Diabetes and Endocrinology Consultants of Pennsylvania, LLC (DEC-PA LLC)

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Please complete **ALL** forms and bring to your first appointment or visit our website at **www.dec-pa.com** , download and print them.

1. Patient Demographic + Consent Form
2. Medical History Form
3. E-Mail Communication Consent Form
4. Office Financial Policy

You will also need to bring:

- A valid **Photo ID** (driver's license etc.)
- Your most current **Health Insurance cards**
- Your most recent **Tests/Laboratory results**
- **Glucose meter/Insulin pump** (for patients with Diabetes)
- Your most current **Medication list**
- Any **Medical Reports** you would like included in your file
- **Referral** if required by your insurance (it is the patient's responsibility to request a valid referral prior to the visit)

A valid **credit card** is required to reserve your first consultation. Personal checks are not accepted on the first visit and payment may only be made by cash, money order or a major credit card (Visa, MC, Discover, Amex +4%).

We dedicate 45 minutes to 1 hour for your first consultation. To avoid a missed/no show charge, we require notification of any change or cancellation at least **48 business hours (2 business days)** in advance of your scheduled in-person or telemedicine appointment.

Please carefully read our enclosed Financial Policy and contact our Billing manager with any questions.

We welcome you to our practice and look forward to meeting you.

Thank you,
DEC-PA, LLC Staff

NEW PATIENT DEMOGRAPHIC FORM + CONSENT FORM (2 pages)

(Please Print Clearly and answer all)

Date: _____Name: _____ Date of Birth __/___/___

Last First Middle Initial

Address: _____

Sex: Male / Female Marital Status: □ Single □ Married □ Widowed □ Divorced

Social Security #:_____E-mail Address: _____@_____

Phone #: Home: _____ Cell: _____ Work: _____ Ext: _____

Patient Occupation:_____ Employer Name:_____

Employer Address:_____ Phone: _____ Ext: _____

Guarantor/Responsible Party: (Spouse, Child, Power of Attorney) If same as above, write same

Name: _____.____

Last First MI Relationship to Patient

Date of Birth: _____/_____/_____ Guarantor Social Security #:_____

Address of Guarantor: _____Phone#:_____

Spouse Name:_____ Date of Birth:___/___/___ Spouse SS#:_____

Spouse Occupation:_____ Employer Name:_____

Employer Address:_____ Phone: _____ Ext: _____

Name of Referring Physician: _____Phone:_____ Fax: _____

Address: _____

Emergency Contact Name: _____ Relationship: _____

Phone: Home:_____ Cell: _____Work:_____

Insurance Information:

Primary Insurance: _____Phone #_____ Referral needed (Y / N)

Subscriber/Cardholder Name_____ DOB ___/___/ ____

Relationship to Patient _____Policy #_____ Group # _____

Secondary Insurance: _____Phone #_____

Subscriber/Cardholder Name_____ DOB ___/ __/____

Relationship to Patient _____Policy #_____Group # _____

Pharmacy Information:

Prescription Plan Name: _____ Policy #:_____ __

Pharmacy Name: _____ Phone #_____

Pharmacy Address: _____ Fax: _____

CONSENT TO TREAT - I (or my legal guardian or parent) request and consent to the performance of such service, procedures and medical treatment by *DECPA LLC* as the practice may believe to be necessary, advisable or beneficial to my health or the health of _____ of whom I am a legally authorized representative. This consent extends to the physician and other health care providers engaged by *DECPA LLC*, who may provide services connected to my care. I recognize and agree that practice of medicine is not an exact science and hence *DECPA LLC* can make no guarantee as to the results of its evaluation or treatments.

As per our Notice of Privacy Practices, we may disclose your protected health information to someone involved in your care or for payment of your care, such as a spouse, family member, or close friend. Please designate your Patient Representative(s):

_____ _____ _____

Print Name *Signature* *Date*

_____ _____ _____ _____

Print Name *Relationship to Patient Representative* *Home Phone #* *Cell Phone#*

MEDICAL HISTORY FORM (2 pages)

NAME: _____ **DOB**_____

WHAT IS THE MAIN PURPOSE OF COMING TO OUR OFFICE TODAY? PLEASE CHECK ALL THAT APPLY.

Diabetes: Type__ Duration___(years/months)

Any Complications? Nerve__ Circulation __ Eye __ Kidney __ Stomach__ Erectile Dysfunction__

Thyroid: Overactive__ Underactive__ Nodule(s) __ Cancer__ Surgery__

Pituitary Disorder_____ **Adrenal Disorder**_____ **High Cholesterol/Triglycerides**___

Calcium Disorder: High__ Low__ Osteoporosis__ Fracture(s) (Y/N, which bone)___

High Blood Pressure__ **Alcohol/Drug Addiction**__ **HIV/AIDS**__

Kidney Disorder: Stone_____ (date, type); Dialysis___(type, duration); Other___

Heart Disease: Heart Attack__ Congestive Heart Failure__ Irregular Heart Rhythm__ Valve Problem__ Angioplasty___ Stent___ Bypass surgery___ Other Heart Surgery___(date)

