PDEC

PORTLAND DIABETES & ENDOCRINOLOGY CENTER, P.C.

Thank you for scheduling with us!

We are pleased to welcome you to our clinic. PDEC is a specialty practice providing consultation and/or treatment for patients with diabetes, thyroid disorders and other hormone abnormalities. We are not Primary Care Providers; all new patients are expected to have a personal (Primary Care) provider as their contact for general health and non-endocrine care.

Enclosed is a card verifying the date, time and location of your appointment as well as several forms for you to complete ahead of time and bring with you.

Other important information and instructions to help you navigate your initial visit with us are:

Medical Records: We will attempt to get pertinent medical records from the provider referring you to us. Sometimes, there is a delay in this process. It is helpful if you assist us with this process by arranging to have relevant past records sent to our office in advance of your appointment date. These should include recent chart notes and any pertinent lab or diagnostic reports. Enclosed is an "Authorization for Release of Medical Records" form. **Please complete this form and MAIL OR FAX IT to your CURRENT DOCTOR'S OFFICE IMMEDIATELY to avoid delays.**

Referrals: If we know your health insurance requires a referral for specialty services, we will make every effort to have this in place before you arrive. However, it is your responsibility to make sure any referrals required by your insurance plan are in place prior to your visit. If authorization has not been verified, you will be required to sign a waiver agreeing to be responsible for payment if our claim is denied.

Insurance Card/Photo ID: Upon arrival for every appointment with us, we are required to see and make copies (if needed) of your insurance card(s) and photo id, as required by Federal law.

Co-Payments: All patients should be prepared to pay any known Specialist co-pay amounts upon arrival at every appointment. For your convenience, we accept cash, check, VISA, MasterCard and Discover. Due to increased billing costs, we charge a $25.00 processing fee to bill you for any co-pays not collected at any visit. Uninsured patients will need to pay a $150.00 deposit when checking in for each visit. This deposit can always be prepaid by calling our billing department at (503) 274-4808. Our billing department is always available to talk with you about payment plans if you are ever concerned about paying your account balances with us.

Current List of Medications: Please bring us a complete listing of your current medications, including any you purchase "over-the-counter" and all vitamins and herbal supplements to every appointment.

Special instructions for our patients with Diabetes: Always bring your blood glucose meters and blood sugar records to all appointments, whether you are seeing your Endocrinologist or one of our Nurse Practitioners. Our protocol is that new patients with diabetes will be booked for a follow-up visit with our Nurse Practitioner for further education and medical management of diabetes.

Appointment Cancellations and No Shows: If you must cancel, we require a minimum of 72 hours. As you are aware, Endocrinology services are not readily available in our area. Letting us know at least 2 days in advance allows us to provide service to one of the many patients on our urgent waiting list. We may charge a $25.00 fee to patients that cancel or miss their visit without 72 hours' notice to us. New patients missing their first appointment without 48 hours notice will not be rescheduled without first making a $150.00 non-refundable deposit.

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1130 N.W. 22ND • SUITE 400 • PORTLAND, OREGON 97210 • (503) 274-4884 • FAX (503) 274-4897
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PDEC

PORTLAND DIABETES & ENDOCRINOLOGY CENTER, P.C.

Our appointment scheduling message line may be reached directly at (503) 274-4880 at any time day or night. *Due to high demand for our specialty services, patients who miss more than one appointment with us may be dismissed from our practice.*

Follow-up Appointments: At your initial visit, your PDEC provider will let you know if/when you need to return for your next visit. Our schedules are full several months in advance so we highly recommend you always make this future appointment while checking out at our front desk for your current appointment. Regularly scheduled follow-up appointments are an important part of your treatment regimen. *Failure to follow the visit schedule defined by your provider may result in our refusal to refill prescriptions or dismissal from our practice.*

Please complete the enclosed paperwork (front and back) and bring it with you to your first appointment along with the other items listed above. Plan to arrive at least 15-20 minutes early to complete our new patient check-in process. High traffic volumes and available parking should always be taken in consideration when coming to appointments at our clinic. Both offices are located on Hospital campuses and have Valet Parking available.

We look forward to seeing you! Our doctors and staff work together to provide quality treatment and courteous service. If you have any questions about your upcoming appointment, feel free to contact our staff at (503) 274-4884 or (503) 297-3336.

Physicians and Staff at Portland Diabetes & Endocrinology Center, PC

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PORTLAND DIABETES & ENDOCRINOLOGY CENTER P.C.

