Institute of Diabetes and Endocrinology, P.C.
and Clinical/Research Laboratory

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WELCOME TO THE INSTITUTE

Thank you for choosing our facility. It was designed especially for you, our patient.

Our goal is to respectfully, compassionately, and empathetically work with our patients and professional peers to provide the highest quality health care and to elevate the regional standard for Endocrine care.
Everything we do here is geared toward providing you nothing less than the best care available.

Office Hours and Telephone

We encourage you to call us if you have any questions or problems. Our office hours are from 8:00 am to 5:00 pm, Monday – Thursday, and Friday until 12:00 pm, except holidays. We are closed for lunch daily from 12 pm to 1:15 pm. Non-emergency calls are best handled during business hours. Emergency and after-hours call are handled by our answering service or forwarded to the provider on call. If you need to cancel your appointment, please call as early as possible. Our telephone number is: 541-776-2003.

221 Stewart Avenue, Suite 101, Medford, OR 97501
Phone: (541) 776-2003 Fax: (541) 776-9833

INSTITUTE OF DIABETES
& ENDOCRINOLOGY, P.C.
221 Stewart Ave. Suite 101
Medford. OR 97501

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name of Patient:_____Birthdate:_____

Print Name of Authorized Representative (if applicable):

_____

Signature of Patient or Authorized Representative:

_____

Date:_____

Comments of Institute of Diabetes and Endocrinology regarding why a written acknowledgement was not obtained:

_____

_____

_____

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PATIENT INFORMATION TODAY'S DATE: _____

Legal Name_____
Last First Middle
Home Phone_____ Work Phone _____
Cell Phone_____ E-Mail Address_____
Address_____
Street or PO Box City State Zip
Date of Birth_____ Social Security # _____
Marital Status_____ Sex: Male_____ Female_____
Employer_____ Occupation_____
Have you ever received medical treatment under another name? _____

Emergency Contact (non-family member, outside of your home)
Name_____ Contact Phone _____

Spouse / Guardian
Legal name _____
Last First Middle

Home Phone_____ Work Phone _____
Cell Phone_____ E-Mail Address_____
Address_____
Street or PO Box City State Zip
Date of Birth_____ Social Security # _____
Employer_____ Occupation_____

Insurance Information
How do you intend to pay for your visit?
Cash _____ Check _____ Credit Card _____ Insurance _____ Medicare _____ Oregon Health Plan _____ Other _____

Primary Health Insurance:
Company _____
Mailing Address _____
Policy Number _____ Group Number _____
Insured Name _____ Relationship to Patient _____

Secondary Health Insurance:
Company _____
Mailing Address _____
Policy Number _____ Group Number _____
Insured Name _____ Relationship to Patient _____
I am receiving medical treatment as a result of an accident. Yes _____ No _____
If yes, what type of accident? Motor Vehicle _____ Work Accident _____ Other _____

ASSIGNMENT OF INSURANCE BENEFITS - The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted of behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted. This is for myself and/or dependents under 18. In addition, this signature will bind me as though the undersigned had personally signed the particular claim. I also understand that the Institute of Diabetes & Endocrinology, PC will accrue an interest charge of 9% annually on all unpaid bills over 90 days. By my signature I attest that I agree to the terms listed above and that all the information I have submitted is true and complete to the best of my knowledge.

_____ _____
Signature of Patient or Legally Authorized Representative Date

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Name_____Today's Date_____DOB_____Sex____Age_____
Address_____Phone (Home)_____(Work)_____
Occupation_____Edu. Level_____Primary Care Provider_____
Other Care Providers_____Allergies_____

Main concern(s)/reason for this visit:_____

Family History (if any blood relative has any of the following-circle & indicate which relative)

(1) Thyroid Disorder_____ (2) Diabetes_____
(3) Heart Disorder _____ (4) Hypertension_____
(5) High Cholesterol/Triglycerides_____(6) Stroke_____
(7) Recurrent Kidney Stones_____(8) Osteoporosis_____
(9) Anemia_____(10) Adrenal Disorder_____
(11) Growth Hormone Deficiency_____(12) Cancer_____

