Diabetes & Endocrinology Associates, Inc.
100 Highland Avenue, Suite 203
Providence, RI 02906
Phone: (401) 351-7100 | Fax: (401) 751-6179
patient@diabendo.com | www.diabendo.com

Valerie A. Thomas, M.D.
Robert J. Dobrzynski, Jr., M.D.
Roberto Ortiz, M.D.
ManChin Chang, M.D.
Sanam Lathief, M.D.
Ameya Hodarkar, M.D.

Welcome to Diabetes & Endocrinology! We have been in practice since 1974 as a private group and since then have amassed over 100 years of professional experience in diabetic, endocrine and metabolic conditions. Our providers are consistently rated among "*Rhode Island's Top Docs*" by *Rhode Island Monthly Magazine*. Our five physicians are affiliated and perform consults at both Rhode Island Hospital and Miriam Hospital. Our office is fully equipped with a licensed Nurse Educator, certified Nutritionist and an onsite laboratory. To ensure the best experience possible, we ask that you familiarize yourself with our office policies as detailed below.

OFFICE POLICIES

- At the time of your first visit, we request that you bring or have sent prior any clinical documents (including but not limited to laboratory results, radiology reports and office notes) from your previous care provider(s) that relate to the purpose of your visit.
- Our physicians or their representatives will contact patient with laboratory or radiology results either by phone, e-mail or postal mail (per your approved permission). *As a result, it is not necessary to contact the office looking for results.*
- While we do have staff capable of speaking Spanish, patients are responsible for obtaining any translation services for office visits.
- By law, per the Health Insurance Portability and Accountability Act (HIPAA) of 1996, a written request must be made to release medical records to an external facility, person or other entity. *A few may be charged for these services per postal services and paper supply.* How we use and disclose your *Protected Health Information* is included in the last page of this packet, titled "*Notice of Privacy Practices*".
- Appointment cancellations or rescheduling requires a full 24-hour notice. *If a new patient fails to follow this policy, he OR she may not be given another new patient appointment.*
- Once you have become an established patient (after first visit / check-in), you cannot switch to another physician in our practice. If you prefer to see a specific provider within the practice, please make this known to our staff before your first visit such as when we call you to book your first appointment.

HOURS OF OPERATION

Office hours vary with each individual physician, normally between 7:30AM – 4PM.

Valerie A. Thomas, M.D.	(401) 490-5870	Billing Department	(401) 490-5854
Robert J. Dobrzynski, Jr., M.D.	(401) 490-5877	Medication & Prescriptions	(401) 351-7100 ext 8
Roberto Ortiz, M.D.	(401) 490-5867	Medical Records	(401) 490-5866
ManChin Chang, M.D.	(401) 490-5872	New Patient Coordinator	(401) 490-5886
Sanam Lathief, M.D.	(401) 490-5871	Laboratory	(401) 490-5888
Ameya Hodarkar, M.D.	(401) 351-7100		

We sincerely look forward to taking part in your healthcare and thank you in advance for your trust, cooperation, confidence and support in our office(s).

Sincerely,
Physicians & Staff of Diabetes & Endocrinology Associates, Inc.

Patient Information

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip Code

Home Phone	Primary? ☐	Work Phone	Primary? ☐	Cell Phone	Primary? ☐

Previous Name(s)	E-mail Address

Gender ☐ Male ☐ Female	Social Security Number	Preferred Language	Marital Status

Occupation	Employer	Employer Phone Number
Emergency Contact Name	Emergency Contact Phone Number	Emergency Contact Relationship to Patient

Approved Forms of Contact	Approved Places to Leave Messages	Race	Ethnicity
☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-Mail	☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-Mail	☐ American Indian OR Alaskan Native ☐ Asian ☐ Black OR African American ☐ Native Hawaiian OR Pacific Islander ☐ Hispanic ☐ White ☐ Other ☐ Decline	☐ Hispanic OR Latino ☐ Not Hispanic OR Latino ☐ Decline

Primary Care Physician Name	Primary Care Physician Phone Number

Primary Care Physician Address	Primary Care Physician City	PCP State	PCP Zip Code

