Welcome

to Endocrinology Consultants

of East Tennessee

At Endocrinology Consultants of East Tennessee, our primary desire is to partner with our patients and other health care professionals on their care team to deliver the best possible endocrine care available. To accomplish this mission, we would like you to take a moment to review this welcome packet and complete the relevant sections.

1

PATIENT REGISTRATION

Please complete the enclosed Patient Registration Form to ensure we have accurate information on your account . We will ask you to confirm the information on this form during check-in at each visit to ensure we can properly bill your insurance company.

2

REGISTRATION AGREEMENT AND CONSENTS

As a medical practice, we are required to obtain your consent for medical treatment and the disclosure of information in accordance with our privacy practices. Please read this agreement in its entirety, sign and date, and then return it to the registration desk.

3

PATIENT ACCESS INFORMATION

This section of your welcome packet contains important information about your appointment; for example, how to prepare for your first appointment and what to expect as a patient of our practice. This section also contains a summary of our privacy practices and other useful tools for staying connected with your care team. This information is yours to keep and we encourage you to maintain it as a handy reference.

4

HEALTHCARE QUESTIONNAIRE

Depending on the reason you were referred to our practice, you may be asked to complete a brief healthcare questionnaire that will greatly assist your assigned healthcare provider evaluate your condition. If this questionnaire was included in your welcome packet, please have it completed and bring it to your first appointment.

MR#: _____
MR# to be entered by the practice

ENDOCRINOLOGY CONSULTANTS
OF EAST TENNESSEE
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Date Completed:	

PATIENT INFORMATION

Patient Name			**SSN#**	**Birthdate**	**Gender**
First	M.I.	Last			☐ Male ☐ Female ☐ Other

Mailing Address			
Street	City	State	Zip

Home Phone	**Mobile Phone**	**Alternate Phone**

Email Address	**Marital Status**
	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer Name	**Occupation**	**Work Phone**

Race	**Ethnicity**	**Primary Language**
☐ White ☐ African American/Black ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown/Other _____ ☐ Prefer Not to Report	☐ Hispanic ☐ Non-Hispanic ☐ Prefer Not to Report	☐ English ☐ Spanish ☐ Prefer Not to Report ☐ Other _____

LEGAL GUARDIAN

If patient is a minor or requires a guardian, provide the information requested below; otherwise leave blank

First	M.I.	Last	Relationship	Primary Phone	Secondary Phone

RESPONSIBLE PARTY/GUARANTOR INFORMATION

If guarantor (individual responsible for fees not paid by insurance) is not the patient, provide information below; otherwise mark "SAME AS PATIENT"

Guarantor Name ☐ SAME AS PATIENT			**SSN#**	**Birthdate**	**Gender**
First	M.I.	Last			☐ Male ☐ Female

Mailing Address			
Street	City	State	Zip

Primary Phone	**Secondary Phone**	**Relationship to Patient**

INSURANCE INFORMATION

If insurance policy holder is different from patient, provide policy holder information; otherwise mark "SAME AS PATIENT" for policy holder name

PRIMARY	Insurance Company Name	Insurance Plan Name (if known)		Insurance Plan/Group ID (if known)
	Policy Holder Name ☐ SAME AS PATIENT	Birthdate	SSN#	Relationship to Patient
	Policy Holder's Address			Policy Holder's Phone
SECONDARY	Insurance Company Name	Insurance Plan Name (if known)		Insurance Plan/Group ID (if known)
	Policy Holder Name ☐ SAME AS PATIENT	Birthdate	SSN#	Relationship to Patient
	Policy Holder's Address			Policy Holder's Phone

MR#: _____

CARE TEAM INFORMATION	
Primary Care Physician	**Referring Provider (i.e. who sent you to our office?)**

Providers we share information with (List name and specialty if known)	
Name	**Specialty**

APPOINTMENT REMINDERS
It is the patient's responsibility to keep track of appointments and notify us in advance of cancellations. As a courtesy, you will receive a reminder notification 5 days in advance of your appointment. If you do not intend to keep your appointment or wish to reschedule you will need to contact us by 11:30am the business day before to not incur additional charges.

PATIENT PORTAL
☐ Already enrolled
☐ Yes, I would like to be enrolled on your patient portal **(email address must be provided on front side of form)**
☐ No, please do not enroll me in your patient portal; I understand and accept my communication options might be limited

IF OPTING IN- PLEASE SUPPLY EMAIL ADDRESS ON THE FRONT SIDE OF THIS FORM!