Hospitalizations/Procedures (List hospitalized illness or operation, test & year)

Year Procedure/Illness/Operation

_____
_____
_____
_____

Prescriptive Medications, over-the-counter medical & nutritional supplements presently taking, dosage & times (Add another page if needed)

_____
_____
_____
_____
_____

Medical History (Circle current problems or symptoms you are experiencing)

Dizzy Spells	High Blood Pressure	Anemia
Fainting	High Blood Fats	Bruising
Headaches, Recurrent	Phlebitis/Clots	Pituitary Disorder
Seizures	Edema/Fluid Retention	Adrenal Disorder
Strokes	Leg Pain When Walking	Growth Disorder
Tremors/Hands Shaking	Loss of Appetite	Osteoporosis/Osteopenia
Tingling/Numbness	Body Weight Gain/Loss	Sleeping Trouble
Double Vision	Nausea/Vomiting	Memory Loss
Loss of Smell/Taste	Abdominal Pain	Flushing
Change in Voice	Diarrhea/Constipation	Breast Discharge
Sore Throat, Recurrent	Kidney Disorder	Change in Menses
Trouble Swallowing	Kidney Stones	Sexual Trouble
Heart Disorder	High Blood Calcium	Excess Body Hair
Heart Murmur	Parathyroid Disorder	Diabetes
Shortness of Breath	Bladder Infections, Recurrent	Hypoglycemia
Chest Pain	Depression/Nervousness/Anxiety	Thyroid Disorder
Cancer/Malignancy		

Other_____

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CONDITIONS OF TREATMENT

Patient Name_____
Date of Birth_____
Today's Date_____

1. **Insurance Verification and/or Pre-Authorization** - Many insurance companies require pre-authorization or a second opinion for some medical procedures. The Institute of Diabetes and Endocrinology, PC will assist the patient in obtaining the necessary pre-authorizations or second opinions when needed. It is ultimately the patient's responsibility to determine the procedures in which these things are needed. Failure to obtain necessary pre-authorization or second opinions may result in a reduction or rejection of benefits by the insurance company.

2. **Assignment of Insurance Benefits** - I hereby authorize my insurance company to pay the Institute of Diabetes & Endocrinology, PC directly. I understand that I am responsible for charges not covered by my insurance company including late penalty charges. I agree that a photocopy of this authorization is as effective as the original.

3. **Confidentiality** - Confidential information expressly identifies the medical nature of the service rendered to a patient, and includes all information and records obtained in the course of treatment. It includes information from history and physician examination, diagnosis, treatment rendered, laboratory and radiology results, progress notes, and miscellaneous medical reports.

4. **Medicare authorization: Patient's certification authorization to release information and payment request** - I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient named above to release such information to the Social Security Administration or its intermediaries or carriers, effective from (today's date) _____ forward.

5. **Authorization for disclosure of Information for Purpose of Service Reimbursement** - I hereby authorize the Institute of Diabetes & Endocrinology, PC to disclose all or part of the medical record of the above patient to any company that may be responsible for payment of all or part of that patient's medical changes. Disclosure of the medical record may be necessary to determine eligibility for benefits and to obtain reimbursement for health care services. I hereby release the Institute of Diabetes & Endocrinology, PC from all legal responsibility or liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing, except to the extent that the Institute of Diabetes & Endocrinology, PC has already taken action on my claim.

6. **Financial Agreement** - I understand that in consideration of the services rendered, I am obligated to pay the Institute of Diabetes & Endocrinology, PC in accordance with its regular rates, terms, or contractual agreements. I understand that I am responsible for any service "not covered" by insurance and that the obligation to pay for medical services may not be deferred for any reason. If the account is referred to any agency for collection, I agree to pay all collection expenses.

7. The **Institute of Diabetes & Endocrinology,** PC reserves the right to amend this form at any time. I, as a patient, have a right to the amended form.

8. **I have read and understand this financial agreement. I have had an opportunity to ask questions and, at my request, received a copy of my signed form. I accept the responsibility of its terms.**

_____ _____

Patient Signature Date

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CO-PAY AND DEDUCTABLE POLICY

As you know, the cost of medical care is rising at an alarming rate, which is disturbing to all of us. Part of this rise is due to the increasing cost of sending statements to our patients. To keep down the cost of the billing, we would like to explain our office policy.

