An Official Sponsor of the San Antonio Spurs

Diabetes & Glandular Disease Clinic, P.A.

LEADING THE SEARCH FOR BETTER HEALTH

Dear New Patient,

The Providers and staff would like to Welcome and thank you for choosing and trusting Diabetes & Glandular Disease Clinic, P.A. with your health care needs. Our goal is to make your visits as pleasant and informative as possible.

We understand the sensitive nature of your visit and respect your privacy. For these reasons, we are asking you to **complete** the enclosed new patient packet and mail or fax them to us prior to your first visit. Our direct confidential fax number is (210)615-1083. If you are unable to complete the new patient packet prior to your visit, please bring it in completed at the time of your first visit. New patients are encouraged to register online at www.dgdclinic.com in order to have access to our patient portal where you can conveniently fill out the new patient packet at home instead of mailing, faxing or bringing it with you to your first appointment. As an established patient you will be able to access information in reference to future appointments, lab results, prescriptions and account billing summaries through our patient portal.

If you were previously treated at another clinic or facility for the same care you will be receiving from our clinic, it is very important to provide us with your records before your initial appointment. Since this can take up to four weeks, we realize that not every patient will have their medical records available by the first visit. However, the quality of one's visit is enhanced when we have the ability to review your health records prior to your visit, especially when a patient has a medical history of diabetes/ glandular disease.

Please plan for your first appointment to be at least 45 minutes to an hour long. As a new patient, dependent on diagnosis and/or recommended treatment by your provider at the time of your first visit, you may be encouraged to attend a group class given by our Educators on staff. If applicable, the group class will be scheduled during your check out.

Insurance and required demographic information to verify insurance is taken by our staff before your appointment is scheduled. Insurance information is verified within 2 days of your appointment. If insurance and required demographic information is not obtained, the appointment will not be confirmed and may be rescheduled.

As a part of the patient information packet please know that payments all applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your visit. We accept cash, checks, Visa, MasterCard, and American Express. If patients are not able to pay their co-pay and/or deductibles at the time of their appt., the patient's appointment will be rescheduled for a date when the patient is able to pay the co-pay and/or deductible. Cancellation and Appointment Time information is included in the packet.

We encourage you to visit our website at www.dgdclinic.com for information about our providers and the services we provide.

Thank you for choosing and trusting our providers and staff with your healthcare and we look forward to your first visit.

Sherwyn L. Schwartz, M.D.
Founder 1979
Diplomate
American Board of Internal Medicine
American Board of Endocrinology

Jerome S. Fischer, M.D.
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Ann Marie Straight, M.D.
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www.dgdclinic.com

210.614.8612
210.615.1666 FAX
5107 Medical Drive
San Antonio, Texas 78229

Diabetes & Glandular Disease Clinic, P.A.

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Pt's Acct. # ____________________

New Patient Information

(Please Print)

Patient Name ____
First Middle Last

Address: ______________________________ Apt/ Suite ____________________

City:__________________________ State: ____________ Zip: __________

Phone # _(______)______________________ Social Security # ________-_____ -_________
Area Code

Date of Birth: ______________ Marital Status ______________ Sex: [ ] Male [ ] Female

Email: ____

Emergency Contact: ____________________________Phone # _(______)____________________
Area Code

Employer: ______________________________ Work Phone # _(______)____________________
Area Code

Primary Insurance

Name of Insurance: ____________________________Phone # _(______)____________________

Policy Holder Name: ______________________________ S.S.N#________-_____ -_________
First Middle Last

Insurance ID # ______________________________ Group # ______________________________

Secondary Insurance

Name of Insurance: ____________________________Phone # _(______)____________________

Policy Holder Name: ______________________________ S.S.N#________-_____ -_________
First Middle Last

Insurance ID # ______________________________ Group # ______________________________

Other

Referred By: ______________________________ Phone # _(______)____________________
(Name of Doctor)

Pharmacy Name ______________________________ Phone # _(______)____________________

ASSIGNMENT OF BENEFIT: I hereby authorize payment directly to physician of benefits due to me for his/her services. I understand I am financially obligated for charges not covered by this authorization. I authorize the release of any medical or other information necessary to process this claim.