Date ______________ Account # ____________________ Primary Physician ______________________ Physician Phone ______________

Referred By ____

Patient Email ____

PATIENT INFORMATION

Patient Name ____ Home Phone ______________

(First) (M.I.) (Last)

Social Security # __________________________ Birthdate _______________ Cell Phone ____________________ Male ☐ Female ☐

Address ____ City ______________________ State ________ Zip ________

Employer ____ Work Phone ____________________________

SPOUSE INFORMATION / GUARDIAN INFORMATION

Spouse/Guardian Name ____ Birthdate ____________________

Social Security # ____ Cell Phone ____________________

Address ____ City ______________________ State ________ Zip ________

Employer ____ Work Phone ____________________________

PRIMARY INSURANCE INFORMATION

Insurance Co. ___________________________________ Subscriber ______________________________ Birthdate ______________

Insurance Address ____ City ______________________ State ________ Zip ________

I.D. # ______________________________ Group # ________________________ Employer ______________________________

SECONDARY INSURANCE INFORMATION

Insurance Co. ___________________________________ Subscriber ______________________________ Birthdate ______________

Insurance Address ____ City ______________________ State ________ Zip ________

I.D. # ______________________________ Group # ________________________ Employer ______________________________

FRIEND OR RELATIVE TO NOTIFY IN CASE OF EMERGENCY

1) Name ____ Relationship ____________________ Home Phone ____________

Address _____________________________ City ____________________ State _____ Zip __________ Work Phone ____________

2) Name ____ Relationship ____________________ Home Phone ____________

Address _____________________________ City ____________________ State _____ Zip __________ Work Phone ____________

NOTICE: PATIENT PRIVACY

We are required by law to protect the privacy of your medical information. We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains rights and obligations under the law, both for the patient and for the clinic. Patients may obtain a copy of the policy from our front desk. It is also available in a notebook in our Reception Area.

Acknowledged by Initials: ______________ *Date* ____________________

NOTICE: PRIMARY CARE RECOMMENDATION

PDEC physicians do not serve as Primary Care Providers; services are limited to Endocrine conditions and direct complications. We strongly recommend that you have a Primary Care Provider to manage your general health.

Acknowledged by Initials: ______________ *Date* ____________________

ASSIGNMENT FOR INSURANCE BENEFITS AND AGREEMENT TO PAY

In consideration for services rendered,

- I hereby authorize payment by my Insurer to the Physician or Supplier
- I authorize the release of any medical information necessary to process this claim, as permitted by HIPAA Patient Privacy policies
- I agree to be responsible for payment of any co-pays, deductibles, or other charges not paid by insurance, including non-covered services.

________________________________ ____________________

Patient Signature *Date*

PDEC

PORTLAND DIABETES & ENDOCRINOLOGY CENTER, P.C.

Portland Diabetes & Endocrinology Center PC uses an electronic program to send prescription information directly to your pharmacy.

We need the following information from you in order to expedite your new or refilled prescriptions:

Today's Date:_______________

Patient Name:_______________________________ **Date of Birth:**______________

Your Local Pharmacy Name:____

Local Pharmacy Address/Location:_______________________________________

(If you aren't sure, please list the approximate address i.e. SE 65th and Burnside to assist us in sending it to the correct location)

Do you also utilize a mail order Pharmacy? If so, please check the name below. If the company you use is not listed, please write it under "other".

- ❑ Aetna
- ❑ Byram
- ❑ CCS
- ❑ CVS/Caremark
- ❑ Providence Home Services
- ❑ Express Scripts
- ❑ Medco
- ❑ Walgreens
- ❑ Other:__________________________

If you receive a new or refill prescription during your visit, it will be sent to your local and/or mail order pharmacy before the end of the day, ready for pick-up at your local pharmacy the next business day.

When you need refills to your current PDEC prescribed medication, ***please call your pharmacy directly***. They will notify us electronically, allowing us to process this request much faster than if you call our office.

Thank you!

PDEC Medical Staff

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PDEC

PORTLAND DIABETES & ENDOCRINOLOGY CENTER, P.C.

Patient Financial Responsibility Form

Thank you for choosing Portland Diabetes and Endocrinology Center, PC as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- As our patient, you (or your legal guardian) are ultimately responsible for payment for all treatment and care you receive from a PDEC provider. As a courtesy we will bill your insurance for you. However, it is your responsibility to provide the most current and up-to-date information regarding insurance. You are always financially responsible for all charges whether or not they are covered by your insurance.
- Patients are responsible for payment of co-payments, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan. For your convenience, we accept Cash, Personal Checks, Visa, MasterCard, Discover and Debit cards.
- All co-payments are due at each visit. There is a $25.00 charge for failure to pay your co-payment at check-in.
- Discounts are available for private pay patients only if the estimated balance is paid in full at time of service. Please contact our Billing Department for more information at (503) 274-4808. Discounts are not available for patients with high-deductible insurance plans.
- Coinsurance, deductibles and non-covered items are due immediately upon receipt of our first billing statement.
- Patient responsible balances over 60 days without payment in full or official payment plan arrangement will be assessed a rebilling fee of $35 each month until the patient responsible balance is paid in full or payment plan arrangements are made and kept. Payments not made as required may be considered for collection assignment. If it becomes necessary to turn your account over to an outside collection agency, a non-negotiable fee of $100.00 will be added to the account balance. **Payment Plans can be set up at any time with our billing department at (503) 274-4808.**
- If your insurance requires a referral from your primary care provider to our office, it is your responsibility to have one in place prior to their appointments. If a referral is not received prior to care it may become your obligation to cover all services rendered. Patients without a referral must sign a waiver in order to see the provider.
- Due to the increased demand for our specialty services, we are unable to reschedule New Patient appointments missed or rescheduled without 72 hours' notice unless a non-refundable $150.00 deposit is made. Return appointments missed or rescheduled without 24 hours' notice will be assessed a $50.00 missed appointment fee.
- You may incur, and are responsible for payment of additional charges, if applicable. These charges may include (but are not limited to):
    - **$35.00 charge for returned checks**
    - **$150.00 charge for missed New Patient appointments without 72 hours' notice.**
    - **$50.00 charge for missed Return Patient appointments without 24 hours' notice.**
    - **$25.00 charge for failure to pay co-payments at check-in.**
    - **$35.00 charge for rebilling unpaid patient responsible balances in excess of 60 days old.**
    - **$100.00 charge for account collection assignment (non-negotiable).**
- You may also receive a separate bill from an outside lab for tests not performed on-site at PDEC.
- Always let us know when your blood is drawn if you have an outside lab preference.

PDEC is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requirks us to take additional measures to protect personal information and to inform our members about those measures.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form:

Print Name	**Signature**	**Date**

(continued on other side)

PDEC

PORTLAND DIABETES & ENDOCRINOLOGY CENTER, P.C.

PATIENT RESPONSIBILITY DISCLAIMER

I understand that Portland Diabetes & Endocrinology Center, P C will bill my insurance company with the information I provide.

I also understand that if full payment is not received from my insurance company, *I will be financially responsible* for any remaining balance on all charges incurred at Portland Diabetes & Endocrinology Center, PC. This includes Visits, Lab Charges, Testing Charges and X-rays *(approximately $250.00 to $750.00 depending on the services performed).*

If I do not have insurance, I understand that ***payment arrangements should be made before the date of my appointment*** with the Billing Department at Portland Diabetes & Endocrinology Center, PC. PDEC Billing can be reached at **(503) 274-4808.**

______________________________ ______________________

Patient Name (Print) **Date**

____

Patient Signature (Parent or Guardian if patient is under 18)

______________________________ ______________________

Witness **Acct Number**

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PORTLAND DIABETES & ENDOCRINOLOGY CENTER, P.C.

Thanks for signing up for our Patient Portal!

As part of our ongoing commitment to your health, we'd like to invite you to connect with your patient information and PDEC online. Having new ways to manage your health can help you achieve your goals, and we think MyHealthRecord.com will meet many of your needs, no matter when or where they arise.

At MyHealthRecord.com, you can:

- See your health information including your care plan and lab results on any Internet-enabled device, including smartphones and tablets
- Send secure messages to us asking non- urgent questions about your care and receive prompt replies
- Request prescription refills
- Receive documents from us
- Request copies of your health information
- Download copies of your health information
- Electronically update your health history, personal demographics and insurance information
- Send your health records to other providers electronically
- Request future appointments
- Pay your bill
- Appointment reminders
- Upload documents to us — ***coming soon***

This convenient way to manage your care will save you time so you can get back to doing the things you love most, while still feeling confident about your health and treatment plans. Plans are in the works for additional functionality so once your account is activated, log back in frequently for updates.

Once you've received your email invitation from **MyHealthRecord.com,** activating your account can quickly and easily be done from any Internet-enabled device, including smartphones and tablets. Don't wait — the emailed invitation is only valid for 7 days.

- Once you click on the link within the emailed invitation, you'll be asked for your **First Name, Last Name, Date of Birth and Zip Code.** The information you fill in must match what we have in our system for you.
- The system will ask you to set up your username and password plus some security questions. We are unable to reset these items for you but if you have trouble once your account is active, there are links at the MyHealthRecord.com site to help you get back in.

Have other questions? Please let us know. We can be reached at either of the numbers below.

Patient Name:____

Patient's Email Address:______________________________________

_______Not interested at this time

Portland Diabetes & Endocrinology Center, P.C.

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❑ 9135 S.W. BARNES RD. • SUITE 985 • PORTLAND, OREGON 97225 • (503) 297-3336

Full Name ______________________ Birth Date ______________ Age ______

Primary Care Provider ______________________ Referred By ______________________

REASON FOR SEEKING ENDOCRINE SERVICES AT THIS TIME:

Were you previously under the care of another physician for the current problem: Yes / No

If so, who? ____

PERSONAL HISTORY OF PAST ILLNESSES: Check any you've had and indicate the year

	YEAR		YEAR
❑ Diabetes Mellitus	______	❑ Thyroid Disease (describe)	______
❑ If insulin treated, since when?	______	______________	______
❑ Eye Disease Due to Diabetes	______	❑ Heart attack/Coronary Artery	______
(Retinopathy)	______	Disease/Heart Failure	______
❑ Nerve Damage Due To Diabetes	______	❑ High Blood Pressure	______
(Neuropathy)	______	❑ High Cholesterol	______
❑ Severe Hypoglycemia Including		❑ Stroke	______
Related Seizures	______	❑ Kidney Disease	______
❑ Diabetic Ketoacidosis	______	❑ Depression	______
❑ Adrenal Disorders	______	❑ Cancer	______
❑ Polycystic Ovarian Syndrome (PCOS)	______	Type: ____________	______
❑ Pituitary Disorders	______	❑ Lung Disease	
❑ Osteoporosis	______	Type: ____________	______
		❑ Other: ____________	______

SURGERIES AND HOSPITALIZATIONS: List any major events

Date	Surgery or Reason for Hospitalization	Where	Doctor

CURRENT MEDICATIONS - Please include those you buy over-the-counter without a prescription:

1. Aspirin use, dose? ____________
2. Calcium intake? ____________
3. ____________
4. ____________
5. ____________
6. ____________
7. ____________
8. ____________
9. ____________
10. ____________
11. ____________
12. ____________

ALLERGIES (describe reaction):

- ❑ Penicillin
- ❑ Sulfas
- ❑ Aspirin
- ❑ Other:

____

____

IMMUNIZATIONS: (Date of last vaccination) Influenza ____________ Pneumonia ____________

OTHER SPECIALISTS:

Eye Doctor: ____________ Last Visit: ____________
Podiatrist: ____________ Last Visit: ____________
Heart Doctor: ____________ Last Visit: ____________
Kidney Doctor: ____________ Last Visit: ____________

HABITS:

Cigarettes ____________ packs per day Other tobacco? ____________
Weekly alcohol consumption: ____________
Currently using other recreational drugs?: ____________
Any history of IV drug use? ____________
Have you ever used alcohol, medication or other substances excessively? ____________
Caffeine (cups per day) ____________
What kind of exercise do you engage in on a regular basis? ____________

SOCIAL/EMPLOYMENT HISTORY:

Marital Status: ______________________________

Occupation: ______________________________

What other kinds of work have you done? ______________________________

Do you require assistance with medications or daily activities? ______________________________

FAMILY HISTORY:

Family History	**Age**	**Health Problems**	**If Deceased, Cause + Age**	**Has a blood relative ever had:** (If yes circle and note which relative, e.g. mother)
Father				Diabetes
Mother				Heart Disease
Brother or Sister				High Blood Pressure
1.				High Cholesterol
2.				Stroke
3.				Overweight
4.				Osteoporosis
5.				Kidney Stones - Kidney Disease
6.				Pituitary Disease
7.				Adrenal Disease
Children				Thyroid Disease
1.				Other:
2.				
3.				

Please CHECK OFF any of the symptoms that you have had in the last 2 MONTHS

GENERAL:
- ❑ Unusual fatigue or weakness
- ❑ Significant weight changes
- ❑ Excessive thirst
- ❑ Heat or cold intolerance (circle one or both)
- ❑ Unable to sleep
- ❑ Snoring

EYES:
- ❑ Change in vision
- ❑ Blurry vision
- ❑ Double vision
- ❑ Blind areas

THROAT & MOUTH:
- ❑ Wear dentures
- ❑ Sore or swollen tongue, lips mouth (circle one or more)
- ❑ Hoarseness
- ❑ Neck Pain

HEART:
- ❑ Irregular or skipped beats (circle one or both)
- ❑ Racing, fluttering or pounding
- ❑ Chest pain / pressure

BREAST:
- ❑ Discharge

LUNGS:
- ❑ Persistent cough
- ❑ Coughing up blood, pus, mucous
- ❑ Shortness of breath / wheeze (circle one or both)
- ❑ Sit up to breath at night

STOMACH & INTESTINAL
- ❑ Poor appetite
- ❑ Difficulty swallowing
- ❑ Frequent indigestion / heartburn
- ❑ Post-eating bloating or vomiting (circle one or both)
- ❑ Constipation
- ❑ Diarrhea
- ❑ Black stool

URINARY:
- ❑ Night frequency, excessive
- ❑ Day frequency, excessive

NERVOUS SYSTEM:
- ❑ Sensation loss or abnormality in extremities ____________
- ❑ Pain in extremities (describe): ____________
- ❑ Paralysis ____________
- ❑ Trembling ____________
- ❑ Frequent headaches
- ❑ Dizzy / lightheaded
- ❑ Fainting spells (describe): ____________
- ❑ Loss of balance or falls

EXTREMITIES:
- ❑ Foot trouble (describe): ____________
- ❑ Muscle weakness, cramping or soreness (circle one or more) Where? ____________
- ❑ Swelling / edema

SKIN:
- ❑ Bruise easily
- ❑ Dryness
- ❑ Excessive sweating
- ❑ Sore, not healing well
- ❑ Changes in pigmentation

MOOD:
- ❑ Generally happy
- ❑ Mood disturbance, describe ____________

SEXUAL:
- ❑ Unsatisfactory
- ❑ Trouble in performance
- ❑ Painful intercourse
- ❑ Other

MENSTRUAL:
- ❑ Age of onset ____________
- ❑ Last period ____________
- ❑ Duration of flow (days) ______
- ❑ Bleeding between periods
- ❑ Excessive menstrual bleeding
- ❑ Birth control? Method: ____________
- ❑ Hot Flashes
- ❑ Bleeding after menopause

Do you have any concerns not included on this page?

❑ Yes ❑ No

Specify: ____________

PDEC

PORTLAND DIABETES & ENDOCRINOLOGY CENTER, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS - PDEC is a HIPAA-Compliant Clinic

PATIENT INFORMATION

Name: ______________________ Birthdate: ______________

Address: ______________________ Phone Number: (   ) ______________

City: ______________ State: ________ Zip: ______________

FACILITY/PERSON(S) TO **RECEIVE** RECORDS

Name: **Portland Diabetes & Endocrinology Center, PC** Phone Number: **(503) 274-4884**

Address: **1130 NW 22nd Ave Suite 400** FAX Number: **(503) 274-4897**

City: **Portland** State: **OR** Zip: **97210**

FACILITY/PERSON(S) TO **RELEASE** RECORDS

Name: ______________________ Phone Number: ______________

Address: ______________________ FAX Number: ______________

City: ______________ State: ________ Zip: ______________

By initialing (please do NOT check mark) the spaces below, I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist:

By placing my **INITIALS** in the applicable space next to the type of information, I authorize the following records to be released:

________ Chart (Progress) Notes
________ History & Physical
________ Hospital Reports
________ Diagnostic/Lab Reports
________ Other

Forms rec'd without initials will be returned

By placing my **INITIALS** in the applicable space next to the type of information, I understand and agree that this information will be disclosed:

________ HIV/AIDS - related information
________ Drug/Alcohol treatment and/or related information
________ Genetic Testing Information
________ Mental Health information

Forms rec'd without initials will be returned

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert applicable date or event) ______________. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS test or result information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

______________________________ (Signature of Patient/Guardian)

______________ (Date)