We ask that all office visits and services be paid for at the time they are provided. The exceptions to this are patients covered by companies with whom we have signed participating agreements. These include, but are not limited to, the HMO's (Health Maintenance Organizations): Regence/HMO Oregon, Health Net, ODS, and Preferred Choice 65. We also participate in Medicare and Providence Preferred programs. If you are covered by the Oregon Health Plan, we are specialists for Care Oregon, DCIPA, DOCS IPA, and MRIPA.

Those patients that have the following insurances will be given laboratory orders to be drawn at their respective draw stations: Lab One, Health Future, MRIPA, FAMCARE, and Cascade Comp Care. Please inform your provider and the laboratory of your coverage. Failure to do so will result in laboratory expenses that will be paid by the patient.

If your insurance is an HMO, you are required to obtain an authorization from your primary care provider, your family physician, or nurse practitioner before we can see you. This would allow us to see you during a specific time period and for a specific number of visits. It is extremely important that we know this information before your appointment. We will make every effort to help you with this. If we do not have an authorization at the time of your visit, you will be asked to sign a waiver that makes you responsible for services performed on that day. If you do not wish to sign the waiver, your appointment will be rescheduled. **Please come prepared to pay your co-pay whenever you are seen. Failure to do so will result in an additional charge or rescheduling your appointment.**

For non-HMO insurances with whom we participate, **please come prepared to pay your co-payment and deductibles.** Arrangements can be made when expenses require installment payments. If you need to discuss a budget plan, please contact our billing department before your initial appointment and any time thereafter, if the need arises.

We understand that it is a burden for many of our patients to bill their insurance(s), so we have decided to provide this service for them. **We will bill your insurance company if you will provide us with current insurance information. Please bring all of your insurance cards to the office with you and notify us whenever there are changes in your coverage.** If you would rather bill your insurance company yourself, and we are not providers with the company, please let us know. We are not providers for and do not see patients with industrial injury or vehicle claims.

Please mail the enclosed registration and patient information forms back to us. If you are able to make photocopies of your insurance cards, please do so.

Please bring all of your medications in their original containers to your first appointment, including your non-prescriptions, vitamins or mineral supplements.

I have read and understand this policy and accept the responsibility of its terms.

_____ _____

Patient Signature Date

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NO SHOW POLICY

Our goal here at the Institute of Diabetes & Endocrinology, PC is to provide quality service to all of our clientele in a timely manner. Failure to keep scheduled appointments is costly to both the clinic and you as a patient. This letter is to inform you of our policy concerning "No Shows".

Patients who are unable to keep their appointments are requested to give 24-hour notice prior to their appointments. We realize this is not always possible and the practice will consider each individual case. Providing such notice allows the clinic time to offer other persons the opportunity to see our providers, thus using the time more efficiently.

If an established patient fails to provide notice twice, it will be necessary to charge them a $25.00 fee that will be billed to his/her account. If a patient has confirmed his/her appointment and fails to keep that appointment, there will be a $50.00 fee billed to his/her account. If a patient fails to keep his/her appointments on a regular basis, or has missed 3 consecutive appointments, he/she will be considered dismissed from the practice, and a letter of dismissal will follow.

I have read and understood this policy, and accept the responsibility of its terms.

_____ _____

Patient Signature Date

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PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

❑ Home Telephone:_____

❑ O.K. to leave message with detailed information
❑ Leave message with call-back number only

❑ Work Telephone: :_____

❑ O.K. to leave message with detailed information
❑ Leave message with call-back number only

❑ Written Communication

❑ O.K. to mail to my home to my home address
❑ O.K. to mail to my work/office address
❑ O.K. to fax to this number _____

❑ Other Friends/Family _____

_____

_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of information for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to use or disclosures made pursuant to an authorization requested by the individual.

Health care entities must keep records of *PHI* disclosures. Information provided below, if completed properly will constitute an adequate record.

Note: Uses and disclosures for TPO may he permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to whom Address/Fax Number	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed