



Diabetes and Endocrinology Consultants of Pennsylvania, LLC (DEC-PA LLC)

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Please complete **ALL** forms and bring to your first appointment or visit our website www.dec-pa.com to download and print them.

1. Patient Demographic + Consent Form
2. Medical History Form
3. E-Mail Communication Consent Form
4. Telemedicine/Telehealth Consent Form
5. Office Financial Policy

You will also need to bring:

- A valid **Photo ID** (driver's license etc.)
- Your most current **Health Insurance cards**
- Your most recent **Tests/Laboratory results**
- **Glucose meter/Insulin pump** (for patients with Diabetes)
- Your most current **Medication list**
- Any **Medical Reports** you would like included in your file
- **Referral** if required by your insurance (it is the patient's responsibility to request a valid referral prior to the visit)

A valid **credit card** is required to reserve your first consultation. Personal checks are not accepted on the first visit and payment may only be made by cash, money order or a major credit card (Visa, MC, Discover, Amex +4%).

We dedicate 45 minutes to 1 hour for your first consultation. To avoid a missed/no show charge, we require notification of any change or cancellation at least **48 business hours (2 business days)** in advance of your scheduled in-person or telemedicine appointment.

Please carefully read our enclosed Financial Policy and contact our Billing manager with any questions.

Please contact our office during our normal business hours (Mon-Thurs 9-4, Fri-hours vary) to schedule your in-person or telemedicine appointment. For questions regarding our office policies, billing, or prescription refills (3 business days turnaround time), please contact us via our Patient Portal.

We welcome you to our practice and look forward to meeting you.

*Thank you,
DEC-PA, LLC Staff*

NEW PATIENT DEMOGRAPHIC FORM + CONSENT FORM (2 pages)

(Please Print Clearly and answer all)

Date: _____ Name: _____ Date of Birth ___/___/___

Last First Middle Initial

Address: _____

Sex: Male / Female Marital Status: Single Married Widowed Divorced

Social Security #: _____ E-mail Address: _____@_____

Phone #: Home: _____ Cell: _____ Work: _____ Ext: _____

Patient Occupation: _____ Employer Name: _____

Employer Address: _____ Phone: _____ Ext: _____

Guarantor/Responsible Party: (Spouse, Child, Power of Attorney) If same as above, write same

Name: _____

Last First MI Relationship to Patient

Date of Birth: ___/___/___ Guarantor Social Security #: _____

Address of Guarantor: _____ Phone#: _____

Spouse Name: _____ Date of Birth: ___/___/___ Spouse SS#: _____

Spouse Occupation: _____ Employer Name: _____

Employer Address: _____ Phone: _____ Ext: _____

Name of Referring Physician: _____ Phone: _____ Fax: _____

Address: _____

Emergency Contact Name: _____ Relationship: _____

Phone: Home: _____ Cell: _____ Work: _____

Insurance Information:

Primary Insurance: _____ Phone # _____ Referral needed (Y / N)

Subscriber/Cardholder Name _____ DOB ____/____/____

Relationship to Patient _____ Policy # _____ Group # _____

Secondary Insurance: _____ Phone # _____

Subscriber/Cardholder Name _____ DOB ____/____/____

Relationship to Patient _____ Policy # _____ Group # _____

Pharmacy Information:

Prescription Plan Name: _____ Policy #: _____

Pharmacy Name: _____ Phone # _____

Pharmacy Address: _____ Fax: _____

CONSENT TO TREAT - I (or my legal guardian or parent) request and consent to the performance of such service, procedures and medical treatment by *DEC-PA LLC* as the practice may believe to be necessary, advisable or beneficial to my health or the health of _____ of whom I am a legally authorized representative. This consent extends to the physician and other health care providers engaged by *DEC-PA LLC*, who may provide services connected to my care. I recognize and agree that practice of medicine is not an exact science and hence *DEC-PA LLC* can make no guarantee as to the results of its evaluation or treatments.

As per our Notice of Privacy Practices, we may disclose your protected health information to someone involved in your care or for payment of your care, such as a spouse, family member, or close friend. Please designate your Patient Representative(s):

Print Name Signature Date

Print Name Relationship to Patient Representative Home Phone # Cell Phone#

MEDICAL HISTORY FORM (2 pages)

NAME: _____ **DOB** _____

WHAT IS THE MAIN PURPOSE OF COMING TO OUR OFFICE TODAY? PLEASE CHECK ALL THAT APPLY.

