive these reminders, please notify the office.

Please note we cannot accept incoming text messages. If you change your mobile number, please inform the practice. Any information transmitted will remain HIPAA compliant.

Patient Name: _____

Date of Birth: _____

Mobile Number: _____

☐ I decline

(Initial) _____ I have thoroughly read the Text Message Consent Form above and agree to comply.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please list your Primary care doctor and/or other physicians

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care provider Syed Hussain M.D. to use or disclose my health information during the term of this Authorization to and from the recipient(s) that I have identified below.

Patient Name: _____ DOB: _____
Previous Name: _____ Last 4 digits of SSN: _____

1. Primary Care Doctor or Specialist:

Name: _____ Phone: _____ Fax: _____
Location: _____

2. Primary Care Doctor or Specialist:

Name: _____ Phone: _____ Fax: _____
Location: _____

This request and authorization apply to: Please check all that apply
___ All Healthcare information
___ ONLY Labs
___ Other: _____

Patient Signature: _____ Date: _____

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FINANCIAL POLICIES

Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is your responsibility.

- **Payment.** Payment must be made at the time we provide services to you. There are no exceptions. There is a $35.00 service charge for returned checks.
- **Insurance:** If we do not participate with your managed care plan, payment in full is required at the time of service.
- **3rd Party Insurance:** You may be charged Self Pay Rates to assure claims will be paid. Once claims are being paid, refunds will be provided accordingly.
  - **Co-payments and deductibles.** All co-payments, deductibles and co-insurance must be paid at the time of service.
  - **HMO Referrals.** If you're managed care plan requires prior approval or authorization for referrals to a specialist, it is *your* responsibility to arrange for the referral *prior* to your appointment with Dr Hussain. Retroactive referrals cannot be accepted.
  - **NO SHOW/Missed appointments.** Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. If you are late for your appointment, we may cancel it to facilitate our clinic operations. If you cancel your appointment less than 24 hours in advance, you will be charged $50 which must be paid before your next scheduled appointment.
  - **Form completion.** All forms requiring medical review and physician signature – including FMLA, disability or other paperwork – may be subject to an administrative fee of $50.00.

- **Requests for medical records.** Institute of Diabetes Hormone and Metabolism requires written requests for the release of medical records in accordance with Texas law. There will be a $25.00 fee for expedited copies of medical records. A $.50 charge will be applied for every page more than 20 pages. For electronic medical records there will be a $25 fee for 500 pages and $50 for anything over 500 pages.

- There is a $25.00 fee for written correspondence to an employer or school (excluding excuses from work or school due to illness or clinic visits).
- **Care for minors.** A parent or legal guardian must accompany minor patients on their visits. The accompanying adult is responsible for payment of the account, according to the policy outlined above.
- **Delinquent accounts.** Statements will be mailed for outstanding balances. If more than one statement is mailed to collect an outstanding debt an administrative fee may be assessed. Delinquent accounts will be submitted to an outside collection agency.

- **Returned checks**: Returned checks will incur a fee of $35.00. If more than one returned check is received on your account, we will require all future payments be made by cash, cashier's check or credit card.

(Initial) _____ I have thoroughly read the policies above and agree to comply.

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AUTHORIZATIONS, CONSENTS AND AGREEMENTS

CONSENT TO TREATMENT: I, the undersigned, as the patient or on behalf of the patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in judgments of the treating physician. I am free to ask questions about such treatment and testing. I understand that no guarantee or assurance has been made as to the result that may be obtained.

FINANCIAL AGREEMENT: I hereby guarantee payment of services rendered. I understand that should any portion of the bill unpaid it may result in collection activity. I further understand that I will be responsible for court costs, attorney fees and agency fees which may be incurred.

ASSIGNMENT OF BENEFITS: I hereby authorize all insurance companies to pay directly to Syed Hussain, M.D., FACE and any ancillary providers, any benefit and fees under my insurance policy or policies. I understand that this does not relieve me of my obligation to pay my account, co-payments and deductibles. Any balance that is not covered or paid by the insurance company is my financial responsibility.

RELEASE OF MEDICAL INFORMATION: I hereby consent and authorize Syed Hussain, M.D., FACE, affiliates or agents, to release any medical information in connection with the services rendered for determination of benefits, or for collection of said benefits from my health insurance carrier(s) and or other parties responsible for payment.

MEDICARE BENEFICIARIES ONLY: I certify that the information given in applying for payment under Title XVII of the Social Securities Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made directly to Syed Hussain, M.D., FACE. I understand that I am responsible for health insurance deductibles and co-insurance.

MEDICARE SUPPLEMENTS: I further authorize Syed Hussain, M.D., FACE to claim and receive benefits through my Medicare Supplement. This authorization includes claims of Medigap Benefits. This authorization shall remain in effect until and unless revoked in writing.

I HAVE READ THE AUTHORIZATIONS, CONSENTS AND AGREEMENTS, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE.

(Initial) _____ I have thoroughly read the policies above and agree to comply.

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CONTROLLED SUBSTANCE POLICIES

Please be advised that it is extremely hazardous to obtain prescription medications for controlled substances from numerous providers.

- You acknowledge and agree to notify our clinic of any new medications as well as any all-medical conditions and/or adverse affects you experience from any of the medications that you consume. You shall utilize the prescribed dosage for the prescribed controlled substance. You will not share, sell, trade, exchange your prescription(s) for revenue, products, and services or in any other manner enable other individuals to possess use of this (these) prescription(s). You consent to keep and/or maintain this (these) prescription(s) in a secure and safe location.
- Refills are exclusively provided as determined by Dr. Hussain absolutely no premature refills will be provided regardless of the circumstances (i.e., stolen, misplaced, mislaid, exceeding prescribed dosage etcetera.)
- Schedule II Controlled Substance prescriptions cannot be telephoned or faxed to the clinic and MUST be filled within 21 days (twenty-one days.) In circumstance where a prescription for any stimulant medication is not filled within 21 days (twenty-one days,) the expired prescription must be returned before a new prescription can be reissued. Please note there shall be a $20.00 (twenty-dollar) charge to rewrite expired prescriptions.
- Changes and/or alterations in prescriptions shall only be made during clinic visits and never via telephone and / or during non-clinic hours.
- Urine drug screenings may be requested to track your consumption of prescribed controlled substances and to screen for the use of illegal substances. Refusal to consent to such testing shall subject you to a medication taper schedule and may result in the discontinuance of your prescription.
- Altering the date, quantity, and / or strength of medications or altering a prescription by any means, shape, or form is prohibited.

Forging prescriptions and / or Dr. Hussain's physician's signature is prohibited and violates state and federal law. Our clinic fully cooperates with local, state and federal law enforcement agencies as well as the Drug Enforcement Agency (DEA) regarding infractions involving prescription medications. If it is determined that any of the above policies have been violated, all orders for these prescriptions will cease and the patient may be dismissed from the care of this office.

ACKNOWLEDGEMENT OF CONTROLLED SUBSTANCE POLICY: I have read and understand the policies regarding controlled substance prescriptions. I agree to the terms involved in the Controlled Substance Policy and have received a copy of this policy. I understand that if any of the above policies are violated or I choose not to adhere to these policies, I will be dismissed from this clinic and will not receive any refills from the treating physician.

(Initial) _____ I have thoroughly read the policies above and agree to comply.

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OFFICE POLICIES

- **Appointments:** I acknowledge that appointment reminders are an additional, but not guaranteed service. The responsibility of attending or cancelling appointments still rests with the patient. I understand that if I am not able to not keep an appointment, I will phone the office to cancel. Office visits are by appointment only. Please arrive at least 15 minutes before your scheduled appointment.
- **Feedback.** Patients are our priority. We welcome your feedback about your experience here and the service we provide you. Please let us know how we are doing.
- **Confidentiality.** Doctor - Patient confidentiality is the cornerstone of treatment. For adults, nothing you reveal during an appointment will be disclosed without your explicit consent, except when required by law. If our staff believes your life is in jeopardy, we will take necessary steps to protect you. Likewise, if someone else is in danger because of your actions, we will take necessary steps to protect third parties. Dr. Hussain is also required by Texas state law to report that a child has been abused or neglected or may be abused or neglected.
- **Client Communications.** For routine matters, please leave a message with the office. You may also communicate through your patient portal.
- **Emergencies.** For emergencies, please call 911 or go to the nearest emergency room.
- **Prescription Refills.** New prescriptions will not be issued without a consultation with Dr. Hussain. All prescription refill requests require 2 business days' notice. It is the patient's responsibility to monitor the prescription prior to depletion and call the clinic to request a prescription. Prescriptions for a stimulant medication (Schedule II controlled substance) CANNOT be called or faxed into the pharmacy and MUST be filled within 21 days. If multiple prescriptions are issued to a patient, in compliance with Section 481.074(d-1) of the Texas Health and Safety Code, the prescription must be filled within 21 days after the earliest fill date indicated.
- **Termination.** We reserve the right to stop providing services to patients who are non-compliant with treatment, do not pay for services, miss more than three scheduled appointments, or for other reasons we deem reasonable.

ACKNOWLEDGEMENT OF Financial Policies, Controlled Substance, Authorizations Consents and Agreements, and Office Policies:

I have read and understand the policies listed above regarding ***Financial Policies, Controlled Substance, Authorizations Consents and Agreements, and Office Policies***. I agree to the terms involved and have received a copy of each policy. I understand that if any of the above policies are violated or I choose not to adhere to these policies, I will be dismissed from this clinic and will not receive any refills from the treating physician. **I, the undersigned, as the patient or on behalf of the patient, have been given the opportunity to receive and read a copy of Syed Hussain, M.D., FACE's Notice of Privacy Practices.**

_____ _____

Signature of Patient/Responsible Party Date