Signature: ________________________________ Date: ____________________

Printed Name: ____________________________

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Diabetes & Glandular Disease Clinic, P.A.

Pt's Acct. # ____________________

HIPAA Acknowledgment Form
PATIENT ACKNOWLEDGEMENT

Health Insurance Portability and Accountability Act (HIPAA)

Our clinic's Notice of Privacy Practice provides information about how we may use and disclose protected health information about you, the patient. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgment. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office.

The Summary of our Notice of Practices is posted in our main lobby. The complete Notice of Privacy Practices is also available in our main lobby for your review. If you would like to receive a copy of the Summary and complete Notice, we have one available for you at the front desk.

If you wish for persons other than those released under normal operations, as indicated in the Notice, to receive confidential information that is now protected under this law, you must release them in writing. Please indicate on your patient registration form a spouse, or any family or friends whom you wish to be able to receive information about you. You may, of course, choose not to release anyone. You may also be more specific in your restrictions for the persons you have released, provided that the request is made in writing. Parents or Guardians of minors do not need to be released.

Please be aware that our staff must follow federal law on information that we release by phone. We may at anytime choose not to release information of any kind by phone if we deem the person requesting information is not authorized or that the information is too sensitive.

By signing this form, you are acknowledging that the Diabetes & Glandular Disease Clinic has made our Notice of Privacy Practices available to you for review and that we have offered you a personal copy.

Patient Name: ________________________________ Date of Birth: _______________

Signature: ____________________________________ Acct.#: ____________________

This acknowledgement was signed by:

____ Date: _______________________

Printed Name (Patient or Representative)

Relationship to Patient
(if other than patient): ________________________________

Diabetes & Glandular Disease Clinic, P.A.

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Pt's Acct. # ____________________

Health History

(please Print)

Past Medical History

Please list all medical problems and approximate dates of onset:
(Example: Diabetes, Hypertension, Heart Disease, Thyroid Cancer, etc.)

____
____
____

Hospitalizations

Please list all hospitalizations, include dates and reasons, including surgeries:

____
____
____

Bone fractures and injuries

Please list all injuries such as bone fractures, etc:

____
____
____

Birthing and Menstrual History

Number of pregnancies: ____________ Number of live births: ________________
Age of each pregnancy: ____________ Weight of babies: ____________________
Complications: ____

Age when period started: _____________ Date of last period: ___________________
Frequency/ length of periods: __________ Pain with periods: ____________________
Hot flashes or sweats: ____

Psychiatric

Please list any history of depression, hospitalization for mental illness, suicidal thoughts?

____
____
____

Patient's Name: _________________________________ Date:______________

Account No. ____________________________________ Age: ______________DOB:______________

Diabetes & Glandular Disease Clinic, P.A.

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Pt's Acct. # ____________________

Review of Body Symptoms

(please Print)

Patient Name:____ **Date** __________________________

Weight- Have you gained or lost weight? ____
Height- Have you lost height? ____
General- Fatigue, fever, chills, tolerance of heat and cold? ______________________________
Head- Headaches, loss of consciousness, dizziness? __________________________________

Eyes- Vision change, eye pain or dry feelings, double vision, eye bulging? ________________
____

Mouth-Hoarseness, dental problems, bleeding after brushing?___________________________
____

Nose- Bleeding, frequent sinus infectious?____
____

Neck-Stiffness, pain, swelling, goiter? ____

Breast- Masses, tenderness, nipple discharge? _____________________________
____

Last mammogram? ____________________________ Where? __________________________

Chest- Pain, cough, bringing up blood, night sweats? ______________________
____

Cardiac- How far can you walk? __________________________________
Any chest pain or tightness?_____________________________
Irregular heart beat? ____________________________________
How many pillows do you sleep on? _____________________
History of heart murmur or rheumatic fever? ______________

Muscle/ Bone- Arthritis, joint pain or swelling, leg edema? ___________________
____

Nerves- Problems with strength, balance, numbness, pain or needles and pins feelings in
the extremities, tremor, falls, blackouts? ___________________________________

Skin- Rash, itching, jaundice, increased hair of body? _______________________
____

Urinary- Problems with stopping or starting urine stream, pain with urination, history of
urinary infections, prostate problems, blood in urine, loss of control of urination?
____

Diabetes & Glandular Disease Clinic, P.A.

