ARTHRITIS & DIABETES CENTER

Endocrinology

Paul Denker, M.D.

Internal Medicine

Hans Langschwager, M.D.

Rheumatology

Karen Zagar, M.D.

Tatiana Nagibina, M.D.

E. Markus Klaus, M.D.

Welcome to Arthritis & Diabetes Center which focuses on performing to the highest standard, **YOUR SATISFACTION.** Our objective is to provide you with one of the best medical experiences that you have ever had.

Enclosed you will find our new patient required paperwork. It is very important to have these forms **filled out in full** and to bring them with you the day of your appointment. We will also need a **photo ID and your insurance card(s).** All co-pays and deductibles are due at the time of service.

We do realize that the wait to be seen in our office can be quite lengthy. We try to accommodate each person as best as we can. If for any reason you cannot make your appointment with us, please contact our office a **minimum** of 24 hours before your scheduled appointment as a courtesy to us and to others wanting to be seen.

If you have questions, please do not hesitate to contact our office at 727-789-2784 Option 0. Please arrive **15** minutes early for your first appointment, so that we can process the paperwork. If you arrive late, or without the paperwork, **your appointment will be rescheduled to another day**.

You are scheduled to see _____ on _____
(provider) (date)

at _____. You will need to arrive no later than _____with completed forms.
(time) (time)

Sincerely,

The Staff of Arthritis & Diabetes Center

32615 U.S. Highway 19 North, Suite 2, Palm Harbor, FL 34684

ARTHRITIS & DIABETES CENTER, INC.

Physician you are scheduled to see: _____

PATIENT INFORMATION **Date: _____**

Patient Name: _____

Address: _____City: _____State:_____ Zip:_____

Cell Phone: _____ Home or Alternate Phone: _____

Secondary Address: _____

DOB: _____ Social Security Number: _____

Circle One: Marital Status: S M D W Sex: M / F Ethnicity: Hispanic or Non-Hispanic

Race: American Indian Asian Black Caucasian Pacific Islander Other

---

Primary Language: _____ E Mail: _____@_____

Emergency Contact Name: _____Phone: _____

Referring Physician: _____Phone: _____ _____

Primary Care Physician: _____ Phone: _____

Your Pharmacy: _____ Phone: _____

MEDICAL INSURANCE INFORMATION REQUIRED:

PRIMARY INSURANCE COMPANY NAME: _____ POLICY#: _____

SECONDARY INSURANCE (*SUPPLEMENT*) COMPANY NAME: _____

POLICY#: _____

PHARMACY PLAN NAME: _____ POLICY#: _____

CANCELLATION / NO SHOW POLICY

NO SHOW OR SAME DAY CANCELLATIONS WILL BE ASSESSED A $50 FEE. CANCELLATIONS NEED TO BE MADE PRIOR TO 24 HOURS OF YOUR SCHEDULED APPOINTMENT TIME.

X_____

ASSIGNMENT OF BENEFITS

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS, BE MADE ON MY BEHALF TO ARTHRITIS & DIABETES CENTER, INC FOR ANY EQUIPMENT OR SERVICES PROVIDED TO ME BY THAT ORGANIZATION.

X_____

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE ADMINISTRATION AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I HEREBY AUTHORIZE MEDICARE TO FURNISH ARTHRITIS & DIANETES CENTER, INC INFORMATION REGARDING MY MEDICARE CLAIMS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT. X_____

ARTHRITIS & DIABETES CENTER FINANCIAL POLICY

Welcome to Arthritis & Diabetes Center. Please read the following for your financial obligation. You understand and agree that you are responsible and liable for payment of all charges for professional services rendered. If our office is participating with your insurance and accepts assignment, this means that we will accept what your insurance allows for the services performed which is less than our standard billed amount. Based on your plan, our office will collect the designated copay or the co-insurance **estimated** patient responsibility amount at the time of your visit. Once your claim processes through your insurance, the patient responsibility may be more or less than the original **estimated** amount. You will receive a statement in the mail if there is a balance owed by you that will be due upon receipt. If you have a credit, our office will apply that credit to any open patient balances on your account. It is our office policy to hold all credits on your account until all open claims have been processed by your insurance company.

You authorize payment of medical benefits to the physician/care center performing the professional services. In the event your insurance company forwards payment directly to you, you will deliver such payment to the Arthritis & Diabetes Center.

