Initial Patient health Survey

Last name: _____ First name: _____ Date:_____

DOB: _____ Age: _____, Sex: Male / Female Height: _____Inch Weight _____ lbs.

Race: Hispanic | Asian | African American | White | Refuse to report | Others: _____

Language: English | Spanish | Indian | Korean | Russian | Refuse to report | Others: _____

Primary Care Physician (PCP) _____ PCP Phone No. _____

Preferred Pharmacy _____ Pharmacy Phone No. _____

Who referred you to us: _____

New Patient Questionnaire

To help us get the most out of today's visit, please answer ALL the following questions:

1. Chief Concern: Please describe the reason for your visit today:
   _____

2. Past Medical History: *Please check if you suffer from, or have been treated for any of the following medical conditions:*

Diabetes	YES	NO		Osteoporosis/Osteopenia	YES	NO		Cancer	YES	NO
High Blood Pressure	YES	NO		Stroke / Mini Stroke	YES	NO		Kidney Stones	YES	NO
High Cholesterol	YES	NO		Pancreatitis	YES	NO		Thyroid Problems	YES	NO
Heart Attack	YES	NO		Fatty Liver	YES	NO		Other:		

(Please Circle)

3. Past Surgical History: *Please list any prior surgeries*

Type of Surgeries	Year		Type of Surgeries	Year

4. Pregnancy
   Are you pregnant? Yes / No

   Last menstrual period: _____

5. Have you been admitted to a hospital during the past five years? Yes / No

If yes, please list the name of hospital, reason for admission and year of admission

Hospital Name	Reason for admission	Year		Hospital Name	Reason for admission	Year

Full Name: _____DOB: _____ Date:_____

Review of systems: (Please check if you recently have had any of the following signs and symptoms)

	Constitutional		Genitourinary		Neurological		Gastrointestinal
	Weight gain		Frequent urination		Headaches		Loss of appetite
	Weight loss		Burning or painful urination		Lightheadedness		Change in bowel movements
	Night sweats		Kidney stones		Dizziness		Nausea
	Fever		Sexual difficulty		Seizures		Vomiting
	Fatigue		Erection problems		Numbness/tingling		Frequent diarrhea
					Tremors		Constipation
	Ophthalmologic		**Musculoskeletal**		Weakness		Stomach pain
	Blurred/impaired vision		Joint pain				Heartburn
	Dry eyes		Joint stiffness or swelling		**Endocrine**		**Psychiatric**
			Weakness of muscle/joints		Thyroid disease		Memory loss or confusion
	ENT		Muscle pain or cramps		Diabetes		Nervousness
	Hearing loss		Back pain		Excessive thirst		Depression
	Sore throat		Cold extremities		Excessive urination		Sleep problems
	Bleeding gums		Leg pain with walking		Heat intolerance		Suicidal thoughts
	Voice change		Leg swelling		Cold intolerance		Anxiety
	Difficulty swallowing		Limb weakness		Dry skin		
	Swollen neck				Infertility		
			Skin		Excessive sweating		**Exercise**
	Cardiovascular		Rash		Decrease in appetite		Type of exercise
	Chest pain/discomfort		Itching skin		Increase in appetite		
	Palpitations/racing heartbeat		Change in skin color		Nipple discharge		
	Swelling of feet, ankles, or hands		Easily bruise				
			Non-healing sores		**Hematologic/Lymphatic**		
	Respiratory		Excessive hair growth		Slow to heal after cuts		
	Frequent coughing		Hair loss		Bleeding tendencies		
	Sputum productive cough		Dry skin				
	Shortness of breath		Darkening of skin		**Diet**		
	Asthma or wheezing		Brittle hair		Low carb		
	Snoring		Brittle nails		Weight reduction diet		
					Low Sodium		

6. Medications: Are you taking any medications (including alternative, herbal and over the counter) now? Yes / No
If yes, please list name and dosage

