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.

(continued on other side)

9135 S.W. BARNES ROAD • SUITE 985 • PORTLAND, OREGON 97225 • (503) 297-3336 • FAX (503) 297-3338

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.*

Patient Portal: This convenient way to manage your care will save you time while feeling confident about your health and treatment plans. Once you have received your email invitation from MyHealthRecord.com, activating your account can quickly and easily be done from any internet-enabled device.

- 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 MyHealthRecord.com to help you get back in.

Text Reminders: You can expect to receive appointment reminder notifications, appointment change notifications and electronic prescription information. Due to HIPAA regulations, you won't see the name of the medication or the pharmacy it was sent to, just that we sent one for you.

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. Our office is located at Providence St Vincent Hospital Campus and valet parking is 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) 297-3336.

Physicians and Staff at Portland Diabetes & Endocrinology Center, PC

PDEC

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 _____

❑ yes ❑ no I would like to receive my general notifications via text message.
❑ yes ❑ no I would like to sign up for the patient portal.

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 and Disclaimer Form

Thank you for choosing Portland Diabetes and Endocrinology Center, P.C. 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 recieve a separate bill from an outside lab for tests not performed on-site ad 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 requires us to take additional measures to protect personal information and to inform our members about those measures.

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, P.C. 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, P.C. PDEC Billing can be reached at **(503) 274-4808.**

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

Print Patient Name	**Patient Signature** **(Parent or Guardian if patients is under 18)**	**Date**
Witness	**Acct Number**	

Portland Diabetes & Endocrinology Center, P.C.

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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**) **297-3336**

Address: **9135 S.W. Barnes Road, Suite 985** FAX Number: (**503**) **297-3338**

City: **Portland** State: **OR** Zip: **97225**

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

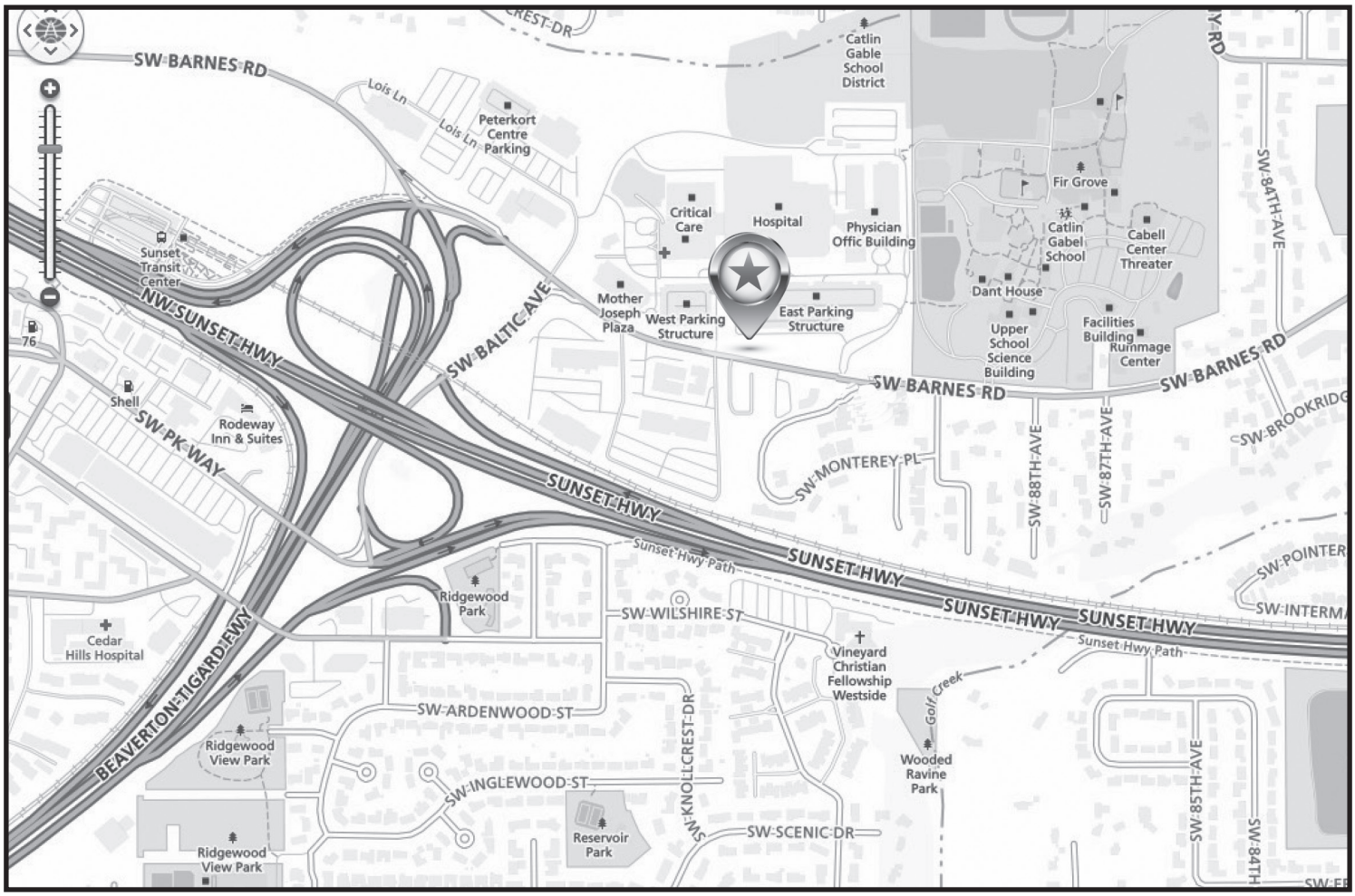
Forms rec'd without initials will be returned

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)

Portland Diabetes Endocrinology Center PC
9135 SW Barnes Rd, Suite 985, Portland, OR 97225
(503) 274-4880 Appts / (503) 297-3336 - Main



From the North:

South on I-5 across Columbia River

Follow signs to I-405 South, Beaverton-St Helens

Cross Willamette River on Fremont Bridge, staying to the Right

Follow signs to Highway 26 exit

Once on Highway 26 Westbound, take the Barnes Rd exit 69B

Turn Right onto Baltic Ave, Right onto Barnes, Left at the 2nd traffic light entrance into St Vincent

Enter the East Pavillion building, head right of the Info desk and take the new elevators to the 9th floor

From the South:

North on I-5

Follow signs to Highway 217 North

North on Highway 217 to the Barnes Rd exit (follow blue H signs to hospital)

Take the Barnes Rd Exit, turn right onto Barnes

Turn Left at the last traffic light entrance into St Vincent (last entrance to hospital campus)

Enter the East Pavillion building, head right of the Info desk and take the new elevators to the 9th floor

From the West:

East on Sunset Highway/US 26

Take the Barnes Rd exit 69 B to the Hospital

Turn Right onto Baltic Ave, Right onto Barnes, Left at the 2nd traffic light entrance into St Vincent

Enter the East Pavillion building, head right of the Info desk and take the new elevators to the 9th floor

From the East:

West on I-84/Banfield

Highway splits near downtown - stay left, follow signs to I-5 South/Salem

As you cross the river, follow I-405/Beaverton over Markham Bridge

Take the 12th Ave Beaverton exit, staying to the left

Once on Highway 26 Westbound, take the Barnes Rd exit 69B

Turn Right onto Baltic Ave, Right onto Barnes, Left at the 2nd traffic light entrance into St Vincent

Enter the East Pavillion building, head right of the Info desk and take the new elevators to the 9th floor