



For internal use only

Patient's acct. #: _____

Patient's Name: _____

Dear New Patient,

The Providers and staff would like to welcome and thank you for choosing and trusting Diabetes & Glandular Disease Clinic, P.A. with your health care needs. Our goal is to make your visits as pleasant and informative as possible.

We understand the sensitive nature of your visit and respect your privacy. For these reasons, we are asking you to complete the enclosed new patient packet and mail or fax them to us prior to your first visit. Our direct confidential fax number is (210) 615-1083. If you are unable to complete the new patient packet prior to your visit, please bring it in completed at the time of your first visit. New patients are encouraged to register online at www.dgdclinic.com in order to have access to our patient portal where you can conveniently fill out the new patient packet at home instead of mailing, faxing or bringing it with you to your first appointment. As an established patient you will be able to access information in reference to future appointments, lab results, prescriptions and account billing summaries through our patient portal.

If you were previously treated at another clinic or facility for the same care you will be receiving from our clinic, it is important to provide us with your records before your initial appointment. Since this can take up to four weeks, realize that not every patient will have their medical records available by the first visit. However, the quality of one's visit is enhanced when we have the ability to review your health records prior to your visit, especially when a patient has a medical history of diabetes/glandular disease.

Please plan for your first appointment to be at least 45 minutes to an hour long. As a new patient, dependent on diagnosis and/or recommended treatment by your provider at the time of your first visit, you may be encouraged to attend a group class given by our Educators on staff. If applicable, the group class will be scheduled during your check out.

Insurance and required demographic information to verify insurance is taken by our staff before your appointment is scheduled, Insurance information is verified within 2 days of your appointment. If insurance and required demographic information is not obtained, the appointment will not be confirmed and may be rescheduled.

As a part of the patient information packet please know that payments all applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your visit. We accept cash, checks, Visa, MasterCard, and American Express. If patients are not able to pay their co-pay and/ or deductibles at the time of their appt., the patient's appointment will be rescheduled for a date when the patient is able to pay the co-pay and/ or deductible. Cancellations and Appointment Time is included in the packet.

We encourage you to visit our website at www.dgdclinic.com for information about our providers and the services we provide.

Thank you for choosing and trusting our providers and staff with your health care and we look forward to your first visit.



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HIPAA Acknowledgment Form PATIENT ACKNOWLEDGEMENT

Health Insurance Portability and Accountability Act (HIPAA)

Our clinic's Notice of Privacy Practice provides information about how we may use and disclose protected health information about you, the patient. The Notice contains a Patient Rights sections describing your rights under the law. You have the right to review our Notice before signing this acknowledgment. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office.

The Summary of our Notice of Practices is posted in our main lobby. The complete Notice of Privacy Practices is also available in our main lobby for your review. If you would like to receive a copy of the Summary and complete Notice, we have one available for you at the front desk.

If you wish for persons other than those released under normal operations, as indicated in the Notice, to receive confidential information that is now protected under this law, you must release them in writing. Please indicate on your patient registration form a spouse, or any family or friends whom you wish to be able to receive information about you. You may, of course, choose not to release anyone. You may also be more specific in your restrictions for the persons you have released, provided that the request is made in writing. Parents or Guardians of minors do not need to be released.

Please be aware that our staff must follow federal law on information that we release by phone. We may at any time choose not to release information of any kind by phone if we deem the person requesting information is not authorized or that the information is too sensitive.

By signing this form, you are acknowledging that the Diabetes & Glandular Disease Clinic has made our Notice of Privacy Practices available to you for review and that we have offered you a personal copy.

Patient Name: _____

Date of Birth: _____

Signature: _____

Acct.# _____

This acknowledgment was signed by:

Printed Name (Patient or Representative)

Date: _____

Relationship to Patient
(if other than patient): _____



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Health History

(please print)

Past Medical History

Please list all medical problems and approximate dates of onset:

(Example: Diabetes, Hypertension, Heart Disease, Thyroid Cancer, etc.)

Hospitalizations

Please list all hospitalizations, include dates and reasons, including surgeries:

Bone fractures and injuries

Please list all injuries such as bone fractures, etc:

Birthing and Menstrual History

Number of pregnancies: _____

Number of live births: _____

Age of each pregnancy: _____

Weight of babies: _____

Complications: _____

Age when period started: _____

Date of last period: _____

Frequency/ length of periods: _____

Pain with periods: _____

Hot flashes or sweats: _____

Psychiatric

Please list any history of depression, hospitalization for mental illness, suicidal thoughts?