Preferred Pharmacy	Preferred Pharmacy Phone Number

Preferred Pharmacy Address	Preferred Pharmacy City	State	Pharmacy Zip Code

Insurance Information (Guarantor) ☐ Same as Patient

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip Code

Primary Phone Number	Social Security Number	Relationship to Patient

PRIMARY INSURANCE

Primary Insurance Subscriber Name	Subscriber Primary Phone Number	Subscriber Relationship to Patient
Primary Insurance Company Name	Primary Insurance Policy Number / Identifier	Primary Insurance Group Number / Identifier

SECONDARY INSURANCE

Secondary Insurance Subscriber Name	Subscriber Primary Phone Number	Subscriber Relationship to Patient
Secondary Insurance Company Name	Secondary Insurance Policy Number / Identifier	Secondary Insurance Group Number / Identifier

BILLING POLICIES

Payment is requested on the day of service for any non-covered services. This includes co-payments, office visits that are not covered by your insurance carrier, etc. For patients with **Medicare and Plan 65**, assignment is accepted by this office. We will accept their payment as payment in full. If you have **Medicare with a commercial second payer** (IE; AARP), we will file the claim for you if the correct billing information and forms are provided. If you have **Medicare without a secondary insurer**, you will be billed for the 20% co-insurance and deductible not covered by insurance. **The patient is responsible for obtaining an insurance referral from their Primary Care Physician prior to being seen if your insurance is an HMO.**

→ I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE / INSURANCE BENEFITS BE MADE ON MY BEHALF TO DIABETES & ENDOCRINOLOGY ASSOCIATES, INC. FOR ANY SERVICES PROVIDED TO ME BY DIABETES & ENDOCRINOLOGY ASSOCIATES, INC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

Medical History

Reason for Visit

Injuries Related to Visit

Existing Symptoms Checklist

CONSTITUTIONAL	☐ Allergies	☐ Abdominal Pain	☐ Rash OR Mole Change	BLOOD / LYMPHATIC
☐ Fevers, Chills OR Sweats	CARDIOVASCULAR	☐ Blood in Stool	NEUROLOGICAL	☐ Unexplained Lumps
☐ Weight Loss / Gain	☐ Chest Pain OR Discomfort	☐ Nausea,Vomiting,Diarrhea	☐ Headaches OR Migraines	☐ Easy Bruising OR Bleeding
☐ Change in Energy	☐ Palpitations	GENITOURINARY	☐ Dizziness	REPRODUCTIVE
☐ Excessive Thirst / Urination	MAMMARY	☐ Nighttime Urinary / Nocturia	☐ Numbness	☐ Sexual Malfunctions
EYES	☐ Breast Lumps	☐ Urinary Incontinence	☐ Memory Loss	OTHER
☐ Change in Vision	☐ Nipple Discharge / Leakage	☐ Unusual Vaginal Bleeding	☐ Loss of Coordination	
ENT & MOUTH	RESPIRATORY	☐ Vaginal / Penile Discharge	PSYCHIATRIC	
☐ Difficulty Hearing	☐ Cough OR Wheeze	MUSCULOSKELETAL	☐ Anxiety OR Stress	
☐ Ringing in Ears	☐ Difficulty Breathing	☐ Muscle OR Joint Pain	☐ Sleep Issues	
☐ Teeth / Gum Problems	GASTROINTESTINAL	SKIN	☐ Depression	

Medications – ALL medications (prescriptions AND over-the-counter), supplements, etc.

☐ No Medications

PRE-PRINTED & UP-TO-DATE MEDICATION LISTS ARE ACCEPTABLE

Medication Name	Dosage	Frequency

Medication & Food Allergies – ALL known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Medications / Drugs	Food	Miscellaneous (Animal, Latex, Etc.)