Name of Medication	Dosage	Name of medication	Dosage

7. Allergies: Do you have any allergic or adverse reaction to any medications or substance? Yes / No

Allergic Medication/Substance	Reaction to it		Allergic Medication/Substance	Reaction to it

8. Family History: Please circle if your family suffers from, or have been treated for any of the following medical conditions:

Diabetes	YES	NO		Osteoporosis/Osteopenia	YES	NO		Cancer	YES	NO
High Blood Pressure	YES	NO		Stroke / Mini Stroke	YES	NO		Kidney Stones	YES	NO
High Cholesterol	YES	NO		Asthma	YES	NO		Thyroid Problems	YES	NO
Heart Attack	YES	NO		Lung Disease	YES	NO		Other:		

9. Social History:

Are you married? ☐ Yes ☐ No

Do you have any children? ☐ Yes ☐ No If so, how many? _____

Smoking Status: ☐ Current ☐ Former ☐ Daily ☐ Some Days
Year Started: _____ Quit: _____ Packs/Day: _____

Alcohol Use: ☐ Never ☐ Socially ☐ Daily ☐ Quit Drinking
Drinks per day: _____ Per Week: _____

Caffeine Use: ☐ Rarely ☐ Sometimes Heavy

Do you use any illicit (street) drugs? Yes / No If yes, how often? _____

Exercise: ☐ Never ☐ Some Days ☐ Most Days ☐ Daily

I understand the above information is necessary to provide me with surgical / Medical Care in a safe and efficient manner. I have answered all questions to the best of my knowledge. should further information be needed, you have my permission to ask the respect to healthcare provider or agency, who made release such information to you. I will notify the doctor of any change in my health or medications.

Patient / Guardian Signature: _____Date:_____

I have reviewed the form and discussed it with the patient:

Physicians Signature: _____ Date: _____

Phone: (770) 284 3150 | Fax: (770) 284 3170 | www.diabetesendoclinic.com

Patient Intake Form

Patients Information						
Last Name		First Name		Middle Initial	Preferred name	
Street Address			Appt#	City	State	Zip
Home Phone	Cell Phone		SSN# XXXXXXXX	Date of Birth	Sex	Marital status
Employed by				Spouse's Name		
Employer's Address				Spouse Employed by		
Occupation		Business Phone & Ext		Spouse's Occupation	Spouse's Business Phone & Ext	
Nearest friend or relative NOT living with you				Relationship to Insured	Spouse's Phone#	

Policy Holder's Insurance Information

Primary		
Last Name XXXXXXXXXXXXXXXXXXXXXXXXX	First Name XXXXXXXXXXXXXXXXXXXXXXXXX	Relationship to Patient XXXXXXXXXXXXXXXXXXXXXXXXX
Insurance provider's name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	Policy/Subscriber ID: XXXXXXXXXXXXXXXXXXXXXX	Group# XXXXXXXXXXXXXXXXXXXXX
Insurance Providers complete mailing address (See back of the card) XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX		Insurance Providers Phone# XXXXXXXXXXXXXXXXXXXXXX

Secondary		
Insurance provider's name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	Policy/Subscriber ID: XXXXXXXXXXXXXXXXXXXXXX	Group# XXXXXXXXXXXXXXXXXXXXX
Insurance Providers complete mailing address (See back of the card) XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX		Insurance Providers Phone# XXXXXXXXXXXXXXXXXXXXXX

Referring and Primary Provider's Information

Referring Provider's Name		Phone#
Address		
Primary Care Provider's Name		Phone#
Address		
Referral Source (Doctors office, Insurance network, Family Member, Internet, etc.) Please list below.		

Receipt of Notice of Privacy Practices

This is to acknowledge that I have reviewed and/or have access to a copy of Diabetes & Endocrinology Clinic of GA's Notice of Privacy Practices. This information is located at the front office or on Diabetes & Endocrinology Clinic of GA's website, www.diabetesendoclinic.com

Medicare Insurance Records Authorization

I REQUEST THAT PAYMENT OF AUTHORIZED benefits be made to Diabetes & Endocrinology Clinic of GA. I authorize any holder of medical information about me to release to the Center of Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services in reference to Medicare. (NOTE: This office does not accept MEDICAID.)

Out of Network Insurance Notification

This office is out-of-network for these Insurance Plans:

Amerigroup, WellCare, Peachstate, Humana-X, unless considered state health benefits plan, GA Medicaid or any other type of Medicaid (Other insurances may also apply. Please contact your insurance company to find out.)

I hereby authorize the release of any medical information, including information related to psychiatric care, drug & alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any healthcare related utilization, review or quality assurance activities or any healthcare professional requiring this information.

I hereby assign and authorize payment to, of all medical and/or surgical benefits, including major medical policies, to which i am entitled to under any insurance policy or policies, under any self-insurance program, or under any benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimbursed to by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Person providing the authorization (Print Name): _____

Relationship to patient if not the Patient: _____

Patient Portal Information

I ☐ Do ☐ Do Not want to be signed up for the Patient Portal. If you choose to be signed up for, then an email shall be automatically sent to you after your appointment is made.

Email ID (required to join Patient Portal): _____

I have read and understood all the about policies and agree to abide by its terms.

Date: Signature:

General Office Policies

Please read carefully. A copy can be provided to you upon request.

1. We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. Diabetes & Endocrinology Clinic of GA participates in most major insurance plans. For a complete list of insurance participants at this practice please call the practice main line. We will file your insurance for you if we are participating provider of your plan.
2. All Co-Payments and Deductibles are due at the time of service. Please remember to bring your insurance card (HMO, CMO, PPO, etc.) with you to each appointment
3. On your first visit the physician may order labs and or x-rays. These tests must be performed before your next visit in order to prevent delays in your potential treatment.
4. There is a $50 No-Show fees for appointments not canceled or rescheduled within 24 hours
5. We have reserved your appointment time exclusively for you, if you are more than 10 minutes late to your appointment, it may need to reschedule.
6. Lab, X-rays and all diagnostic test results are NOT given over the phone but rather at your next visit. If there is an abnormal result that warrants immediate attention, the office will contact you asap.
7. All patients must present their insurance card at each visit. If you do not update us regarding new insurance or additional insurance, this could affect medical claims and delay authorization for medications.
8. Please advise our front office staff if you have a new phone number, address or email
9. Referrals will be processed within 72 business hours from the receipt of request. Referral request received on Fridays will be processed the following week. If you have change to pharmacies, you will need to update us at the time of the refill request. If you have not kept up with your follow-up visits, your prescriptions may not be refilled.
10. This practice Does Not participate in filling out disability claims forms. This includes short-term disability claim forms. If a case warrants an exception to this policy, it is left to the discretion of the physician.
11. Medical records can be printed at the patient's request with fee of $1 per page, ($25 max) and $10 for CD's. There are no charges for sending medical records to other physician. This process can take up to 2 weeks.
12. FMLA forms can be completed under the discretion of the physician with $25 fees. This office does not fill out long-term or short-term disability forms. Any exception to this policy is at the discretion of the provider(s).
13. Telephone messages left for our staff after 3.00 p.m. will be returned the next business day.
14. Diabetes & Endocrinology Clinic of GA does not allow patients to switch physicians once seen by original provider. All our physicians are excellent in their field and have your best interest as their priority.
15. We do not provide after-hours services. So, if you have any urgent needs after hours, please go to your nearest Urgent care or Emergency Room.

I have read and understood all the about policies and agree to abide by its terms.

Date: Signature:

Pain / Narcotic Medication Policy

Please read carefully. A copy can be provided to you upon request.

1. I agree to take narcotic medication exactly as instructed. I am NOT allowed to change the dosage, amount or alter the time schedule of taking the medication without first talking to my prescribing physician.
2. Narcotics will NOT be phoned in after business hours or on weekends
3. Only ONE pharmacy will be used for filling narcotic prescription
4. The following are the conditions for immediate termination from the practice.
    a. Obtaining narcotics from any other physician while under our care without our knowledge
    b. Altering or forging of a prescription is a felony and will be reported.
5. Testing positive for illegal drugs while taking controlled substance prescribed by a physician at Diabetes & Endocrinology Clinic of GA Patients may be terminated from the practice with 30 days' notice for non-compliance.
6. We will NOT refill prescription that have been lost or misplaced. Please be responsible in keeping up with your narcotic prescription
7. Stolen medication can be replaced ONE TIME ONLY, if you have a valid police report
8. In the case of intolerance or ineffective narcotic medication, a different prescription may be given, provided the unused portion of the previously prescribed medication was returned
9. I have been informed about the use of narcotic adverse side effects such as development of intolerance, dependence, addiction, withdrawal, constipation, nausea, itching, harmful effects to an unborn child, urinary retention, impairment of reasoning & judgement and depression of breathing.
10. I will not combine any narcotic medication with the consumption of alcohol and / or illegal drugs.
11. I will not give, trade or sell pain medication
12. I will allow 24 hours for a prescription refill to be authorized. I also understand that request received after 2 p.m. are handled on the next business day.
13. I understand that at any given time I may be tested by urine or blood for drug use and that a positive test will result in refusal of narcotic medication and possibly subject me to termination from the practice

I have read and understood all the above policies and agree to abide by its terms.

Date: Signature:

Financial Policies

Please read carefully. A copy can be provided to you upon request.

- We understand how helpful it can be to know in advance how payment arrangements are handled visit to the doctor's office is necessary. Outlined below are the Diabetes & Endocrinology Clinic of GA's basic Financial policy
- Diabetes & Endocrinology Clinic of GA, requires you to provide a copy of your insurance card, co-payment and/or deductibles at the time of check-in. As our office often performs many procedures in house, it is your responsibility as a patient, to become familiar with your individual insurance benefits prior to accepting.
- If we participate in your insurance plan, we will file your charges with your insurance company on your behalf. if we do not participate in your insurance plan, payment for services rendered is collected at the time of service.
- Failure to provide updated insurance information in a timely manner may cause Insurance denials and non-coverage for procedures including in-office infusion therapy. Any claims denied due to the lack of updated insurance information will then become the responsibility of the patient. If new insurance information is provided, we will file the claim under that plan if the effective date falls within the range of the date of service. If the claim is denied by the health insurance plan for timely filing, the patient will be responsible for payment of the claim.
- After we file the claim with your insurance, we will wait 60 days for payment from your insurance company. If payment has not been received within 60 days, we will turn the account over to patient responsibility. We ask that you follow up with your insurance company to make sure your claims are processed in a timely manner. Please communicate your findings to us so that we may remain on sound financial footing. If for any reason we are not provided notification of a new insurance plan you are on and the claim is denied for timely filing, the balance will become the responsibility of the patient.
- Although we are reluctant to do so, we utilize a collection agency for accounts not paid within 90 days. Once an account has been sent to the collection agency, it cannot be retrieved. Prompt payment of any balances remaining after insurance has paid will keep your account in good standing.
- Charges for Lab Services performed outside of our office are billed separately and are not typically included with the Physicians bill.
- Patient Portal messages related to Clinical/Radiological Diagnosis, Lab results may result in a Tele visit Claim to patient insurance.
- Our charges for copying medical records are based on the charge set forth by the Georgia office of Planning and Budget pursuant to O.C.G.A 31-33-3. In order to comply with the HIPAA regulations, a signed, written request for medical records must be received along with the payments before records can be released. Varying fees are charged for forms and letters that may be requested.
- Please let us know at least 24 hours prior do your scheduled appointment time if you will not be able to keep your appointment. Appointments not canceled in a timely manner will be assessed a No-show fee off $50. we accept Visa, MasterCard, American Express and Discover as well as cash and personal checks drawn on a local bank with pre-printed name, address and phone number.
- Personal checks returned for insufficient funds are assessed a $35 fee. Checks that are returned by the bank as non-paid are assessed a $35 return check fee. The amount of the non-paid check plus the $35 bad check fee are due within 10 days. We reserve the right to require payment of the non-paid check and the bad check fee by a method other than check (cash, credit/debit, money order). Failure to rectify the situation within 10 days, will result in the account being sent to our collection agency

