DATE_____

DECO
DIABETES & ENDOCRINOLOGY
CENTER OF OHIO

Patient: _____

Is scheduled for an appointment with:

☐ Dr. Pallavy (Polly) Reddy ☐ Dr. Jennifer Rittenberry

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

_____ at _____ AM/PM

- **PLEASE PLAN TO ARRIVE 15 MINUTES PRIOR to your scheduled appointment time to allow for paperwork processing and check in procedures.**
- **If you are unable to arrive by your scheduled appointment time, it may be necessary to reschedule your appointment.**
- **A current insurance card, prescription coverage card (if applicable), photo identification and any copay or coinsurance must be presented at check-in.**
- **For Diabetic patients, please remember to bring your meter for downloading and review.**

In order to expedite the check-in process, please complete the attached paperwork prior to your appointment.

You may fax your completed paperwork to (614)764-1707 or you may mail it to:

DECO, Inc.
7281 Sawmill Road
Dublin, Ohio 43016

If you have any questions regarding this paperwork or your visit, please contact our office at (614)764-0707

We are here to assist you Mon – Wed 7:30am-3:30pm, Thurs 8:00am-5:00pm, and Fri 7:30am-2:30pm

PLEASE NOTE: Our office is located in an office park at the corner of Sawmill Rd. and Bright Rd/Sawbury Rd. (just north of 270 off Sawmill Rd.) Turn LEFT at the second traffic light, if you are northbound on Sawmill. You cannot see our office from Sawmill Rd. We are in an office park with several other one-story buildings. There is a BP gas station across the street from our office park. Our Building is 7281 and there are signs in the windows for DECO, Inc. If you are traveling Northbound on Sawmill Rd and you get to Hard Rd, you've gone one intersection too far. **You enter the office park from Bright Rd and when you turn into the office park, we are the first building on your left.**

DATE_____

DECO
DIABETES & ENDOCRINOLOGY
CENTER OF OHIO

Please be sure to complete all pages including:

- ☐ Complete Demographics Form
- ☐ Complete Pharmacy and Medication Information
- ☐ Complete Medical, Social and Family History
- ☐ Complete List of All Active Physicians
- ☐ Complete Consultation Questionnaire
- ☐ Read and Sign Consent for Service
- ☐ Read and Sign Cancellation and No Show Policy
- ☐ Read and Sign Financial Policy
- ☐ Read and Sign HIPAA Policy
- ☐ Read and Keep Privacy Notice

DECO NEW PATIENT PAPERWORK DATE_____

Patient Demographics

First Name	Last Name	MI	Date of Birth
Address	**City, State**	**Zip**	**SSN#**

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner

Gender: ☐ Female ☐ Male ☐ Transgender

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to Specify

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Asian Indian ☐ Black or African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other Pacific Islander ☐ Decline to Specify ☐ Other_____

PLEASE CHECK PRIMARY PHONE

☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone**

Ok to leave message? ☐ **Yes** ☐ **No** **If so, what kind?** ☐ **Extended** ☐ **Brief**

Email Address:

Preferred Contact: ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone**

Patient's Preferred Name:

Insurance Information

Primary Insurance Company		Effective Date	Secondary Insurance Company		Effective Date
Claims Mailing Address (Street or Box)			**Claims Mailing Address (Street or Box)**		
City	**State**	**Zip**	**City**	**State**	**Zip**
Policy ID	**Group ID**		**Policy ID**	**Group ID**	
Subscriber Name (Policy Holder)		**DOB**	**Subscriber Name (Policy Holder)**		**DOB**
Subscriber SSN		**Relationship to Patient**	**Subscriber SSN**		**Relationship to Patient**

Emergency Contact

Relationship to Patient: *(Ex: Wife, Daughter)*

First Name	Last Name	MI	Date of Birth
Address	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Work Phone**	

DECO NEW PATIENT PAPERWORK DATE_____

Pharmacy Information	
Mail Order Pharmacy	**Local Pharmacy**
Name:	
Address:	
Phone:	
Fax:	

Medications & Vitamins/Supplements (including insulin, birth control such as IUDs, etc). Attach additional sheets if needed	
Medication Name	**Dosage**

Medications Tried and Failed	
Medication Name	**Dosage**

Medication Allergies – List all known allergies and reactions	
Medication Name	**Reaction**

DECO NEW PATIENT PAPERWORK DATE_____

Past / Present Medical History

Check if you have ever experienced the following conditions and year of onset (if known)

CONDITION	YEAR OF ONSET	OTHER MEDICAL CONDITIONS	YEAR OF ONSET	OTHER MEDICAL CONDITIONS	YEAR OF ONSET
☐ **Diabetes Mellitus** (Select: ☐ Type 1 ☐ Type 2)					
☐ **High Cholesterol** (Hypercholesterolemia)					
☐ **High Blood Pressure** (Hypertension)					
☐ **Coronary Artery Disease/Stents/Heart Attack**					
☐ **Stroke/TIA**					
☐ **Kidney Disease/Dysfunction**					
☐ **Depression or Anxiety**					
☐ **Cancer:**					
☐ **Acid Reflux (GERD)**					
☐ **Peripheral Vascular Disease** (PAD)					
☐ **Hyperthyroidism**					
☐ **Hypothyroidism**					
☐ **PCOS**					

