Advanced Diabetes & Endocrine Medical Center, P.A.

The Bridge to Better Health!!!

PATIENT REGISTRATION FORM

Primary Care Physician ______________________ ***Referring Physician*** ______________________________

Patient's Name: (Last)_________________________(First)___________________ (Middle)___________
Address:____Marital Status: S / M / D / W
City/State/Zip:_________________________________ Email: ____________________________________
Social Security: _______/_________/___________ Male / Female DOB: ______/______/_______
Home Phone:________________ Cell:____________________ Work:__________________________
Emergency Contact: Phone: Relationship:

INSURANCE INFORMATION

Primary Insurance:______________________________ ID#: ____________________________________
Primary Holder Name: DOB: / / Relationship:

Secondary Insurance:______________________________ ID#: __________________________________
Primary Holder Name: DOB: / / Relationship

PHARMACY INFORMATION

Preferred Pharmacy Name: _________________________ Zip: _________ Ph: ______________________
Secondary Pharmacy Name : Zip: Ph:

STATEMENT OF FINANCIAL RESPONSIBILITY

As a courtesy, we will file our charges for you with your health insurance carrier(s). By law, insurance carriers are required to pay their portion of the claim within 45 days after services/devices(s) have been delivered. Unpaid balances after that date will automatically become your responsibility. **If we don't accept your secondary insurance, you will be responsible for balance**. A statement will be mailed to you and payment is expected upon receipt. Your health insurance is a contract between you and your insurance company. Coverage cannot be guaranteed. You will need to contact your carrier with any problems or questions. **Should your account be turned over to a collection agency, your unpaid balance will be listed on your consumer credit report, and you will be responsible for balance due in addition to all collection fees in the amount of 33.33%, attorney fees, court cost and any other fees incurred.** INITIAL: __________

RELEASE OF MEDICAL INFORMATION

I hereby consent and authorize Advanced Diabetes & Endocrine Medical Center to release any and all information in my medical records to my Physician for continuity of care and to my Health Insurance Carrier for services provided in order to process medical claims. INITIAL: _________

I agree that all the information provided above is true and accurate. I also agree that all the above posted office financial agreements and that all provisions noted above are accepted and will be honored at my request and authorization.

Signed: Date:

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This notice is being provided to you as part of our compliance with the federal regulation which falls under the HIPAA (Health Insurance Portability and Accountability Act) rules.

Here at ADEMC, we understand that your medical information is personal to you. We are committed to protecting this information.
This notice of privacy practice describes how medical information about you may be used and disclosure and how we can get access to this information.

We are required by law to abide by the terms of this notice of privacy practices. The following is a condensed version of our notice of privacy notice.
Here are few examples of the different ways we will use and disclose medical information about you:

* Medical Treatment	* Emergency situations	* Payment
* Health Care Operations	* Public health risks	* Research
* Communications barriers	* Appointment reminders	* Organ donation
* Law enforcement	* Abuse or neglect	* Lawsuits

You have the right to:

- ❖ Inspect and copy your protected health information.
- ❖ Request a restriction of your protected health information.
- ❖ Request to receive confidential communications from us by alternative means or an alternative location.
- ❖ Have your physician amend your protected health information.
- ❖ Obtain a paper copy of this notice.

You may file a complaint with our office if you believe that your privacy rights have been violated, all complains must be submitted in writing.

____________________________________ ____________________
Print patient name/personal representative Date

____
Signature

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No Show Policy

I understand there is a $50.00 fail to show fee if I do not show up and do not call, or if appointment is not cancelled within 24-hours notice of the scheduled time. INITIAL: _____

Cancellation Policy

All re-scheduled appointments are still considered as a cancellation. I have been informed that 2 cancellations /re-scheduled appointments in a row will result in a pre-discharge. If 3 cancellations/re-scheduled appointments are done in a row or if you have a cancellation followed by a no show, or vise versa, it will result in a discharge from practice. INITIAL: _____

Prescriptions/Lab Orders

Prescriptions or refills should be requested during your visit. If for any reason you are in need of a refill contact your pharmacy and have them fax over a refill request. Please allow 48-72 hours for this process. Prescriptions will not be authorized if appointments are not kept. If for any reason a request for replacement of any order(s) we reserve the right for a processing fee of $10.00. INITIAL: _____