OTHER INFORMATION		
WORKMANS COMP	Are you here under workman's compensation? ☐ Yes ☐ No	Date of Event (if applicable)
ADVANCED DIRECTIVES AND POA	Do you have any advanced directives (e.g. Living Will or Advanced Care Plan)? ☐ Yes ☐ No Do you have a Power of Attorney? ☐ Yes ☐ No ***If you answered yes to either of the above questions, please make sure we have a copy for your medical record.***	

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MR#: _____

PATIENT REGISTRATION AGREEMENT AND CONSENTS

1. CONSENT TO MEDICAL CARE AND TREATMENT

The below-signed individual hereby authorizes Endocrinology Consultants of East Tennessee (the Practice) and its associated professionals to furnish medical treatment and services to the patient and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees. Such consent includes:

a. consent to photographic/video documentation of patient's medical treatment as the patient's treating professional finds medically necessary; and
b. consent to the electronic viewing/downloading of prescription histories maintained by any e-prescription network (e.g. SureScripts) in order to maintain an accurate medication list

There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees the Practice and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

2. CONTACTING PATIENT AND DISCLOSURE OF DIAGNOSTIC RESULTS

The undersigned authorizes the Practice to communicate information related to their treatment and diagnostic test results as specified below:

ALTERNATE CONTACTS FOR EMERGENCY/MEDICAL/FINANCIAL:

Practice may contact any of the individuals listed below and speak to them about an emergency situation, treatment/medical information, and/or financial/billing information as designated in the "Authorizations Granted" column. Please specify at least one emergency (ER) contact below. **NOTE: This does not authorize these individuals to receive the patient's medical record. To release a medical record to another recipient, patient must complete an Authorization for Release of Medical Records in accordance with Practice's Privacy Practices.**

Name	Relation to Patient	Phone	Authorizations Granted		
			ER	Medical	Financial
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

VOICEMAIL AUTHORIZATION:

If Practice is unable to contact me directly, Practice may leave information related to my treatment/diagnostic test results and/or financial obligations with any voicemail system that answers at my designated primary phone number. Please specify either "Yes" or "No."

MEDICAL (Treatment/Diagnostic Results): ☐ Yes ☐ No **FINANCIAL (Billing Obligations):** ☐ Yes ☐ No

NO AUTHORIZATION:

If voicemail authorization is not given above and no alternate contacts are identified, Practice will only speak directly with the patient.
NOTE: Messages will still be left about appointments unless patient has opted out of this service on their Patient Registration Form.

3. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and as authorized or permitted by federal or state law.

Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

4. PATIENT IDENTIFICATION

The undersigned acknowledges that the Practice may request to take a photograph of me upon my admission for the sole purpose of patient identification, and I consent to the taking of my photograph for this purpose. I understand that the photograph will be maintained in a secure manner and will not be released except upon written authorization from me or my authorized representative or as required or permitted by law.

5. PERSONAL PROPERTY AND VALUABLES

The undersigned agrees that the Practice is not responsible for loss, theft, or damage of any money, personal property, or other valuables.

MR#: _____

6. CONSENT TO COMMUNICABLE DISEASE TESTING

The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge to the patient.

7. CALCULATION AND PAYMENT OF CHARGES

The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following:

a. The Practice's charges are set out in a charge master, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the charge master. Charges on the patient's account are calculated based on charge master rates in effect as of the date services are accrued.
b. The patient is liable for the uninsured portion of the Practice bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient or designated guarantor.
c. Any specimens (e.g. blood, urine, or biopsy) collected for tests not performed by the Practice's lab may be sent to hospitals or outside laboratories. Insurance information is provided to such outside entities for the purpose of billing the patient and/or their insurer for these services.
d. The undersigned acknowledges receipt of the Practice's Payment Policies, which is incorporated into this Agreement by reference, and understands the Practice may charge a "no show" or "late cancellation" fee to any patient that fails to show up (no shows) for their appointment or cancels their appointment with less than twenty four (24) hours of notice. The patient will not be able to have their appointment rescheduled until such fee is paid in full. The Practice reserves the right to modify its payment policies at any time and will make every reasonable effort to inform the patient (e.g. posted at check-in/check-out desks, posted on web site, etc.) of these changes; however the patient agrees to abide by the Practice Payment Policies as long as they are receiving services from the Practice.
e. After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

8. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS

The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice billing such payers for items and services furnished by the Practice. The undersigned hereby irrevocably assigns to Practice all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to Practice all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section 7 (CALCULATION AND PAYMENT OF CHARGES) or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers do not pay. Any sums not paid by a third-party payer are the patient's obligation. The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as non-covered or excluded items or services. If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

9. HEALTH PLAN NOTIFICATION/AUTHORIZATION

If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals may order (e.g. lab services). The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

10. AMENDMENTS

Revisions to this Agreement are not effective or enforceable unless accepted in writing by an authorized agent of the Practice.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

Signature of Patient or Legal Representative	Date

Printed Name	Patient Name (if signed by representative)	Relationship to Patient

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Patient Access Information

Please retain the information contained in this section for your future reference

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Important Information
Pertaining to Your Office Visit

Appt. Date: _____ **Time:** _____

Provider: _____ **Location:** Main/Dowell Springs **(see map on reverse side)**

Please arrive at: _____ **to allow time for check-in procedures and/or laboratory tests.**

- **You are responsible for confirming or cancelling your appointment.** New patient appointments require a minimum of one hour of your time. As this time has been scheduled for you, it is important that you keep this appointment or call well in advance if you must cancel. We will call you approximately three days prior to your appointment to obtain your confirmation. Please note that you may also receive an automated appointment reminder a few days in advance of your appointment. If it becomes necessary for you **to cancel your appointment you must contact our office before 11:30 a.m. on the business day prior to your appointment or you may be charged a fee**. If we have not received your confirmation, another patient may be scheduled for your appointment time.

- **Please verify that ECET is a participating provider of your insurance plan.** This information is generally available on our website (www.endoconsultants.com). If we are a participating provider, we will file the proper forms with your insurance company for reimbursement. If you do not have insurance, a minimum of $300 for a deposit must be paid at check-in with any remaining balance expected at check-out. If you cannot pay the remaining balance after the deposit, a payment plan must be established with our Billing Department. Generally, everyone is responsible for a deductible, co-insurance or co-payment, which we are required to collect at check-out. If you anticipate any problems with payment please contact our Billing Department prior to your appointment at 865-637-8812.

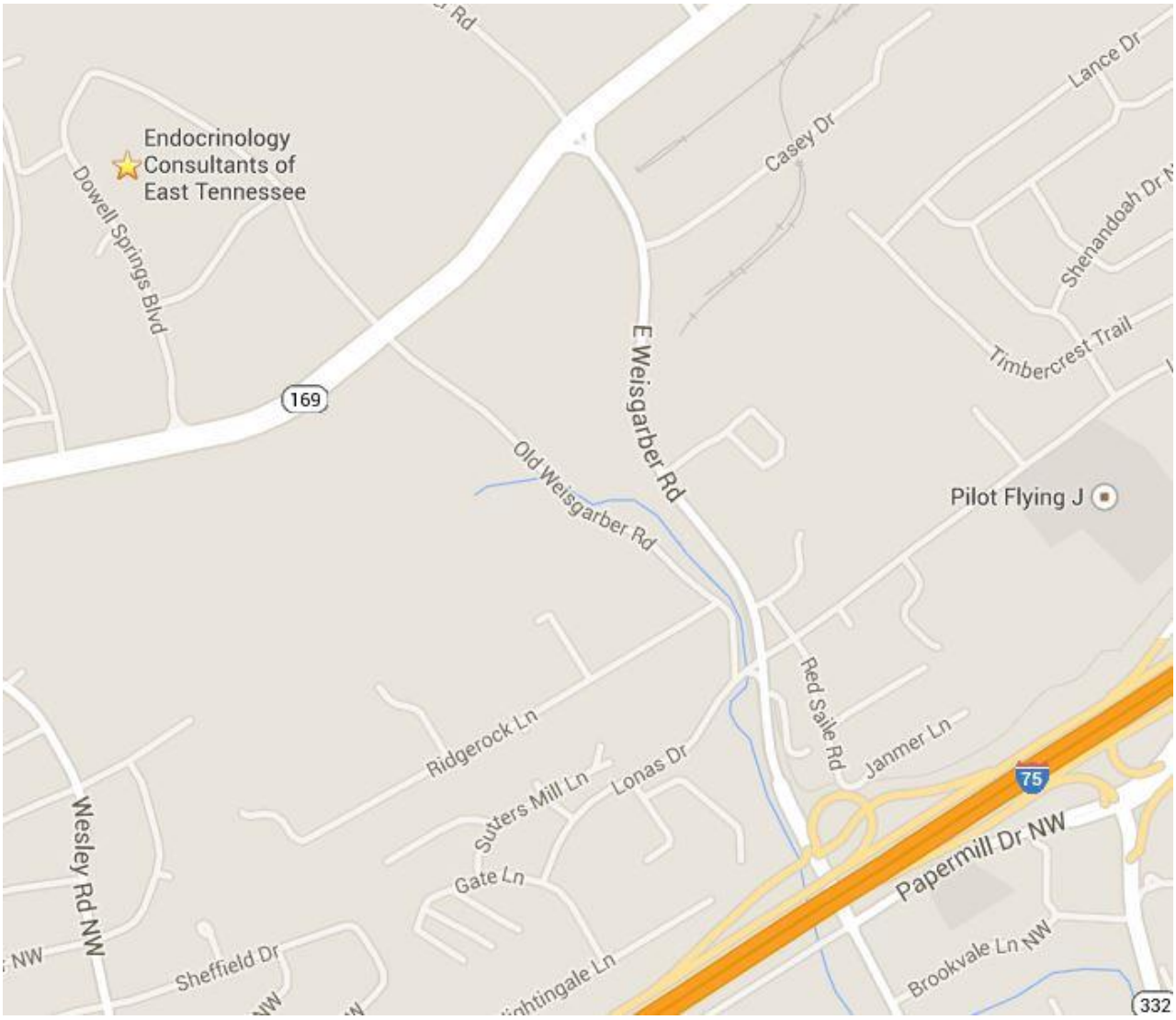
- **Please bring the following items/information to your first appointment:**