I have read and understood all the above policies and agree to abide by its terms.

Date: Signature:

Ways to Help us to help you

We are committed to high-quality healthcare for you and your family. We have compiled a list of information that will assist us in providing you with the highest level of patient care and customer service. Please familiarize yourself with this information so you would know what to expect in the event you should need our assistance.

Pharmacy Prescription Refills:

You are encouraged to have prescription refills addressed at the time of your visit with your provider. Should you need a refill during the interim, please have your pharmacy fax your request to our fax line at 770-284-3170 or send electronically. This will help expedite the refill process. Please remember that your provider reviews all prescription refill requests and must approve the refill. The review could take up to 72 hours. Contact your Pharmacy prior to calling our office to confirm whether your prescription refill has been approved.

Labs, X-Rays and Diagnostic Testing Results:

Labs, X-rays and all Diagnostic test results are NOT given over the phone but rather at your next visit. If there is an abnormal test result that warrants immediate attention, the office will contact you. It is most important that we have your current phone number on file so you can receive your results.

Insurance:

Please bring your insurance card with you to every visit. We will need to review it and scan the card. This will assist us in filing your claim for payment. In the event your coverage has lapsed ore expired on the date the services are rendered, all charges will be your responsibility and payable that same day. Any Coinsurance, Deductible or Co-payments are collected upfront at the time of service.

Phones:

To better serve you, if someone does not answer your call at our office, please leave a voicemail message. Messages left before 3p.m. will be returned to the same day. Please do not leave multiple messages as this delays our response time to your original message.

We are very pleased that you have chosen our office for your care. If you have any special needs or questions, please let our staff know or feel free to call the Office Manager at 770-284-3150. Thank you for your confidence in us.

We do not provide after-hours services. So, if you have any urgent needs after hours, please go to your nearest Urgent care or Emergency Room.

I have read and understood all the above policies and agree to abide by its terms.

Date: Signature:

No Show Policy

- When an appointment is missed without a call from someone to cancel or reschedule your appointment, it is considered a NO-SHOW. When a patient does not appear for their appointment, the time is lost not only for the physician, but also for the patient we might have been able to schedule at that time.

- The NO-SHOW rate has steadily increased over time. Almost every day there is someone that we are not able to see because we have no remaining available appointments. Even though we try to accommodate as many of our patients as possible, there is a limit to how many patients we can book as we assume that everyone will keep that appointment. Therefore, after much consideration, and in fairness to all our patients who do keep their appointments or call at least 24 hours in advance to reschedule, we feel it is necessary to implement a NO-SHOW policy as follows

    - Patient who miss their appointments without calling at least 24 hours in advance to cancel, will receive a charge of $50 on their account for missed appointment. At the time of the third missed appointment the patient will be advised that another no-show may result in discharge/termination from the practice.

- We value you as a patient and recognize the difficulties you face in trying to coordinate all the demands made up on your time. We know that unavoidable emergencies occur sometimes. We hope that you understand about the need to implement this policy in our attempt to accommodate all of our patient's time constraints. Thank you for your understanding and support.

Please sign below indicating that you have reviewed the NO-SHOW policy

I have read and understood all the above policies and agree to abide by its terms.

Date: Signature:

Authorization for Release of Health Information

Please read carefully. A copy can be provided to you upon request.