Medical History (continued)

Current OR Previously Existing Medical Conditions

☐ Adrenal Disorder	☐ Depression / Suicide Attempt	☐ Irritable Bowel Disease	☐ Pituitary Disease
☐ Anemia	☐ Diabetes	☐ Infectious Disease	☐ Peptic Ulcer Disease
☐ Anxiety	☐ Gallbladder Disease	☐ Liver Disease	☐ Renal Disease
☐ Arthritis	☐ GERD	☐ Metabolic Disease	☐ Seizure Disorder
☐ Asthma	☐ Growth Disorder	☐ Migraines / Headaches	☐ Stroke
☐ Blood Clots	☐ Hepatitis	☐ Myocardial Infarction	☐ Thyroid Disease
☐ Coronary Artery Disease	☐ High Cholesterol	☐ Osteoarthritis	☐ Thyroid Nodules or Goiter
☐ COPD	☐ Hyperlipidemia	☐ Osteoporosis	Other:
☐ Crohn's Disease	☐ Hypertension	☐ Parathyroid Disease	
☐ Dementia	☐ Hypogonadism	☐ PCOS	

Surgical History

Surgical Procedure Name	Date Performed	Surgeon / Performing Physician Name

Family Medical History

☐ Adopted

Medical Condition, Disorder OR Disease	Affected Relative to Patient	Medical Condition, Disorder OR Disease	Affected Relative to Patient

Social History

Tobacco Use
☐ Never ☐ Former, Quit Date:_____ Estimated Use(s) per Day: _____

Tobacco Use Method (if applicable)
☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless

Alcohol Use
☐ Never ☐ Former, Quit Date:_____ Estimated Use(s) per Day: _____

Alcohol Use Method (if applicable)
☐ Beer ☐ Wine ☐ Liquor ☐ Other:_____

Caffeine Use
☐ Never ☐ Former, Quit Date:_____ Estimated Use(s) per Day: _____

Caffeine Use Method (if applicable)
☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets

Recreational Drug Use
☐ Never ☐ Former, Quit Date:_____ ☐ Occasionally ☐ Frequently ☐ Everyday

Recreational Drug(s) Used (if applicable)

Exercise Activity
☐ Never Estimated Exercise Sessions per Week: _____ Estimated Minutes per Session: _____

Types of Exercise(s) (check all that apply)
☐ Aerobic ☐ Strength ☐ Balance ☐ Flexibility

Sun / UV Protection
☐ Never ☐ Occasionally ☐ Frequently ☐ Always

Seat belt Use
☐ Never ☐ Occasionally ☐ Frequently ☐ Always

Tattoo(s) Quantity

Piercing(s) Quantity

Have you ever been a victim of physical abuse?
☐ Never ☐ Yes, Previously ☐ Yes, Currently

Have you ever been a victim of domestic abuse?
☐ Never ☐ Yes, Previously ☐ Yes, Currently

Do you have a history of drug abuse or dependency?
☐ Yes ☐ No

Miscellaneous

Reactions to Anesthetics
☐ No ☐ Yes → Explain: _____

Increased Bleeding Tendencies
☐ No ☐ Yes → Explain: _____

Previously Received Blood Donation OR Transfusion
☐ Yes ☐ No

Previously Treated for Mental Disorder(s)
☐ No ☐ Yes → Explain: _____

History of Scarring
☐ No ☐ Yes → Location: _____

Possibility of Pregnancy (*women only*)
☐ Yes ☐ No → Last Menstrual Period: _____

I, *the undersigned*, hereby certify that (1) the previously entered information is true and correct to the best of my knowledge. I understand (2) that the extent of my care, access and restrictions to my *Protected Health Information* <u>*MAY*</u> depend on some of this information. Furthermore, (3) I have had any questions with respect to these forms answered to my full satisfaction.

_____ _____

PRINTED Name of Patient or Legal Representative of Patient | Date

_____ _____

SIGNATURE of Patient or Legal Representative of Patient | Relationship to Patient or Legal Authority

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DIABETES & ENDOCRINOLOGY ASSOCIATES, INC. MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Diabetes & Endocrinology Associates, Inc. is required by law to maintain the privacy of your *Protected Health Information*. This information consists of ALL records related to your health, including demographic information, either created by Diabetes & Endocrinology Associates, Inc. or received by Diabetes & Endocrinology Associates, Inc. from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your *Protected Health Information*. These legal duties and privacy practices are described in this *Notice*. Diabetes & Endocrinology Associates, Inc. will abide by the terms of this *Notice*, or the *Notice* currently in effect at the time of the use or disclosure of your *Protected Health Information*.[1]

Diabetes & Endocrinology Associates, Inc. reserves the right to change the terms of this *Notice* and to make any new provisions effective for all *Protected Health Information* that we maintain. Patients will be provided a copy of any revised *Notices* upon request. An individual may obtain a copy of the current *Notice* from our office at any time.

Uses and Disclosures of your *Protected Health Information* not requiring your consent

Diabetes & Endocrinology Associates, Inc. may use and disclose your *Protected Health Information* without your written consent or authorization for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

→ For example; Diabetes & Endocrinology Associates, Inc. may determine that you require the services of a specialist. In referring you to another doctor, Diabetes & Endocrinology Associates, Inc. may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Diabetes & Endocrinology Associates, Inc. to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtain pre-certification and pre-authorization of services to be provided to you.

→ For example; Diabetes & Endocrinology Associates, Inc. will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review legal services, and auditing functions.

→ For example; Diabetes & Endocrinology Associates, Inc. may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Diabetes & Endocrinology Associates, Inc. may contact you by telephone or mail to provide appointment reminders. You must notify use if you do not wish to receive appointment reminders.

We may not disclose your *Protected Health Information* to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations where Diabetes & Endocrinology Associates, Inc. is permitted or required to use or disclose your *Protected Health Information* without your consent or authorization. Examples include the following:

- *As permitted or required by law*
  In certain circumstances we may be required to report *Protected Health Information* to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as the result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- *For public health activities*
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.
  We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food & Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protected the patient or community from imminent and substantial danger.

1 This *Notice* is prepared in accordance with the Health Insurance Portability & Accountability Act, 45 C. F. R. 164.520

- *For health oversight activities*
  We may disclose healthcare records, including treatment records, in response to a written request by any federal state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.
- *Judicial and administrative proceedings*
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of ALL healthcare records except for HIV test results.
- *For activities related to death*
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.
- *For research*
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- *To avoid a serious threat to health or safety*
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.
- *For workers' compensation*
  We may disclose your health information to the extent that such records are reasonably related to any injury for which workers' compensation is claimed.

Diabetes & Endocrinology Associates, Inc. will not make any other use or disclosure of your *Protected Health Information* without your written authorization. You may revoke such authorization at any time, except to the extent that Diabetes & Endocrinology Associates, Inc. has taken action in reliance thereon. Any revocation must be in writing.

Your rights regarding your *Protected Health Information*
You are permitted to request that restrictions be placed on certain uses of disclosures of your *Protected Health Information* by Diabetes & Endocrinology Associates, Inc. to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your *Protected Health Information* is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and / or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Diabetes & Endocrinology Associates, Inc. may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Diabetes & Endocrinology Associates, Inc. send *Protected Health Information*, including billing information, to you by alternative means or to alternative locations. You may also request that Diabetes & Endocrinology Associates, Inc. not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Diabetes & Endocrinology Associates, Inc. amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your *Protected Health Information* made by Diabetes & Endocrinology Associates, Inc. for the 6 (SIX) years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this *Notice*, if you had previously received or agreed to receive the *Notice* electronically.

Any person or patient may file a complaint with Diabetes & Endocrinology Associates, Inc. and / or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Diabetes & Endocrinology Associates, Inc., please contact the Privacy Officer at the following:

ManChin Chang, M.D.
Diabetes & Endocrinology Associates, Inc.
100 Highland Avenue, Suite 203
Providence, Rhode Island 02906-2752

It is the policy of Diabetes & Endocrinology Associates, Inc. that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards. **This Notice of Privacy Practices is effective April 14, 2003; last updated October 18, 2017.**

Diabetes & Endocrinology Associates, Inc.
Acknowledgment of Receipt of Notice of Privacy Practices

I, the undersigned, acknowledge that I have received a copy of Diabetes & Endocrinology Associates, Inc.'s ***NOTICE OF PRIVACY PRACTICES.*** This notice describes how Diabetes & Endocrinology Associates, Inc. may use and disclose my *Protected Health Information*, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my *Protected Health Information.*

_____ _____

PRINTED Name of Patient or Legal Representative of Patient | Date of Birth | Date

_____ _____

SIGNATURE of Patient or Legal Representative of Patient | Relationship to Patient or Legal Authority