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Pt's Acct. # ____________________

Review of Body Symptoms (Cont.)

(please Print)

Patient Name:______________________________________ **Date** _________________________

Sexual- Male- Problems with potency or ejaculation? ____________________

Female- Painful intercourse, problems with lubrication, vaginal discharge?
____

Medications- Include over the counter medications:

Name	Dosage	Date Started	For what Condition

Allergies- Medicine ____
____
Food ____
____

Social History

Smoke _________ Packs/ Days For how long? _____________ When did you quit? _____________

Alcohol (indicate amount of intake per week): _____________________________

Exercise: Type of exercise: ____
Times per week: ____
Sedentary _________ Low__________ Moderate ________ Intense ______

Sleep: Sleep all night? ____________________Insomnia? _____________

Typical Diet: Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Caffeine: Coffee ________ Tea ________ Sodas _________Chocolate ______

Diabetes & Glandular Disease Clinic, P.A.

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Pt's Acct. # ____________________

Family History

(please Print)

Patient Name:____ **Date** __________________________

Family History (Please state disease and if deceased, at what age)

Father: ____
____

Mother: ____
____

Brother: ____
____

Sister: ____
____

Other family: ____
____

Diabetes & Glandular Disease Clinic, P.A.
Leading the search
For better Health

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ELECTRONIC PRESCRIPTION CONSENT FORM

Patient Name ________________________________

Account # ________________________________

Date of Birth ________________________________

Social Security # ________________________________

Daytime Phone # ________________________________

The name of my pharmacy is:

____
Name of pharmacy

____
Address

Phone (   ) __________ – ____________________

I would like to have my prescriptions sent electronically to the pharmacy listed above, and I hereby authorize the Diabetes and Glandular Disease Clinic to view the prescription history of:

______________________________ ____________________
Signature of Patient ***Date***

YOUR PHARMACY MAY NOTIFY YOU OF THE AVAILABILITY OF AN ELECTRONIC PRESCRIPTION PRIOR TO YOU RECEIVING YOUR LABS

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

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Pt's Acct. # ____________________

Patient Information

Welcome to the Diabetes & Glandular Disease Clinic. We appreciate the opportunity to work with you. The following information is provided for your benefit so that we may serve you better. Please read carefully and sign at the bottom. You will be given a copy for your records.

1. **PAYMENTS:** All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your visit. We accept cash, checks, Visa, MasterCard, and American Express.
2. **CANCELLATIONS:** If you need to cancel your appointment, be sure to call us at least 24 hours before your scheduled appointment. There will be a $25.00 administrative charge to all patients who miss their appointment and do not call to cancel or reschedule their appointment at least 24 hours in advance. This charge is not payable by any insurance company and I understand that this will be my responsibility.
3. **APPOINTMENT TIME:** We ask that out patients arrive on-time for their appointments; this will facilitate our ability to see you as scheduled. In an effort to serve all our patients well, patients arriving past their appointment time may be rescheduled.
4. **HMO & PPO REFERRALS:** If your policy requires written authorization from your Primary Care Physician, we will request authorization in advance **for established patients only**. This is done as a courtesy for our patients; however, we cannot guarantee authorization will be granted. Please keep in contact with your physician to ensure your visit is pre-approved, to avoid having to make payment in full.
5. **CHANGE OF INFORMATION:** Please provide us with any change regarding your address, phone number or insurance information as soon as possible. Change of insurance will require the completion of a New Patient Information Form and may not be changed over the telephone.
6. **MEDICATION REFILL REQUESTS:** Please contact your pharmacy first. They will call our office for authorization of the refill.
7. **AFTER HOURS CARE** ***In a life-threatening emergency, please call 911.*** For urgent non-emergency matters, please dial the main office number (210) 614-8612 and leave a message with the answering service. The physician-on-call will return your phone call as soon as possible.
8. **MEDICAL RECORD/ LAB RESULTS COPY REQUEST** Requests for copies of your medical records must be made in writing on a form provided by our office. Our office will respond within 15 business days to a properly completed written request. **FEES:** As per the rules adopted by the Texas State Board of Medical Examiners, our office will charge the following for copying your medical records:
   - 8.1. $25.00 for the first 20 pages, $.50 cents for each page thereafter, and the actual cost of mailing, shipping or delivery, if applicable.
   - 8.2. Lab Results are available at no cost on DGD Clinic Patient's Portal. All Lab Result paper copy request will incur a $6.00 processing fee per visit.
   - 8.3. Copies of medical records/ lab results will be retained until payment is received, unless requested by a licensed Texas health care provider or any American or Canadian licensed physician for acute or emergency medical care, or to support an application for disability or other benefits or assistance under Aide to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, Federal Old-Age and Survivor Insurance, or the Veterans Administration.
9. **COLLECTION AGENCY:** In the event of a delinquent account balance, I will be responsible for all collection fees assessed by the collection agency onto the account.