Cancer: Breast_____ (date, side) Colon__ Prostate___ Lung___ Testicular___ Other___(date)

Blood Problem: Anemia__ Platelets (low/high) __ Leukemia__ Other__

Arthritis: Osteo__ Rheumatoid__ Lupus__ Gout__Psoriasis__ Scleroderma ___ Other__
Disc Problem__ (upper/mid/lower back)

Gastro-Intestinal: Reflux__ Gall Bladder__ Crohn's__ Ulcerative Colitis__ IBS__ Celiac Dz__ Other__

Lungs: Asthma__: Bronchitis/Emphysema__ Nodule(s)__ Interstitial Lung Disease__ Blood clot__

Neuro: Headache/Migraine__ Dementia/Alzheimer's__ Multiple Sclerosis__ Seizure__ Stroke__ Parkinson's Disease__ Other__

Psychiatric Condition: Depression__ Anxiety__ Bipolar__ Schizophrenia__ Other__

Women's Issue: Irregular Menses__ No Menses__ Breast Discharge__ Excessive Hair Growth__
Pregnancy___(weeks/months)

Men's Issue: ED__ Muscle Wasting__ Lack of Libido__ Loss of Body Hair__ Enlarged Prostate__

Weight Issues: Overweight__ Sleep Disorder__ Weight loss__

Surgeries w Date(s):
 SURGERIES: ____ / DATES_____

OTHER ISSUES _____

PLEASE LIST ALL PHYSICIANS AND THEIR PHONE #, SEEN IN THE PAST/PRESENT.

FAMILY / PRIMARY CARE PHYSICIAN: _____ PHONE _____FAX_____
REFERRING PHYSICIAN _____ PHONE _____FAX_____
OTHER PHYSICIAN_____ PHONE_____FAX_____
ALL PHYSICIANS SEEN IN THE PAST TWO YEARS WITH PHONE AND FAX NUMBERS
_____PHONE_____FAX_____
_____PHONE_____FAX_____
_____PHONE_____FAX_____
_____PHONE_____FAX_____
PLEASE LIST ALL HOSPITALIZATIONS / ACCIDENTS / PRIOR TRAUMA / OTHER RELAVANT INFORMATION BELOW WITH DATES:

_____
_____
_____
_____

DO YOU HAVE ANY ALLERGIES? NO ( ) YES ( ) _____
DO YOU HAVE ANY DIET RESTRICTIONS? NO ( ) YES ( ) _____ _____
DO YOU USE A METER TO CHECK YOUR BLOOD SUGAR NO ( ) YES ( ) _____
INSULIN PUMP TYPE _____
WHAT IS THE MAIN PURPOSE OF COMING TO OUR OFFICE TODAY? (IF YOU HAVE A COMPLAINT, INDICATE HOW LONG IT HAS BEEN PRESENT, WHAT IT FEELS, WHAT MAKES IT BETTER OR WORSE AND WHAT YOU ARE CONCERNED THE PROBLEM MIGHT BE)_____
_____
WHAT DO YOU DO FOR EXCERCISE?_____

FOR HOW LONG? _____ HOW OFTEN? _____

DO YOU SMOKE OR CHEW TOBACCO? _____ IF YES, HOW MUCH PER DAY? _____
DO YOU USE ANY RECREATIONAL DRUGS? NAME_____

HOW MUCH ALCOHOL DO YOU CONSUME PER WEEK? _____

HOW MUCH CAFFEINE DO YOU CONSUME PER DAY? (I.E. COFFEE, TEA, CHOCOLATE, SODA) _____

HOW MANY MEALS DO YOU HAVE A DAY? _____ OCCUPATION _____ PERSON YOU LIVE WITH_____

PLEASE LIST ALL MEDICATION(S) YOU ARE CURRENTLY TAKING (NAME, DOSAGE AND PRESCRIBING PHYSICIAN) BELOW:

DRUG NAME	DOSAGE	DOCTOR NAME

FORM COMPLETED BY: _____ DATE: _____

E-Mail Communication Consent Form

Patient Name: _____Date of Birth: _____

Patient E-mail Address: _____

If you elect to use e-mail to communicate with us, DEC-PA, LLC cannot guarantee the security and confidentiality of e-mail transmissions.

We cannot be responsible for misaddressed, misdelivered, or interrupted e-mail or liable for breaches of confidentiality caused by yourself or a third party.

- Use E-mail for routine matters and simple questions.
- Do Not use e-mail for **urgent** or **emergency** situations or for **time sensitive issues** which require an immediate response-contact us by phone or via our Patient Portal.
- Do Not use e-mail for communicating sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse.
- We will attempt to read and respond promptly to your e-mail, but cannot guarantee that your e-mails will be read and responded to within a particular amount of time.
- Please include your full name, birthdate, and telephone number in all e-mails and the subject of your e-mail in the "Subject" line of your message.
- Your provider may forward your e-mail to other staff members as necessary for response. Emails regarding diagnosis or treatment may be made part of your permanent health record.
- To prevent the introduction of computer viruses into our system, do not send attachments to us in your e-mail.
- You are responsible for protecting your password or other means of access to e-mail.