PRIVATE PAY: Full payment is expected when services are rendered if patient is not using health insurance. We accept cash and most major credit/debit cards. Personal checks are not accepted for self-pay patients.

PPO's & HMO's: You are responsible for any copays, deductible, co-insurances, and non-covered services.
****It is the patient's responsibility to verify any required authorizations/referrals are in place prior to their visit****

Medicare: We are Medicare providers and accept Medicare assignment. You are responsible for the Medicare yearly deductible, co-insurance, and non-covered services. We will also file your secondary insurance as courtesy. If your secondary insurance does not make payment, you are responsible for this balance. We do not bill tertiary plans; this is the patient's responsibility.

Medicaid: We do not participate with ANY Medicaid. The patient is responsible for payment if you have Medicaid. If you have Medicaid as a SECONDARY plan, we will agree to write off the 20 % that the primary plan does not cover after completion of a hardship form with our business office.

Litigation/Attorney: Our office does NOT accept Worker's Compensation, Auto/Personal injury cases, nor do we accept Letters of Protection.

You are responsible for keeping our office informed of **any changes in your insurance company or plan**. If you fail to inform us of a change and the wrong insurance is billed, you will be responsible for the balance and billing to the new plan.

It is the policy of our office that a failure to show for a scheduled appointment or same day cancellation will be assessed a $50 fee. Cancellations need to be made prior to 24 hours of your scheduled appointment time. This is to allow us to accommodate another patient who needs to be seen.

By signing below, you are stating you understand and agree to all of the above terms and policies:

"I understand that I am ultimately responsible for all charges incurred regardless of my existing medical coverage. I accept responsibility for all patient balances due according to the above terms. Should my account become past due, the full balance is due and payable immediately. I will be responsible for all collection and legal costs incurred for collecting the delinquent on my account. "

_____ _____ _____

Patient Signature Patient Printed Name Date

HIPAA Notice of Privacy Practices

ARTHRITIS & DIABETES CENTER
32615 US HWY 19 N., SUITE 2
Palm Harbor, FL 34684
727-789-2784

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

This Notice of Privacy Practices 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 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, 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, employee review, training of medical students, licensing, fundraising, 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose 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, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under 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. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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 and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. 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. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means 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 request an amendment to 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 any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to 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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of the Arthritis & Diabetes Center's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

ARTHRITIS & DIABETES CENTER

Internal Medicine Patient History Form

Date of first appointment: ____/___ /___ Birthplace: _____
MONTH DAY YEAR

Name:_____ Birthdate:____/__ /____ Sex: ❑ F ❑ M
LAST FIRST MI MAIDEN MONTH DAY YEAR

Phone: Home: _____ Cell: _____

Address:_____ _____
STREET APT #

_____ _____ _____
CITY STATE ZIP

Facility where you reside (if applicable): _____

Facility Phone : _____

Occupation_____ Do you work day shift or night shifts? (Circle)

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional
Name of person making referral:

_____

Emergency Contact Name: _____ Relationship:_____
Phone: _____

Medical Power of Attorney Name (if applicable): _____
Phone: _____

Do you have a Living Will ?: YES NO (Circle one)

ARTHRITIS & DIABETES CENTER
INTERNAL MEDICINE PATIENT HISTORY FORM

PATIENT HEALTH HISTORY

Date Today:	

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name:	Date of Birth:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had	Name the Drug	Reaction You Had

MEDICAL HISTORY

Please check YES or NO if you HAVE BEEN DIAGNOSED with ANY of these conditions in your past:

Common Conditions	YES	NO	Common Conditions	YES	NO
Hypertension			Hypothyroidism		
Type 1 Diabetes			Coronary Artery Disease		
Type 2 Diabetes			Congestive Heart Failure		
High Cholesterol			COPD		
Osteoporosis			Osteoarthritis (generalized)		
Depression			Anxiety		
Cancer			**Gastrointestinal**		
Have you ever been diagnosed with Cancer?			Acid Reflux		
TYPE:			Barrett's Esophagus		
Hearing/Eyes/ENT			Peptic Ulcer Disease		
Glaucoma			Ulcerative Colitis		
Macular Degeneration			Irritable bowel syndrome		
Diabetic Retinopathy			Diverticulosis		
Hearing Loss			H/O Colon Cancer		
Ear Infections			**Urinary/Renal**		
Sinusitis Chronic			Polycystic kidney disease		
Respiratory			Nephrolithiasis		
Asthma			Urinary Incontinence		
COPD			History of UTI's		
Chronic Bronchitis			**Musculoskeletal**		
Interstitial lung disease			Arthritis - Location(s):		
Emphysema			Osteopenia/Osteoporosis		
Pulmonary Embolism			Lumbar disc disease		
Obstructive Sleep Apnea			Restless Leg Syndrome		
Tuberculosis exposure			Rotator cuff syndrome		
Cardiology			Sciatica		
Atrial Fibrillation			Spinal Stenosis of:		
Pacemaker / Date of Placement:_____			Cervical Spine		
Angina			Lumbar Spine		
CHF (Congestive Heart Failure)			H/O compression - Fractures		
Heart Attack (myocardial infarction)			**Rheumatology**		
Aortic Valve Disorder			Gouty Arthritis		
Mitral Valve Disorder			Fibromyalgia		