Patient's Name: _____ Date: _____

Age: _____ DOB: _____



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Review of Body Symptoms

(please print)

Patient's Name: _____ **Date:** _____

Weight- Have you gained or lost weight? _____

Height- Have you lost height? _____

General- Fatigue, fever, chills, tolerance of heat and cold? _____

Head- Headaches, loss of consciousness, dizziness? _____

Eyes- Vision change, eye pain or dry feelings, double vision, eye bulging? _____

Mouth- Hoarseness, dental problems, bleeding after brushing? _____

Nose- Bleeding, frequent sinus infections? _____

Breast- Masses, tenderness, nipple discharge? _____

Last mammogram? _____ Where? _____

Chest- Pain, cough, bringing up blood, night sweats? _____

Cardiac- How far can you walk? _____ Any chest pain or tightness? _____

Irregular heart beat? _____ How many pillows do you sleep on? _____

History of heart murmur or rheumatic fever? _____

Muscle/ Bone- Arthritis, joint pain or swelling, leg edema? _____

Nerves- Problems with strength, balance, numbness, pain, or needles and pins feelings in the extremities, tremor, falls, blackouts? _____

Skin- Rash, itching, jaundice, increased hair of body? _____

Urinary- Problems with stopping or starting urine stream, pain with urination, history of urinary infections, prostates problems, blood in urine, loss of control of urination? _____



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Review of Body Symptoms (Cont.)

(please Print)

Patient Name: _____ **Date:** _____

Sexual- Male- Problems with potency or ejaculation? _____

Female- Painful intercourse, problems with lubrication, vaginal discharge? _____

Medications- Include over the counter medications:

Name	Dosage	Date Started	For What Condition

Allergies- Medicine _____

Food _____

Social History

Smoke _____ Packs/Days For how long? _____ When did you quit? _____

Alcohol (indicate amount of intake per week): _____

Exercise: Type of exercise: _____

Times per week: _____

Sedentary _____ Low _____ Moderate _____ Intense _____

Sleep Sleep all night? _____ Insomnia? _____

Typical Diet: Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Caffeine: Coffee _____ Tea _____ Sodas _____ Chocolate _____



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Family History

(please Print)

Patient Name: _____ **Date:** _____

Family History (Please state disease and if deceased, at what age)

Father: _____

Mother: _____

Brother: _____

Sister: _____

Other family: _____



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ELECTRONIC PRESCRIPTION CONSENT FORM

Patient Name: _____

Account # _____

Date of Birth _____

Social Security # _____

Daytime Phone # _____

The name of my pharmacy is:

Name of pharmacy

Address

Phone

I would like to have my prescriptions sent electronically to the pharmacy listed above, and I hereby authorize the Diabetes and Glandular Disease Clinic to view the prescription history of:

Signature of Patient

Date

YOUR PHARMACY MAY NOTIFY YOU OF THE AVAILABILITY OF AN ELECTRONIC PRESCRIPTION PRIOR TO YOU RECEIVING YOUR LABS

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patients is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.



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Patient Information

Welcome to the Diabetes & Glandular Disease Clinic. We appreciate the opportunity to care for you. The following information is provided for your benefit so that we may better serve you. Please read carefully and sign at the bottom. You will be given a copy for your records.

1. **PAYMENTS:** All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your visit. We accept cash, checks, Visa, MasterCard, and American Express, Apple Pay
2. **CANCELLATIONS:** If you need to cancel your appointment, be sure to call us at least 24 hours before your scheduled appointment. There will be a \$65.00 administrative charge to all patients who miss their appointment and do not call to cancel or reschedule their appointment at least 24 hours in advance. This charge is not payable by any insurance company and understand that this will be your responsibility. If you cancel or reschedule your appointment without a 24hr notice, this may be considered a no show or missed appointment. After two missed appointments or no shows we may decide to terminate care.
3. **APPOINTMENT TIME:** We ask that our patients arrive on-time for their appointments. In an effort to serve all our patients well, patients arriving past their appointment time may be rescheduled. We require you to confirm your appointments by text message, email or by phone in order to ensure your appointment time, if your appointment is not confirmed you may be asked to be re assigned or rescheduled at time of arrival.
4. **HMO & PPO REFERRALS:** If your policy requires written authorization from your Primary Care Physician, we will request authorization in advance **for established patients only**. This is done as a courtesy for our patients; however, we cannot guarantee authorization will be granted. Please keep in contact with your physician to ensure your visit is pre-approved, to avoid having to make payment in full.
5. **CHANGE OF INFORMATION:** Please provide us with any change regarding your address, phone number or insurance information as soon as possible. Change of insurance will require the completion of a New Patient Information Form and may not be changed over the telephone.
6. **PORTAL MESSAGES:** All our patients have the capability to send a portal message to your provider or providers staff. Please know that if the provider feels the matter should be discussed in a visit to ensure proper time to review an issue you may be asked to schedule an appointment.
7. **MEDICATION REFILL REQUESTS:** At your office visit, your doctor will give you enough medication to last you until your next appointment. To request a refill, you can send us a portal