" I, the Guarantor of Payment and Responsible Party, have read and agree to the above policies and terms regarding payment and payment responsibilities.

____________________	____________________	____________________
Printed Name	Signature	Date

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Diabetes & Glandular Disease Clinic, P.A.

LEADING THE SEARCH FOR BETTER HEALTH

Pt's Acct. # ____________________

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to Diabetes and Glandular Disease Clinic, P.A., For medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by the insurance.

Authorization to Release Information

I hereby authorize Diabetes and Glandular Disease Clinic, P.A. to: (1) release any information necessary to insurance carrier(s) regarding my or my child's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Diabetes and Glandular Disease Clinic, P.A. on behalf of myself and/or my dependents and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I have read and understand the Diabetes and Glandular Disease Clinic, P.A. Financial Policy. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the charge by the collection agency for costs of collections. A photocopy of this assignment is to be considered as valid as the original. I also understand and agree that the practice may amend such terms from time to time.

____

Print Name of the Patient

____ ____________________

Signature of Insured or Authorized Representative Date

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Diabetes & Glandular Disease Clinic, P.A.

Pt's Acct. # ____________________

Nurse Practitioner
Physician Assistant
Consent For Treatment

This facility has on staff nurse practitioners and physician assistants to assist in the delivery of medical care.

Nurse practitioners and physician assistants are not doctors. A nurse practitioner is a registered nurse who has received advanced education and training in the provision of health care. A nurse practitioner can diagnose, treat and monitor common acute and chronic diseases, as well as provide health maintenance care. In addition, the nurse practitioner may treat minor lacerations and other minor injuries.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic
- procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness and therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

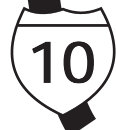
I have read the above, and hereby consent to the services of a nurse practitioner or physician assistant for my health care needs.

I understand that at any time I can refuse to see the nurse practitioner or physician assistant and request to see a physician.

Name:______________________________________ Acct#:___________________

Signature___________________________________ Date:__________________

Witness:(optional) ______________________________________



HUEBNER
10
THE COLONNADE
TEXAS MED CLINIC
Santa Rosa Northwest Tower I
Santa Rosa Northwest Tower II
Renal Associates
DGD CLINIC
5107 Medical Dr.
WARM SPRINGS
FLOYD CURL
BABCOCK
MEDICAL DRIVE
WARM SPRINGS
Univ. Of Tx Health Science Center
N
Medical Plaza & STRIC
WURZBACH
PHYSICIANS PLAZA 2
PHYSICIANS PLAZA 1
EWING HALSELL
FREDERICKSBURG
Billing Concepts
VON SCHEELE
CVS
JOHN SMITH DR.
Wurzbach Towers
Methodist Specialty and Transplant
Medical Center Tower I
Medical Center Tower II
10
South Texas Medical Plaza
Compass Bank
Diagnostic Clinic
St. Luke's Hospital
Exxon
WURZBACH
University Hospital
Methodist Plaza
MEDICAL DRIVE
FLOYD CURL
Texas Neuroscience Institute
South Texas Cardiovascular Center
CTRC
Audie Murphy V.A. Hospital
Methodist Hospital
Oak Hills
LOUIS PASTEUR
410
MERTON MINTER
CALLAGHAN
BABCOCK
FREDERICKSBURG
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CALLAGHAN
410
410
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