Diabetes: Type__ Duration__(years/months)

Any Complications? Nerve__ Circulation __ Eye __ Kidney __ Stomach__ Erectile Dysfunction__

Thyroid: Overactive__ Underactive__ Nodule(s) __ Cancer__ Surgery__

Pituitary Disorder____ **Adrenal Disorder**____ **High Cholesterol/Triglycerides**____

Calcium Disorder: High__ Low__ Osteoporosis__ Fracture(s) (Y/N, which bone)____

High Blood Pressure__ **Alcohol/Drug Addiction**__ **HIV/AIDS**__

Kidney Disorder: Stone____ (date, type); Dialysis__(type, duration); Other__

Heart Disease: Heart Attack__ Congestive Heart Failure__ Irregular Heart Rhythm__ Valve Problem__ Angioplasty__
Stent__ Bypass surgery__ Other Heart Surgery__(date)

Cancer: Breast____ (date, side) Colon__ Prostate__ Lung__ Testicular__ Other__(date)

Blood Problem: Anemia__ Platelets (low/high) __ Leukemia__ Other__

Arthritis: Osteo__ Rheumatoid__ Lupus__ Gout__ Psoriasis__ Scleroderma __ Other__
Disc Problem__ (upper/mid/lower back)

Gastro-Intestinal: Reflux__ Gall Bladder__ Crohn's__ Ulcerative Colitis__ IBS__ Celiac Dz__ Other__

Lungs: Asthma__ : Bronchitis/Emphysema__ Nodule(s)__ Interstitial Lung Disease__ Blood clot__

Neuro: Headache/Migraine__ Dementia/Alzheimer's__ Multiple Sclerosis__ Seizure__ Stroke__ Parkinson's Disease__
Other__

Psychiatric Condition: Depression__ Anxiety__ Bipolar__ Schizophrenia__ Other__

Women's Issue: Irregular Menses__ No Menses__ Breast Discharge__ Excessive Hair Growth__
Pregnancy__(weeks/months)

Men's Issue: ED__ Muscle Wasting__ Lack of Libido__ Loss of Body Hair__ Enlarged Prostate__

Weight Issues: Overweight__ Sleep Disorder__ Weight loss__

Surgeries w Date(s):

▮ SURGERIES: ____ / DATES _____

OTHER ISSUES _____

PLEASE LIST ALL PHYSICIANS AND THEIR PHONE #, SEEN IN THE PAST/PRESENT.

FAMILY / PRIMARY CARE PHYSICIAN: _____ PHONE _____ FAX _____
REFERRING PHYSICIAN _____ PHONE _____ FAX _____
OTHER PHYSICIAN _____ PHONE _____ FAX _____
ALL PHYSICIANS SEEN IN THE PAST TWO YEARS WITH PHONE AND FAX NUMBERS
_____ PHONE _____ FAX _____
_____ PHONE _____ FAX _____
_____ PHONE _____ FAX _____
_____ PHONE _____ FAX _____

PLEASE LIST ALL HOSPITALIZATIONS / ACCIDENTS / PRIOR TRAUMA / OTHER RELAVANT INFORMATION BELOW WITH DATES:

DO YOU HAVE ANY ALLERGIES? NO () YES () _____
DO YOU HAVE ANY DIET RESTRICTIONS? NO () YES () _____
DO YOU USE A METER TO CHECK YOUR BLOOD SUGAR NO () YES () _____
INSULIN PUMP TYPE _____
WHAT IS THE MAIN PURPOSE OF COMING TO OUR OFFICE TODAY? (IF YOU HAVE A COMPLAINT, INDICATE HOW LONG IT HAS BEEN PRESENT, WHAT IT FEELS, WHAT MAKES IT BETTER OR WORSE AND WHAT YOU ARE CONCERNED THE PROBLEM MIGHT BE) _____

WHAT DO YOU DO FOR EXCERCISE? _____
FOR HOW LONG? _____ HOW OFTEN? _____

DO YOU SMOKE OR CHEW TOBACCO? _____ IF YES, HOW MUCH PER DAY? _____
DO YOU USE ANY RECREATIONAL DRUGS? NAME _____

HOW MUCH ALCOHOL DO YOU CONSUME PER WEEK? _____
HOW MUCH CAFFEINE DO YOU CONSUME PER DAY? (I.E. COFFEE, TEA, CHOCOLATE, SODA) _____
HOW MANY MEALS DO YOU HAVE A DAY? _____ OCCUPATION _____ PERSON YOU LIVE WITH _____

PLEASE LIST ALL MEDICATION(S) YOU ARE CURRENTLY TAKING (NAME, DOSAGE AND PRESCRIBING PHYSICIAN) BELOW:

DRUG NAME	DOSAGE	DOCTOR NAME
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____

FORM COMPLETED BY: _____ DATE: _____

E-Mail Communication Consent Form

Patient Name: _____ Date of Birth: _____

Patient E-mail Address: _____

If you elect to use e-mail to communicate with us, DEC-PA, LLC cannot guarantee the security and confidentiality of e-mail transmissions.

We cannot be responsible for misaddressed, misdelivered, or interrupted e-mail or liable for breaches of confidentiality caused by yourself or a third party.

- Use E-mail for routine matters and simple questions.
- Do Not use e-mail for **urgent** or **emergency** situations or for **time sensitive issues** which require an immediate response-contact us by phone or via our Patient Portal.
- Do Not use e-mail for communicating sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse.
- We will attempt to read and respond promptly to your e-mail, but cannot guarantee that your e-mails will be read and responded to within a particular amount of time.
- Please include your full name, birthdate, and telephone number in all e-mails and the subject of your e-mail in the "Subject" line of your message.
- Your provider may forward your e-mail to other staff members as necessary for response. Emails regarding diagnosis or treatment may be made part of your permanent health record.
- To prevent the introduction of computer viruses into our system, do not send attachments to us in your e-mail.
- You are responsible for protecting your password or other means of access to e-mail.

Signature of Patient/Legal Guardian: _____

Print Patient Name/Legal Guardian: _____

Date: _____

DEC-PA, LLC Telemedicine/Telehealth Consent

PATIENT NAME: _____ DATE OF BIRTH: _____

PHYSICIAN NAME: _____ DATE CONSENT OBTAINED: _____

The purpose of this form is to obtain your consent for a Telehealth visit with the physician at DEC-PA, LLC. Telehealth is medical care provided by any means other than a face-to-face or in-person visit. During a Telehealth, medical and mental health information is exchanged interactively from one site to another through electronic communications or a technology-assisted format and is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

I understand that...

1. Telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan my coverage and follow DEC-PA's Financial Office Policy.
2. Telehealth may involve electronic communication of my personal medical information to other medical providers who may be in other areas, including out of state.
3. Electronic communication may be used to communicate highly sensitive medical information.
4. All electronic medical communications carry some risks which include but are not limited to:
 - Security protocols may fail, causing a breach of privacy of my personal medical information.
 - Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
 - Information transmitted via telehealth may not be sufficient (e.g., poor resolution of images) and may limit my physician's ability to fully diagnose a condition or disease.
 - Delays in medical evaluation and treatment could occur due to limitations, deficiencies or failures of the equipment used.
 - Lack of access to complete medical records may result in adverse drug interactions, allergic reactions, prescription refills may not be possible, and appointment(s) may need to be rescheduled.
5. I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office. If I do opt out, there may be a delay in receiving in-person services, prescription refills etc. as per changing restrictions.
6. I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
7. My physician is not responsible for breaches of confidentiality caused by an independent third party or by me.
8. Federal and state laws that protect the privacy and confidentiality of medical information also apply to Telemedicine. This includes my right to access my own medical records (and copies of medical records) with applicable fees.
9. Electronic communication should never be used for emergency communications or urgent matters. Emergency communications should be made to the provider's office or to the existing emergency 911 services.

Patient Consent to The Use of Telemedicine

I have read and understood the information provided above regarding Telemedicine, have discussed it with my physician or his designated assistant(s), and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Patient/Legal Representative (circle one) Signature _____

Physician/ Practice staff obtaining Consent:

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician/Practice staff Initial (check one): AC AS NW BK CD

DEC PA LLC Office Financial Policy (2 pages)

We participate with Independence Blue Cross (IBC), Original Medicare & certain Medicare Advantage Plans.

Please have your Photo ID and Insurance Cards at every in-person or telemedicine visit.

- Your Copay/Coinsurance/Deductible are payable at time of service per your plan benefits.
- **Non-participating insurance:** For insurances we do not participate in, payment in full is due at time of service. An itemized receipt may be requested for you to submit to your health plan.
- Personal checks are not accepted on your first office visit. Payment may be made with cash, money order or a valid credit card (Visa, MasterCard, Discover, Amex+4%).
- To avoid additional late fees or rescheduling of your appointment, all office visit fees including copays, coinsurance, deductible, or outstanding balance(s) on your account are due and payable at the time of visit. Postdated checks are not accepted.
- Check(s) returned by the bank for any reason will be assessed a \$35.00 processing fee per check. Payments for continued care will only be accepted in cash, money order or a valid credit card.
- Any adult accompanying a minor is responsible for full payment at the time of the visit. Unaccompanied minors will be denied non-emergency treatment unless charges have been prepaid or pre-authorized in advance to an approved credit card.
- Referral: If your visit requires a referral/prior authorization, it is your responsibility to make sure we have your referral prior to your visit. If there is no valid referral, your appointment may be rescheduled, or you will be responsible for full payment of your visit at time of service.
- Medical Records: Pre-payment of State approved fees and a signed HIPAA authorization release form will be required for processing and release of any medical records, copies of lab results, or any form which requires the Doctor's signature (disability, long-term insurance, etc.). Please allow 7-10 business days for preparation and duplication.
- *Appointments are confirmed as a **courtesy** only. There will be a charge for a cancelled or missed in person or telemedicine appointment unless we receive advance notice of at least 48 hours (2 business days).*
- *3 visits missed without a valid reason may result in dismissal from our practice.*

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- ***I have read and fully understand the Financial Policy of DEC PA LLC.***
 - **I hereby authorize DEC PA LLC to release any medical information to my insurance carrier necessary to process my claims. I authorize direct payment of medical benefits to this provider for charges not paid in full by myself.**
 - **I understand that I am financially responsible for all charges for medical services rendered to me or my legal dependent, regardless of insurance coverage and/or payment.**
 - **I understand that should my account be placed in Bad Debt/Collections, I will be responsible for all collection costs, including court costs and reasonable attorney fees.**

Signature of Patient, Legal Guardian, or Personal Representative

Date

Print Patient Name, Legal Guardian, or Personal Representative

Date

Medicare Patients

We participate with **Original Medicare** and certain **Medicare Advantage Plans (MA)**.

Please contact our Billing Manager regarding your specific insurance health plan.

- **Original Medicare:** At time of your visit, you will be expected to pay any unmet portion of your annual Medicare Deductible and your 20% Medicare Coinsurance if not covered directly to our office by a secondary or supplemental insurance.
- **Medicare Advantage Plans:** At time of your visit, you will be expected to pay your Copay/Coinsurance/Deductible or Medicare Allowed Amount as per your plan benefits.

Please have with you all your Medicare and Secondary Insurance cards at every appointment.

As per Federal Regulations, please check applicable items and sign below:

I am: employed unemployed retired disabled

I am 65 years of age or older and am covered by an Employer Group Health Plan (EGHP) through my own employer or that of my spouse.

I am under 65 years of age and covered by Medicare due to disability.

I am entitled to Medicare coverage due to End Stage Renal Disease.

I am currently receiving Worker's Compensation Benefits

I am covered through the Federal Black Lung Program

I am covered by the Veterans' Administration Program

I am currently receiving benefits due to No fault or Liability Case (i.e., Automobile Accident)

Medicare Identification # (Health Insurance Claim Number) _____

Name/Address of Secondary Insurance: _____

Subscriber Name _____ Relationship to patient: _____

Subscriber Social Security # _____ Date of Birth: _____

Policy# _____ Group# _____

PLEASE READ AND SIGN: I certify this information is true and complete to the best of my knowledge. I request that payment of authorized Medicare/Medigap/Medicare Advantage Plan Benefits be made either to me or on my behalf to DECPA LLC for any services furnished to me by this provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services/Medigap/Medicare Advantage Insurer, and their agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient/Beneficiary, Legal Guardian/Personal Representative

Date

Print Name Patient/Beneficiary/Legal Guardian/Personal Representative and Relationship to patient