Note: If the form is not complete, signed and dated, it becomes Invalid and cannot be accepted.

Patients Name: _____ DOB: _____

Consent to release your medical record information:

In an event, Diabetes & Endocrinology Clinic of GA may need to contact you regarding your Medical Records or Appointment. For such events, please list the phone numbers and email at which you may be reached:

Home: _____ Cell: _____

Work: _____ Email: _____

In the event you are not available or not reachable:

Do you give permission for Diabetes & Endocrinology Clinic of GA to leave a Voice Message on a voice messaging device?

☐ Yes, I give permission for HOME / CELL / WORK (please circle all that apply)

☐ No, I do not give permission

Do you give permission for Diabetes & Endocrinology Clinic of GA to release information verbally regarding your medical records, test results, appointment details or additional information to person(s) listed below?

☐ Yes, I give permission ☐ No, I do not give my permission

List the person(s) to release information to:

1) _____

Name Relationship Contact number

2) _____

Name Relationship Contact number

3) _____

Name Relationship Contact number

List of Person(s) to restrict from receiving information:

X) _____

Name

By signing the form, you verify that the information listed above is correct. If you wish to remove or add additional person(s) to this form you will need to fill out a new form and submit it to the front office.

Patient's Signature: Date:

Authorization for use or Disclosure of Protected Health Information

What is this? This form gives our practice authorization to pull as well as send your medical records from/to other healthcare institutions and/or practices to be reviewed by our/other physician(s) respectively.

Patients Info					
	Last Name	First Name		Middle Initial	
	Full Address				
	Home Phone	Cell Phone	SSN# XXXXXXXXXXXX	Date of Birth	Sex

☒ I authorize Diabetes & Endocrinology Clinic of GA to use or disclose my protected health information as indicated

Print above the name of entity to receive this information

11731 pointe place roswell Ga 30076

Print above the full address of the entity to receive this information

☐ I Authorize (Print Entity name) _____

to release my protected health information to Diabetes & Endocrinology Clinic of GA as indicated below

	Information to be released		Purpose of Disclosure
☐	From & to dates:	☐	Changing Physicians
☐	History and Physical exam	☐	Continue care
☐	Office notes	☐	At patients request
☐	X-ray reports	☐	Second opinion
☐	Lab reports	☐	Legal
☐	Hospital records (OP notes, discharge summary)	☐	Insurance/ Workers Compensation
☐	Medication records	☐	School
☐	Others:	☐	Others:

I understand that this authorization will expire on _____
(Expiration date or Defined event)

I understand that I may revoke this authorization at any time by notifying Diabetes & Endocrinology Clinic of GA in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

Date: Signature:

DIABETES & ENDOCRINOLOGY —CLINIC OF GA—

DIABETES AND ENDOCRINOLOGY CLINIC OF GA

Phone: (770) 284 3150 | Medical Record Fax: 404-905-5424 | Fax: (770) 284 3170 | Email: info@arcenterpc.com

MUTUAL AGREEMENT

Arthritis and Rheumatology Center PC & Diabetes and Endocrinology clinic of GA (collectively labeled "Practice") is committed to providing best possible medical care to our patients. Our doctors and staff work very hard to make all interactions welcoming, professional and efficient as possible.

There may be a time when the expectation of a patient is different than what is provided. We offer each patient an opportunity to provide feedback in writing during check out at each visit. All comments and concerns are reviewed promptly by our appropriate staff and, if needed, escalated to supervisor or manager to resolve any issue.

We at Arthritis and Rheumatology Center PC & Diabetes and Endocrinology clinic of GA take pride in our established reputation for outstanding medical care we provide to all our patients. We value your feedback as we strive to provide best possible medical care to our patients. However, please note that any defamatory statements published in social, print, or other media are not accepted and may be dealt through litigation.

- ✓ I have read and agree to the Mutual Agreement.

X

Patient Name | Patients Signature | Date