List All Hospitalizations

☐ **I have never been hospitalized**

Date	Hospital	Reason

List All Surgeries

☐ **I have never had a surgery**

Date	Hospital	Reason

DECO NEW PATIENT PAPERWORK DATE_____

Family History

Check if any family member(s) has had any of the following conditions

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other Family			
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Cancer-Type	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes: (note type 1 or type 2)	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐

Health Maintenance

Check if you have received the following, and date and location of most recent exam

Exam	Date	Doctor/Location of Test
☐ **Cardiac Stress Test**		
☐ **DEXA Scan/ Bone Density Test**		
☐ **Eye Exam**		
☐ **Foot Exam**		
☐ **Flu Vaccine**		
☐ **Pneumococcal Vaccine**		

Social History

Number of pregnancies? _____ ☐ N/A	Number of Children? _____ ☐ N/A
Tobacco Use: ☐ No	☐ Social ☐ Light ☐ Heavy ☐ Former/Year Quit_____ ☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette
Alcohol Use: ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit_____ ☐ Beer ☐ Wine ☐ Liquor
Exercise Activity: ☐ None	☐ Moderate ☐ Vigorous Days/Week_____
Special Diet: ☐ No	☐ Diabetic ☐ Vegan ☐ Gluten Free ☐ Low Salt ☐ Vegetarian ☐ Low Sugar ☐ Other: _____

Advanced Directive/Care Plan

Please select one, provide any supporting documents to office upon check-in

☐ NONE (No Advanced Directive)	☐ POA (Power of Attorney)
☐ LW (Living Will)	☐ DEC (Surrogate Decision Maker Assigned)
☐ DNR (Do Not Resuscitate)	

DECO NEW PATIENT PAPERWORK DATE_____

Please print clearly

Specialty	Name of Physician/Provider	Last Visit	Phone Number	Fax Number
Primary Care				
OB/GYN				
Ophthalmologist				
Podiatrist				
Cardiologist				
Nephrologist				
Other:				
Other:				
Other:				

Employment Information			
☐**Full-time** ☐ **Part-time** ☐ **Retired** ☐ **Not-Employed** ☐ **Self-Employed** ☐ **On Active Military Duty** ☐ **Veteran**			
Employer Name	**Job Title**		**Work Phone**
Address	**City**	**State**	**Zip**
Student? ☐ **Yes** ☐ **No**	**School:**		☐ **Full-time** ☐ **Part-time**

DECO Consultation Questionnaire

NAME _____ **DOB**_____ **DATE OF VISIT**_____

How did you hear about our practice?

_____

What is the reason for your visit?

_____

How long have you had this problem?

_____

When was this problem discovered? _____

- How was it discovered? _____
- What symptoms were/are you having with this problem? _____

What is your main concern or question that you want the doctor to address at your visit?

_____

Have you seen an endocrinologist for this? ☐ **Yes** ☐ **No** **Yes, please list name(s)**_____

Have you seen other types of specialists for this problem? ☐ **Yes** ☐ **No** **Yes, Please specify**_____

What tests have been done for <u>this problem</u>? Check all that apply and list where performed and results:

☐ Blood/Urine Tests_____

☐ X-Rays or Bone Density Test_____

☐ CT or MRI Scans_____

☐ Ultrasounds_____

- Biopsy_____

☐ Nuclear Medicine Scans_____

What treatments have you received for this problem? Provide details and response to treatment:

☐ Diet /Exercise _____

☐ Vitamins/Supplements_____

☐ Medications_____

☐ Surgery _____

☐ Other_____

CONSENT FOR SERVICE

Assignment of Insurance Benefits

I hereby authorize direct payments of medical benefits to Diabetes & Endocrinology Center of Ohio, Inc for services rendered by them in person or under their supervision. I understand that by signing this form, I am financially responsible for payment of any balances due.

Services include, but not limited to: in office visit, dietitian services, laboratory services, remote patient monitoring (i.e. online review of medical devices, with follow up communication about changes and findings), CGMS placement and interpretations, injections, and in office teachings.

Failure to complete all information may result in patient being billed directly for services.

Consent to Treatment

I hereby authorize treatment by the physician and staff as they deem medically necessary for conditions they have diagnosed.

Printed Name:_____**Date**_____

Signature_____

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. When cancellations are made with less than 24 hours' notice, we are unable to offer that slot to other patients.

Any three of the following: no shows, late arrivals, or same day cancellations may lead to a discharge from the practice. No-show appointments or appointments which are cancelled less than 24 hours in advance may be subject to a $25.00 cancellation fee. Procedure cancellations require 5-7 business day notice, without notification they may be subject to a $75.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice.

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the practice manager at 614-764-0707.

Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient Date

Financial Policy

Insurance Information

As a courtesy to our patients, we will file claims to your primary and secondary insurance. Please note your health insurance is a contract between you and your insurance company so it is your responsibility as the patient to make sure our physicians are covered under your plan. All insurance companies do not carry the same benefits so the services rendered to you in this office may or may not be covered. It is the patients' responsibility to know what is covered and if you need a referral.

1. **A valid insurance card must be presented at each visit. If you do not have an insurance card with you and you are unable to obtain a copy prior to your appointment, you will need to pay based on our self-pay fee schedule. Once we have received payment from your insurance company, we will refund any monies due.**
2. **Co-pays are due at the time of service. If you do not have the co-pay amount, you may be charged a $25 fee. This may be billed to you, along with your co-pay amount, upon receipt of payment from your insurance company. This fee will not apply to lab visits.**
3. **In order to successfully file a claim with your insurance company, you must provide all the requested information on the patient demographics form. This includes:**
    - **subscriber's name**
    - **subscriber's date of birth**
    - **subscriber's social security number**
    - **relationship to subscriber**
4. **Quest Diagnostics (lab office at DECO) bills for all traditional Medicare, Tricare, Champva, Caresource, Molina, Aetna, UHC, and Anthem insurances. This process is subject to change and without notice.**

Dietitian Services

Patients who are participating in the DECO Healthy Living Program will not be charged a co-pay for the visit, fees are included in the pricing of the program at the patient's out of pocket expense. We do bill your insurance for the nutrition counseling portion, most insurance companies will pay for a percentage of nutrition counseling services, but not all. For patients on the DECO Healthy Living program, we do not pass any additional charge on to you. For patients who wish to see the dietitian for only nutrition counseling services (including meal planning, carb counting, recipe review, etc.) your insurance will be billed, and you may be charged a co-pay foe these visits up to a max out of pocket rate of $50. For patients who attend group classes with our Registered Dietitian, your insurance will be billed for the class, however we will not pass along any additional charge to the patient. Patients who no-show their visit with the Dietitian may be charged a no-show fee of $10.

Self-Pay Patients

All patients without insurance must pay for the visits at the time of service. Copies of the self-pay rates will be available upon request.

Statements

We will mail statements to the patient approximately every 30 days. A statement will be mailed to the patient once payment or further information regarding the visit has been received from your insurance company.

Payment Arrangements

Under special circumstances payment arrangements can be made with our offsite billing department. They can be contacted at 614-764-0707, select option 2.

Financial Agreement

The responsible party agrees to pay any amount that is allowed but not paid by the insurance company, within 90 days. Failure to keep your account current may result in suspension of treatment or in the termination of the patients' relationship with the practice and physicians. Unpaid accounts will be sent to a collection agency and may be assessed a 35% service charge. We accept cash, check, MasterCard®, Visa®, American Express® and Discover®. Checks that are returned as Non-Sufficient Funds will be assessed a $25.00 returned check fee.

Medications

All medication copays, coinsurances and deductibles will be due in full before the medication is administrated.
This includes the following medications: Prolia and Thyrogen

I have read and fully understand the above policy.

_____ _____

Patient or Authorized Representative Signature Date

HIPAA Consent

The professionals at Diabetes and Endocrinology Center of Ohio are committed to safeguarding the privacy and confidentiality of your medical record including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

From time to time it may be necessary or desirable to contact patients by phone. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

To assist us in protecting your privacy, please complete the following:

Name: _____ **DOB**: _____
(Please print)

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

Primary Phone: _____
Leave a detailed voice mail message? ☐ Y ☐ N
Leave a message with call back number? ☐ Y ☐ N

Email Address: _____
Leave a message to call us? ☐ Y ☐ N

May we speak to someone else regarding your medical care? ☐ Yes ☐ No

Name & phone of person:	**Relationship**
_____	_____
_____	_____

I have been made aware of the privacy policies of DECO and have received (or reviewed or been given the option to receive) a copy of the HIPAA Notice of Privacy Practices. I understand I may revoke this consent at any time.

Signed: _____ Date: _____

Acknowledgement of Privacy and Confidentiality Policy

- If I am not available, I acknowledge that personal and confidential medical information about me, may be left with the person I named above.
- I do so voluntarily and by signing below, I waive this confidentiality.
- It may be left on my answering machine if indicated above.
- I am aware that this permission can be revoked at any time.

Patient Signature: _____Date: _____

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Policy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use your protected health information in the following situations without your authorization. These situations include: as required by law public health issues as required by law, communicable diseases, health oversight, abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners; funeral directors and organ donation, research; criminal activity; military activity and national security, and workers compensation.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative mean or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us of the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effect on/before April 14, 2003
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or at our main phone number.

We participate in an organized healthcare arrangement through OhioHealth Group, Ltd. (Health^4). Health^4 consists of an organized system of healthcare in which multiple covered entities participate. Through Health^4, we participate in joint activities that include utilization review, quality assessment and improvement activities, and certain payment activities. We may disclose your PHI to other participants in this organized healthcare arrangement in order to facilitate the healthcare operations activities of Health^4.