    - **Insurance card** – we will need to obtain a copy of it for our files
    - **A photo ID (such as your drivers' license)**
    - **Any referrals or written certifications needed to ensure insurance payment**
    - **A complete list of all medications you are currently taking**.
    - **Your Meter and Log Book (Diabetic patients only).**

- **Please complete the enclosed questionnaire(s).** You may bring it with you or return it in the enclosed envelope. This will make the best use of your visit time with your physician or nurse practitioner**.**

Please be sure you know where our office is located (see map on reverse side) and that you arrive early enough to accommodate any lab testing prior to your appointment.

Directions to Endocrinology Consultants, Main Location



ADDRESS: Endocrinology Consultants of East TN – Main Office **PHONE: 865-637-8812**
1450 Dowell Springs, Blvd., Suite 300
Knoxville, TN 37909

From East on I-40: Take Exit 383 for Weisgarber Road (stay left when off ramp splits). Turn right onto Weisgarber Road and continue for approximately 1 mile to Middlebrook Pike. Turn left onto Middlebrook Pike and travel approximately 0.6 miles. Turn right into Dowell Springs Office Park. Continue for 0.3 miles on Dowell Springs Blvd. The Cornerstone Building is near the top of the hill on the right.

From West on I-40: Take Exit 383 for TN-332 toward Northshore Drive/Papermill Road. Keep right at the fork and follow signs for Papermill Rd West. Turn right onto Papermill Road and continue for 0.3 miles. Turn right onto North Weisgarber Road and continue for approximately one mile. Turn left onto Middlebrook Pike and travel approximately 0.6 miles. Turn right into Dowell Springs Office Park. Continue for 0.3 miles on Dowell Springs Blvd. The Cornerstone Building is near the top of the hill on the right.

ENDOCRINOLOGY CONSULTANTS
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Your Information.
Your Rights.
Our Responsibilities.

This notice provides a summary of how your medical information may be used and disclosed. **Please review it carefully.**

A full version of our privacy practices is available upon request or from our website; www.endoconsultants.com

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act on your behalf
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information related to:

- Telling family and friends about your condition
- Providing disaster relief
- Including you in a hospital directory
- Providing mental health care
- Marketing our services and selling your information
- Raising funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill you for services
- Help with public health and safety issues
- Perform research activities
- Comply with state and federal laws
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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PRACTICE PAYMENT POLICIES

Cancellations and Missed Appointments: It is the *patient's responsibility* to keep track of all appointments made with the Practice.

- Patients who have missed or cancelled an appointment without notifying our office before 11:30 a.m. the business day prior to the scheduled appointment may be subject to a fee of up to $50.00.

Any patient receiving a fee will be required to pay this charge in full before another appointment can be scheduled.

Insurance Verification: All new patients' insurance will be verified prior to their appointment date. Insurance cards will be reviewed at check-in for all patients and scanned into our system if different from what is maintained in their electronic file.

Co-payments, Coinsurances or Deductibles: Co-payments are expected at the time of service. To the extent that deductibles and coinsurances can be determined; that amount will be collected at check-out on the date of service. All of these payments are expected to be paid in full on the date of service as required by the insurance company.