message or call us at 210-614-8612. We will no longer accept electronic medication refills from pharmacies.

8. **AFTER HOURS CARE *In a life-threatening emergency, please call 911.*** For urgent non-emergency matters, please dial the main office number (210) 614-8612 and leave a message with the answering service. The physician-on-call will return your phone call as soon as possible.
9. **MEDICAL RECORD/ LAB RESULTS COPY REQUEST** Requests for copies of your medical records must be made in writing on a form provided by our office. Our office will respond within 15 business days to a properly completed written request. **FEES:** As per the rules adopted by the Texas State Board of Medical Examiners, our office will charge the following for copying your medical records:
 - 9.1. \$25.00 for the first 20 pages, \$.50 cents for each page thereafter, and the actual cost of mailing, shipping or delivery, if applicable.
 - 9.2. Lab Results are available at no cost on DGD Clinic Patient's Portal. All Lab Result paper copy request will incur a \$6.00 processing fee per visit.
 - 9.3 Copies of medical records/ lab results will be retained until payment is received, unless requested by a licensed Texas health care provider or any American or Canadian licensed physician for acute or emergency medical care, or to support an application for disability or other benefits or assistance under Aide to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, Federal Old-Age and Survivor Insurance, or the Veterans Administration.
10. **COLLECTION AGENCY:** In the event of a delinquent account balance, you will be responsible for all collection fees assessed by the collection agency onto the account.
11. **STAFF SUPPORT:** The Diabetes and Glandular Disease clinic has a no tolerance policy for physical or verbal abuse from patients or family members/caretakers of patients. We understand the medical field can be very difficult but proper communication is needed for care. Any verbal abuse towards clinic staff, may result in ending the physician-patient relationship and you will be terminated from the practice.

"I, the Guarantor of Payment and Responsible Party, have read and agree to the above policies and terms regarding payment and payment responsibilities.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)



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Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/ medical plan, to issue payment check (s) directly to Diabetes and Glandular Diseases Clinic, P.A., For medical services rendered to myself and/ or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by the insurance.

Authorization to Release Information

I hereby authorize Diabetes and Glandular Disease Clinic, P.A. to: (1) release any information necessary to insurance carrier(s) regarding my or my child's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Diabetes and Glandular Disease Clinic, P.A. on behalf of myself and/ or my dependents and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I have read and understand the Diabetes and Glandular Disease Clinic, P.A. Financial Policy. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentations of the appropriate statement. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the charge by the collection agency for costs of collections. A photocopy of this assignment is to be considered as valid as the original. I also understand and agree that the practice may amend such terms from time to time.

Print Name of the Patient

Signature of Insured or Authorized Representative

Date



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**Nurse Practitioner
Physician Assistant
Consent For Treatment**

This facility has on staff nurse practitioners and physician assistants to assist in the delivery of medical care.

Nurse practitioners and physician assistants are not doctors. A nurse practitioner is a registered nurse who has received advanced education and training in the provision of health care. A nurse practitioner can diagnose, treat and monitor common acute and chronic diseases, as well as provide health maintenance care. In addition, the nurse practitioner may treat minor lacerations and other minor injuries.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness and therapeutic interventions
- Offering counseling and education
- Supply sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a nurse practitioner or physician assistant for my health care needs.

I understand that at any time I can refuse to see the nurse practitioner or physician assistant and request to see a physician.

Name: _____

Acct#: _____

Signature: _____

Date: _____

Witness: (optional) _____