Telephone Calls

Patients are welcome to call with any questions they may have on medical problems. However, it would be most unfair to our patients, if the doctor were to answer every phone call. The office staff has been trained to answer many of your concerns. They will also relay your information to the doctor and your call will be returned at the earliest opportunity by a staff member. If you need to contact the physician on call after office hours, leave a message and your call will be returned at the earliest opportunity. INITIAL: _____

Emergencies

In the event of a severe situation, or one in which you are in doubt, go immediately to the Emergency Room of the nearest hospital. If the situation is not that severe, but one where you wish to contact the doctor, please call the office and the doctor will get in touch with you through the office staff to give you instructions on how best to handle your emergency. INITIAL: _____

______________________________ ______________________

Print patient name Date

____

Signature

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MEDICAL RECORD RELEASE FORM

Patient Name: ________________________________ D.O.B. __________

Release Information to:
Rita Y. Rahbany, M.D.
Phone Number: 407-673-4600
Fax: 407-673-4601

From: (Dr) ____

_____ Entire Record (lab results, radiology reports and medication list)

_____ Most recent lab results/radiology reports/office notes

I give special permission to release information regarding:
________ Substance abuse
________ Psychiatric/Psychological health information
________ HIV test and information

Signed: ___________________________ Witness: ____________________
(If not patient, state relationship)

Fax to: ___________________________ Date: _______________________

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Authorization To Release Information

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we must have your signed permission to leave any information with anyone other than you.

If you would like us to discuss your medical information with any person other than yourself, or give that person medical information, you must designate that person or persons below:

1. ______________________________ Relationship ____________________
2. ______________________________ Relationship ____________________
3. ______________________________ Relationship ____________________

Would you like us to leave information about your future appointments on your answering machine?

☐ YES ☐ NO

Signature: ______________________________ Date: ____________________

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Patient Name ______________________________ **D.O.B.** ____________

Y N

Constitutional
- ○ ○ Chills
- ○ ○ fatigue
- ○ ○ fever
- ○ ○ night sweats
- ○ ○ weight gain(unintentional)
- ○ ○ weight loss(unintentional)

Eyes
- ○ ○ blurred/double vision
- ○ ○ glasses/contacts
- ○ ○ sensitivity to light

Ears/Nose/Throat
- ○ ○ nose bleeding
- ○ ○ hoarseness
- ○ ○ thrush

Cardiovascular
- ○ ○ chest pain
- ○ ○ claudication
- ○ ○ dizziness
- ○ ○ palpitations
- ○ ○ leg swelling
- ○ ○ tachycardia
- ○ ○ varicose veins

Gastrointestinal
- ○ ○ abdominal pain
- ○ ○ difficulty swallowing
- ○ ○ constipation
- ○ ○ diarrhea
- ○ ○ heartburn
- ○ ○ hemorrhoids
- ○ ○ nausea
- ○ ○ vomiting

Hematologic/Lymphatic
- ○ ○ easy bruising
- ○ ○ excessive bleeding
- ○ ○ hx blood transfusion

Genitourinary
- ○ ○ blood in urine
- ○ ○ irregular menstrual period
- ○ ○ frequent urination
- ○ ○ urinary incontinence
- ○ ○ erectile dysfunction

Y N

Respiratory
- ○ ○ shortness of breath
- ○ ○ exposure to TB
- ○ ○ wheezing

Musculoskeletal
- ○ ○ joint pain
- ○ ○ back pain
- ○ ○ join stiffness
- ○ ○ muscle pain

Integumentary/Breast
- ○ ○ acne
- ○ ○ dry skin
- ○ ○ nail fungus
- ○ ○ pruritis (itching)
- ○ ○ rashes
- ○ ○ breast tenderness
- ○ ○ nipple discharge

Neurological
- ○ ○ dizziness
- ○ ○ fainting
- ○ ○ memory loss
- ○ ○ tremor
- ○ ○ weakness

Endocrine
- ○ ○ enlarged hands/feet
- ○ ○ hair loss
- ○ ○ heat/cold intolerance
- ○ ○ hot flashes
- ○ ○ excessive hair growth
- ○ ○ infertility
- ○ ○ excessive sweating

Psychiatric
- ○ ○ anxiety
- ○ ○ depression
- ○ ○ mood swing
- ○ ○ poor concentration

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Rita Y. Rahbany, M.D.
Fax: 407-673-4601
Phone Number: 407-673-4600

Medication List

Name: ________________________________ **D.O.B.** __________________

******REQUIRED: List all medications you are currently taking******

	Medication Name	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			