Patient Name:	Date of Birth:

MEDICAL HISTORY CONTINUED:

Neurology			SLE		
Alzheimer's Disease			Rheumatoid Arthritis		
Parkinson's Disease			Lupus Erythematosus		
Seizures			**Hematology**		
Stroke - Area Affected: _____			B-12 deficiency anemia		
Gait Instability with falls			Iron deficiency anemia		
Peripheral Neuropathy			Myelodysplastic Syndrome		
TIAs			Anemia		
Migraine Headaches					

SURGICAL HISTORY

Please check YES or NO if you HAD with ANY of these procedures in your past:

General	**YES**	**NO**	**Women**	**YES**	**NO**
Aortic aneurysm repair			Breast Implants		
Aortic Valve Repair			Breast reduction		
Appendix removal (Appendectomy)			C-Section		
Bariatric surgery			Endometrial biopsy		
Carpal tunnel release			Hysterectomy : Partial Complete		
Cataract surgery : Right Left			Lumpectomy : Right Breast Left Breast		
Colon resection (Colectomy)			Mastectomy : Right Breast Left Breast		
Coronary artery - Bypass surgery			**Men**		
Fracture repair – Where?			Prostate Biopsy		
Gallbladder removal (Cholecystectomy)			Prostate Removal		
Gastric Bypass surgery			**Joint Replacement**		
Hemorrhoid removal (Hemorrhoidectomy)			Left Hip		
Hernia Repair : Femoral Inguinal			Right Hip		
Kidney Removal: (Nephrectomy) Right Left			Left Knee		
Mitral valve replacement			Right Knee		
Parathyroid removal (Parathyroidectomy)			Left Shoulder		
Pacemaker placement			Right Shoulder		
Polyp Removal (Polypectomy)			Right Elbow		
Septum and nose repair			Left Elbow		
Spinal surgery – Where?			**Biopsy**		
Type:			Bone Marrow		
Thyroid removal (Thyroidectomy)			Liver		
Tonsillectomy			Skin		
Varicose vein surgery			Mass Excision - Where?		

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

FAMILY HEALTH HISTORY

please check (√) all that apply

MEMBERS	**STATUS** *(deceased or alive)*	**YOB**	**AGE**	**Diabetes**	**High Blood Pressure**	**Heart Disease**	**Stroke**	**Cancer**	**Mental Disease**	**Unknown**
FATHER										
MOTHER										
BROTHER (s) #____										
SISTER (s) #____										
SON (s) #____										
DAUGHTER (s) #____										

Patient Name:	Date of Birth:

SOCIAL HISTORY

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Tobacco	**Are you a current smoker?** ☐ Yes ☐ No	# of Years:		Year Quit Smoking:
	Status: ☐ Former Smoker ☐ Non-Smoker ☐ Current Every day smoker ☐ Current Occasional Smoker ☐ Unknown ☐ Light cigarette smoker (1-9/day) ☐ Moderate cigarette smoker (10-19/day) ☐ Heavy cigarette smoker (20-39/day)			
	If Current Tobacco User: What type of tobacco do you use? Other forms of tobacco: ☐ Chew ☐ Pipe			
	☐ Chew fine cut tobacco ☐ Chew Loose leaf tobacco ☐ Chew plug tobacco ☐ Chew twist tobacco ☐ Pipe Smoker			
	If Current Smoker: How often do you smoke cigarettes? ☐ Every day ☐ Some days, but not every day			
	How many Cigarettes a day do you smoke? ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 30 or more / full pack			
Alcohol	**Do you drink alcohol?** ☐ Yes ☐ No	History of Alcohol Use?	☐ Yes ☐ No	How many Years? _____
	If yes, what kind?			
	How often do you drink alcohol?	Socially ☐	Daily ☐	Occasionally ☐ Rarely ☐
	How many do you drink?	1-2 day ☐	2-3 day ☐	3-5 day ☐ More than 5 ☐
	Have you ever experienced blackouts?			☐ Yes ☐ No
Drugs	Do you currently use recreational or street drugs?			☐ Yes ☐ No
	Have you ever used recreational drugs? ☐ Yes ☐ No If yes, what date/year(s) ago did you quit?			
	Have you ever given yourself street drugs with a needle?			☐ Yes ☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
Diet	☐ Diabetic Diet ☐ Cardiac Diet ☐ Un-Restricted Diet ☐ Low Carbohydrate ☐ Low Fat ☐ Vegetarian ☐ Vegan ☐ Eat out several days a week ☐ Drink high sugar beverages ☐ Low salt Diet ☐ Low Cholesterol Diet ☐ Low Sugar Diet # of meals you eat in an average day?			
Education:	☐ High School ☐ Undergraduate ☐ Graduate ☐ Doctorate Other: _____			
Religion:				
Exercise	☐ Sedentary (No exercise)	☐ Difficult due to weight	☐ Occasionally	
	Exercise Frequency: ☐ Weekly ☐ Daily ☐ 2 times/week ☐ 3 times/week ☐ 1-2 times/week ☐ 2-3 times/week ☐ 3-4 times/week ☐ Less than 30 min./day ☐ 30-60 minutes/day ☐ 1-2 hours/day			
	☐ **Type of Exercise:** (i.e. golf, bicycling, walking, running, swim, weights):			
Living With:	☐ Alone ☐ Spouse ☐ Significant Other ☐ Family ☐ Friends			
Marital status:	☐ Single ☐ Married ☐ Male Partner ☐ Female Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married			
Employment:	☐ Retired ☐ Full- Time ☐ Part-Time ☐ Unemployed ☐ Self Employed ☐ Military ☐ Homemaker			
Travel:	Have you traveled outside of the country in the last 6 months? If so, where?			

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

ARTHRITIS & DIABETES CENTER
32615 US HIGHWAY 19 NORTH SUITE 2
PALM HARBOR, FL 34684

** If you want us to be able to discuss your health on your behalf please complete the below information. If this isn't completed, we are not permitted to discuss any private healthcare information to anyone but you.

Information to be Used or Disclosed
The information covered by this authorization includes: (check one)

☐ All Health Information ☐ Limited to (e.g. All but my lab results) _____

Purpose of the Disclosure: **Assistance in Care**

Persons Authorized to Use or Disclose the Above Information: ARTHRITIS & DIABETES CENTER, INC

Persons to Whom Information May Be Disclosed (e.g. Caregiver, Spouse, Child) this is a person or organization that you are comfortable with us discussing your healthcare even when you are not present:
****Name of person or organization AND their phone number****

_____

_____

_____

Expiration Date of Authorization
This authorization is effective through (check one) ☐ _____/_____/_____ or ☐ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

_____
Name of patient (Type/Print)

_____
Signature of Patient Date

_____
Signature of Patient Representative (if applicable)

_____
Relationship of Patient Representative to Patient (if applicable)

Provided By HCSI

ARTHRITIS & DIABETES CENTER

Endocrinology

Paul Denker, M.D.

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MEDICAL RELEASE OF INFORMATION **RHEUM OR ENDO** (CIRCLE ONE)

Date_____

Print Name _____ Date of Birth _____

Signature _____Social Security Number(last four) _____

TO _____

FAX _____ PHONE_____

I hereby authorize and request you to release any and all information which you may possess relating to my examination and illnesses, including psychiatric and/or psychological information which may be part of my records.

SPECIAL ATTENTION TO:

OFFICE NOTES _____

LABORATORY AND BIOPSY REPORTS _____

IMAGING : XRAY _____ MRI _____ CT _____ DEXA _____

SPECIAL NOTE:_____

Please forward <u>using this page as your coversheet</u> to:

32615 US HWY 19N
Suite 2
Palm Harbor, FL 34684
Fax (727) 785-3537
Phone (727) 789-2784 Attn: _____

CONFIDENTIAL

If you have received this transmittal in error, please notify the sender immediately. The material in this transmission contains confidential information that is legally privileged. This information is intended only for the use of the individual of entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken based on the contents of this transmission is strictly prohibited.