Signature of Patient/Legal Guardian: _____

Print Patient Name/Legal Guardian: _____

Date: _____

DEC PA LLC Office Financial Policy (2 pages)

We participate with Independence Blue Cross (IBC), Original Medicare & certain Medicare Advantage Plans.

Please have your Photo ID and Insurance Cards at every in-person or telemedicine visit.

- Your Copay/Coinsurance/Deductible are payable at time of service per your plan benefits.
- **Non-participating insurance**: For insurances we do not participate in, payment in full is due at time of service. An itemized receipt may be requested for you to submit to your health plan.
- Personal checks are not accepted on your first office visit. Payment may be made with cash, money order or a valid credit card (Visa, MasterCard, Discover, Amex+4%).
- To avoid additional late fees or rescheduling of your appointment, all office visit fees including copays, coinsurance, deductible, or outstanding balance(s)on your account are due and payable at the time of visit. Postdated checks are not accepted.
- Check(s) returned by the bank for any reason will be assessed a $40.00 processing fee per check. Payments for continued care will only be accepted in cash, money order or a valid credit card.
- Any adult accompanying a minor is responsible for full payment at the time of the visit. Unaccompanied minors will be denied non-emergency treatment unless charges have been prepaid or pre-authorized in advance to an approved credit card.
- Referral: If your visit requires a referral/prior authorization, it is your responsibility to make sure we have your referral prior to your visit. If there is no valid referral, your appointment may be rescheduled, or you will be responsible for full payment of your visit at time of service.
- Medical Records: Pre-payment of State approved fees and a signed HIPAA authorization release form will be required for processing and release of any medical records, copies of lab results, or any form which requires the Doctor's signature (disability, long-term insurance, etc.). Please allow 7-10 business days for preparation and duplication.
- *Appointments are confirmed as a **courtesy** only. There will be a charge for a cancelled or missed in person or telemedicine appointment unless we receive advance notice of at least 48 hours (2 business days).*
- *3 visits missed without a valid reason may result in dismissal from our practice.*

- ***I have read and fully understand the Financial Policy of DEC PA LLC.***
- **I hereby authorize DEC PA LLC to release any medical information to my insurance carrier necessary to process my claims. I authorize direct payment of medical benefits to this provider for charges not paid in full by myself.**
- **I understand that I am financially responsible for all charges for medical services rendered to me or my legal dependent, regardless of insurance coverage and/or payment.**
- **I understand that should my account be placed in Bad Debt/Collections, I will be responsible for all collection costs, including court costs and reasonable attorney fees.**

_____

Signature of Patient, Legal Guardian, or Personal Representative Date

_____

Print Patient Name, Legal Guardian, or Personal Representative Date

Medicare Patients

We participate with **Original Medicare** and certain **Medicare Advantage Plans (MA).**
Please contact our Billing Manager regarding your specific insurance health plan.

- **Original Medicare:** At time of your visit, you will be expected to pay any unmet portion of your annual Medicare Deductible and your 20% Medicare Coinsurance if not covered directly to our office by a secondary or supplemental insurance.
- **Medicare Advantage Plans:** At time of your visit, you will be expected to pay your Copay/Coinsurance/Deductible or Medicare Allowed Amount as per your plan benefits.

Please have with you all your Medicare and Secondary Insurance cards at every appointment.

As per Federal Regulations, please check applicable items and sign below:
I am: __employed __unemployed __retired __disabled
___ I am 65 years of age or older and am covered by an Employer Group Health Plan (EGHP) through my own employer or that of my spouse.
___I am under 65 years of age and covered by Medicare due to disability.
___I am entitled to Medicare coverage due to End Stage Renal Disease.
___I am currently receiving Worker's Compensation Benefits
___I am covered through the Federal Black Lung Program
___I am covered by the Veterans' Administration Program
___I am currently receiving benefits due to No fault or Liability Case (i.e., Automobile Accident)

Medicare Identification # (Health Insurance Claim Number) _____
Name/Address of Secondary Insurance: _____
_____
Subscriber Name_____ Relationship to patient: _____
Subscriber Social Security #_____Date of Birth: _____
Policy#_____ Group#_____

PLEASE READ AND SIGN: I certify this information is true and complete to the best of my knowledge. I request that payment of authorized Medicare/Medigap/Medicare Advantage Plan Benefits be made either to me or on my behalf to DECPA LLC for any services furnished to me by this provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare &Medicaid Services/Medigap/Medicare Advantage Insurer, and their agents any information needed to determine these benefits or the benefits payable for related services.

_____
Signature of Patient/Beneficiary, Legal Guardian/Personal Representative Date

_____
Print Name Patient/Beneficiary/Legal Guardian/Personal Representative and Relationship to patient