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

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Phone: (215) 953-6804
www. endodrpa.com

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Please complete **ALL** forms and bring to your first appointment or visit our website at **www.endodrpa.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)
- **Payment** for copays, deductibles etc.

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 (for initial and follow up visits).

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* *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: _____

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

DEC-PA, LLC Office Financial Policy (please read carefully)

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 or cancelled credit card payments for any reason will be assessed a $40.00 processing fee per check/credit card transaction. 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.
- You will be responsible to provide a current address, telephone number, email address, and insurance information at each visit
- 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 fee (new patients: **$250**, follow up patients**: $170**) 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.
- You are ultimately responsible for payment of charges for services you receive from this practice including those covered by your insurance. As a convenience, this practice will submit claims for reimbursement with your insurance provider; however, all payment responsibility is ultimately mine.
- You agree to provide the above practice and/or its designated payment agent with a valid debit/credit card information. If there is reverted credit/debit card charge, you will be responsible for the amount due and any fees that the practice incurs.
- You understand that your signature below and payment information will be maintained on file for future use by the practice. The applicable payment card will be saved in your chart per the Pennsylvania law(s) by the staff to help maintain the security of your payment information. You will not be provided with advance notice of payments authorized hereunder for transactions up to an amount specified by you.

Cardholder Name _____ Card type: _____

Card #_____ Exp date _____

Security code: _____

BillingAddress _____

City _____ State _____ Zip Code _____

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. To accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to the terms above. I authorize the above practice and/or its designated payment agent to apply charges to my payment card for all amounts owed to the practice for medical visits, procedures, or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) missed appointment fees charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation. Credit card authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be canceled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

_____

Signature of Patient, Legal Guardian, or Personal Representative Date

_____

Print Patient Name, Legal Guardian, or Personal Representative 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:_____ Date:_____