Non-Insured Patients: A minimum deposit of $300 will be **required** at check-in for non-insured patients. A discount of 10% will be applied to self-pay patients who **pay in full** on the day of their appointment. If a full payment is not made, the patient should meet with a member of the billing staff to establish a reasonable payment plan.

Statements: Patients who have account balances will receive monthly statements for balances due. Any unpaid accounts older than 120 days may be turned over to a collection agency if there is no response from the patient and/or an acceptable payment plan has not been established.

Payment Plans: Patients unable to make full payment on the date of service, will be asked to meet with a member of the billing staff to establish a payment plan. Patients who check-in for an appointment or other service who have an existing balance will be asked for payment of that balance at check-in. If unable to make the full payment, they will be asked to meet with our billing staff to establish a payment plan. Automatic credit card or bank account deductions may be set up for patients on payment plans.

DISCRIMINATION
IS AGAINST THE LAW

Endocrinology Consultants of East TN complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Endocrinology Consultants of East TN does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Endocrinology Consultants of East TN provides free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

and provides free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, you may contact: **Practice Administrator**

If you believe that Endocrinology Consultants of East TN has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a grievance with:

Practice Administrator
1450 Dowell Springs Blvd.; Suite 300
Knoxville, TN 37909
Phone: 865-637-8812
Email: administrator@endoconsultants.com

You can file a grievance in person, by mail, fax, or email. If you need help with the process of filing a grievance, our Practice Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights as follows:

- Electronically through the Office for Civil Rights Complaint Portal, available at:

  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

- By mail at:

  U.S. Department of Health and Human Services
  200 Independence Ave. SW
  Room 509F HHH Building
  Washington, DC 20201

- By phone at 1-800-368-1019; 800-537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

INTERPRETER SERVICES

Endocrinology Consultants of East TN has arranged for language assistance services free of charge. Call 865-694-8880 for foreign language assistance. Hearing impaired patients may call 865-579-0832 for assistance.

ENGLISH	If you speak English, language assistance services, free of charge, are available to you.
SPANISH	Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costoalguno.
ARABIC	إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية مجانًا.
CHINESE	□ □ □ □ □ □ □ □ □ □ , □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ 。
VIETNAMESE	Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị, nếu quý vị nói tiếng Việt.
KOREAN	□□□□ 한국어일 경우 무료 언어지원 서비스가 제공됩니다.
FRENCH	Si votre langue est le français, des services d'assistance linguistiques sont mis gratuitement à votre disposition.
LAOTIAN	ຖ້າທ່ານເວົ້າພາສາລາວ ແມ່ນມີບໍລິການຊ່ວຍເຫຼືອພາສາຟຣີໃຫ້ແກ່ທ່ານ.
AMHARIC	አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ዕርዳታ አገልግሎቶችን፣ በነጻ ያገኛሉ።
GERMAN	Wenn Sie deutsch sprechen, stehen Ihnen kostenlos Sprachhilfen zur Verfügung.
GUJARATI	તમે ગુજરાતી બોલતા હો, તો વિના મૂલ્ે, ભાષા સહા્ સેિાઓ તમને ઉપલબ્ધ છે.
JAPANESE	日本語を話される場合には、無償の言語支援サービスがご利用いただけます。
TAGALOG	Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo sa lengguahe na walang bayad.
HINDI	अगर आप हिन्दी बोलते ि ं तो भाषा सिायता सेवा हि:शुल्क उपलब्ध ि।
RUSSIAN	Если ваш язык — русский, то вам могут быть предоставлены бесплатные услугипереводчика.
PERSIAN (FARSI)	اگر شما به فارسی صحبت مےکنید، خدمات کمکهای زبان بطور رایگان در دسترس شما می باشند.

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Endocrinology Consultants Secure Patient Portal

We provide our patients with a secure online Patient Portal that allows you to:

- Maintain demographic information and communicate insurance changes
- Request prescription refills
- Request appointments
- View, download and transmit Clinical Visit Summaries
- View and print lab results
- View balances and make payments online

If you provide us with your email address, you will receive an email shortly after your visit asking you to complete the account setup. This email will contain your username and temporary password, as well as a link that will take you directly to the Patient Portal. Log in using your username and temporary password. You will then be prompted to change your temporary password and answer a few security questions in order to complete the process**.** All communications facilitated by the Patient Portal are encrypted for your protection.

You can access the Patient Portal directly from our website (www.endoconsultants.com) or by directing your Internet browser to the following address:

https://endoconsultants.myezyaccess.com

You can also access the portal using your mobile device. Using a QR scanner application, capture the following image: