WE HAVE MOVED

THE ENDOCRINE AND DIABETES CARE CENTER'S NEW ADDRESS IS:

2100 W. CENTRAL AVE. SUITE 100
TOLEDO, OHIO 43606
419-537-5111

On same side of the road as our old office, approximately 1.3 miles going toward Promedica Parkway on Central Avenue.

Endocrine & Diabetes Care Center

Endocrine and Diabetes
Care Center
2100 West Central Ave
Suite 100
Toledo, Ohio 43606
(419) 537-5111
Fax (419) 537-5131

Dear Patient:

Welcome to the Endocrine & Diabetes Care Center. Enclosed is a card stating the date and time of your appointment along with a map. If it becomes necessary to change or cancel your appointment, we require a 48-hour notice to allow another person to utilize the time.

At the Endocrine & Diabetes Care Center, we use a "Team" concept, consisting of You, Your Physician, Diabetes Nurse Educators, and Diabetes Nutrition Educators. Our physicians have received the Provider Recognition Award from the American Diabetes Association and the National Committee for Quality Assurance. This was awarded with Distinction for Delivery of Quality Diabetes Care. Our Diabetes Education Services Program has been awarded recognition by the American Diabetes Association in accordance with the National Standards for Diabetes Patient Education.

As a new patient there will be TWO SEPARATE APPOINTMENTS

PRE-ASSESSMENT APPOINTMENT (part one)
This visit will last approximately 1-1 ½ hours. At this time, the Diabetes Educator will do a complete medical history, provide instruction on monitoring blood sugars and order additional laboratory testing if required. It is our policy that if this first part of the appointment is NOT kept, *the physician appointment will be cancelled.*

Please bring the following for your pre-assessment appointment:

- The Patient Information sheet with the authorizations for treatment signed
- The Medical History Record
- *ALL* the actual prescription bottles of any medications you are taking
- Your blood glucose meter and supplies
- Your log book with recorded blood sugars

PHYSICIAN APPOINTMENT (part two)
The physician will do a complete physical examination, discuss your diabetes and explain any test results available. They will discuss any individualized program of medication, diet and exercise. Additional laboratory tests may be ordered at this time. This visit will take up to one hour.

About my insurance

- Please have YOUR INSURANCE CARD AT EVERY VISIT
- If you have a *Managed Care Insurance* you will need *a referral*
- Call your Primary Care Physician to make sure the necessary referrals are in place *one week prior* to your visit. It is you're *your responsibility* to see that this is done. If you do not have your referral in place, your appointment may have to be rescheduled.
- BRING YOUR AUTHORIZATION WITH YOU
- All office visit copays are payable at each visit

Please check to see if your particular health insurance will cover your charges. We will bill any insurance for you. If you do not have insurance, you should be prepared to pay on the day the service is rendered. The Billing Department at 419-537-5111, and choose the Option for Billing, can assist you with any questions you have regarding payment.

PLEASE COMPLETE THE ENCLOSED FORMS WITH THE SIGNED AUTHORIZATION AND BRING THEM WITH YOU.

We hope this information has been helpful. If you have any questions regarding your appointments, please phone the office at 419-537-5111. The Team at the Endocrine & Diabetes Care Center looks forward to meeting and working with you in the successful management of your diabetes.

Sincerely,

Richard A. Beham, M.D.
Aparna Brown, M.D.
Guillermo M. Guardia, M.D.
Kalpana Naraharisetty, M.D.
John E. Brunner, M.D.
Bhaskar Gundabolu, M.D.
Kara Fine, M.D.

Enclosure

Adult-Diab
06/23/2016

PATIENT INFORMATION PLEASE PRINT CLEARLY

JEB RAB BG GG AB KF KN

FAMILY DR_____ DATE_____
Name(First & Last) Address Phone

REFERRING DR (If different from Family Dr.) _____
Name (First & Last) Address Phone

PATIENT INFORMATION

NAME_____ DATE OF BIRTH_____ AGE_____ M_____ F_____
Last First Middle

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE(_____)_____ CELL PHONE_____ SOCIAL SECURITY NUMBER_____

MARITAL STATUS M D W S NO. OF CHILDREN _____ RACE (Circle One) African American Asian Caucasian Hispanic Native American Other (explain)_____ Unknown

EMPLOYER_____
Name Address

WORK PHONE(_____)_____ EXT_____ OCCUPATION_____

SPOUSE NAME_____ SOCIAL SECURITY NUMBER_____
(If Applicable)

SPOUSE DATE OF BIRTH_____ HOME PHONE(_____)_____ CELL PHONE(_____)_____

PERSON RESPONSIBLE FOR PAYMENT

NAME_____ DATE OF BIRTH_____ MALE_____ FEMALE_____
Last First Middle

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE(_____)_____ CELL PHONE(_____)_____ WORK PHONE(_____)_____

SOCIAL SECURITY NUMBER_____ EMPLOYER_____

PRIMARY INSURANCE INFORMATION

INSURANCE CO_____ PHONE_____
FOR ELIGIBILITY/CLAIM VERIFICATION

CLAIM MAILING ADDRESS(On Card)_____

SUBSCRIBER/CONTRACT ID#_____ GROUP#_____

NAME OF POLICYHOLDER_____ DATE OF BIRTH_____

EMPLOYER_____ WORK PHONE(_____)_____

SECONDARY INSURANCE INFORMATION

INSURANCE CO_____ PHONE_____
FOR ELIGIBILITY/CLAIM VERIFICATION

CLAIM MAILING ADDRESS(On Card)_____

SUBSCRIBER/CONTRACT ID#_____ GROUP #_____

NAME OF POLICY HOLDER_____ DATE OF BIRTH_____

EMPLOYER_____ WORK PHONE(_____)_____

OVER ⇨

Endocrine & Diabetes Care Center
2100 W. Central Avenue, Suite 100
Toledo, OH 43606
419-537-5111

Endocrine & Diabetes Care Center

I acknowledge that I received a copy of the Notice of Privacy Practice Policy from the Endocrine & Diabetes Care Center.

Please Print Patient
Name:_____

Signature:_____
Parent/Guardian to sign for minor child.

Date:_____/ _____/_____

This form is in compliance of the Health Insurance Portability and Accountability Act (HIPAA)

Notice of Privacy Practices

Endocrine & Diabetes Care Center Inc.

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided at right, under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department 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 the Privacy Manager at:

EDCC Attn: Privacy Manager, 2100 W. Central Ave S-100, Toledo, OH 43606

We will not retaliate against you for filing a complaint.

Effective Date 2/1/2014

Publication Date 2/1/2014

ENDOCRINE & DIABETES CARE CENTER
GUIDELINES

Prescription Refills:
Medication refills are important and should not be left to the last minute. We do electronic prescriptions. We encourage you to call your pharmacy for any refills. They can electronically send us the prescription and makes the medication refill process much quicker. If this is not a refill, you may call 419-537-5111 and choose the pharmacy option. Due to our volume of calls, we ask that you contact your pharmacy to see if your prescription is ready.

Test Results:
Your doctor will review your test results. When appropriate, most of our physicians are using the patient portal to send you a letter about your lab results. We will ask for your email address to activate this process. You will be notified if there are important results that require actions before your next visit. Please always check the patient portal before calling the office for lab results. You will be given instructions when you check in.

Insurance Matters:
Our staff will bill for services performed in our office to your insurance company. However, we need your assistance to ensure we have the most current and accurate information on file. We will require you to show us your insurance card at each visit to our office.

Copays:
Per your insurance contract, copays are due at the time of service and our staff has been instructed to collect copays at the time of your visit.

Completion of Forms:
We are asked to complete a variety of forms for our patients and are happy to accommodate our patients during your regularly scheduled visit. However, a $15.00 handling fee will be charged for any forms requested at other times. Please make every effort to bring ALL forms needing completion to your scheduled appointment.

No Shows & Cancellations:
We ask that patients provide a 24-hour cancellation notice so that we may schedule other patients requiring appointments. Without proper notice we cannot accommodate other patients during these times.

Our office policy is to discharge patients who fail to cancel within a 24-hour time frame, or do not show for 3 appointments.

If you have any questions about these policies please feel free to ask our staff.

ENDOCRINE AND DIABETES CARE CENTER

MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release this.

PLEASE PRINT AND COMPLETE ALL INFORMATION

Last Name	First	Middle	Today's Date ____/____/____	Birthdate ____/____/____

Family History	If Living Age	Health Good	Fair	Poor	If Deceased Death Age	Death Cause
Father						
Mother						
Brother Sister (circle sex)						
1. M F						
2. M F						
3. M F						
4. M F						
5. M F						
[] Husband [] Wife						
Sons Daughters (Circle Sex)						
1. M F						
2. M F						
3. M F						
4. M F						
5. M F						
6. M F						

Any blood relatives who have or have had any of the listed conditions

(check)	Yes	No	Relationship	(check)	Yes	No	Relationship
Adrenal Tumor				Obesity			
Asthma				Osteoporosis			
Arthritis				Pancreas Tumor			
Anemia				Pituitary Tumor			
Bleeding Tend				Stroke			
Cancer				Suicide			
Colitis				Stomach Ulcers			
Congenital Heart				Other:			
Diabetes							
High Bl Press							
High Cholesterol				**THYROID**			
Heart Disease				Enlarged (goiter)			
Kidney Disease				Overactive Thyroid			
Kidney Stones				Underactive Thyroid			
Leukemia				Thyroid Tumor			
Mental Illness				Thyroid Cancer			

MEDICATIONS: LIST OF ALL MEDICATIONS AND DOSES YOU ARE CURRENTLY TAKING INCLUDING OVER THE COUNTER OR HERBAL

1.	6.	11.	16.
2.	7.	12.	17.
3.	8.	13.	18.
4.	9.	14.	19.
5.	10.	15.	20.

DRUG ALLERGIES AND FOOD ALLERGIES:

HOSPITALIZATIONS AND SERIOUS ILLNESS:

Operations you have had:	Year	Diseases you have had requiring hospitalization:	Year
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____

Serious Illness not requiring hospitalization:	Year	Serious Injuries or Accidents:	Year
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____

Habits:

Do You:	Check One		Daily Consumption	
Smoke.....	[] Yes	[] No	Packs:	_____
Drink Coffee.....	[] Yes	[] No	Cups:	_____
Drink Alcohol.....	[] Yes	[] No	Ounces:	_____
Drink Beer.....	[] Yes	[] No	Ounces:	_____
Fall Asleep Easily.....	[] Yes	[] No		
Awaken Early.....	[] Yes	[] No		

Women Only:

Are you still having monthly periods?.....	[] Yes	[] No	
Date of last menstrual period:.....	___/___/___		
Are you now or ever taken birth control pills?..	[] Yes	[] No	When?
How many children born alive?.....	_____		
How many pregnancies?.....	_____		
Have you ever had a miscarriage?....	[] Yes	[] No	When?
Do you regularly have a Pap Test?...	[] Yes	[] No	Date: