

# DIABETES THYROID & ENDOCRINE ADVANCED CARE

2802 Aloma Ave. • Suite 101 • Winter Park, FL • 32792

## PATIENT INFORMATION

*Please answer all question fully*

### PATIENT

|                 |            |    |                 |                |          |
|-----------------|------------|----|-----------------|----------------|----------|
| Last Name       | First Name | MI | Social Security | Birth Date     | Sex      |
| Mailing Address |            |    | City            | State          | Zip Code |
| Home #          | Work #     |    |                 | Marital Status |          |
| Email           |            |    | Ethnicity       |                |          |
| Employer        |            |    | City            | State          | Zip Code |

### RESPONSIBLE PARTY OR POLICY HOLDER (Please indicate which one)

|                 |            |    |                 |                |          |
|-----------------|------------|----|-----------------|----------------|----------|
| Last Name       | First Name | MI | Social Security | Birth Date     | Sex      |
| Mailing Address |            |    | City            | State          | Zip Code |
| Home #          | Work #     |    |                 | Marital Status |          |
| Email           |            |    | Ethnicity       |                |          |
| Employer        |            |    | City            | State          | Zip Code |

|                     |                        |
|---------------------|------------------------|
| Referring Physician | Primary Care Physician |
|---------------------|------------------------|

### INSURANCE

|                   |                   |                         |
|-------------------|-------------------|-------------------------|
| Primary Insurance | Subscriber's Name | Policy and Group Number |
| Primary Insurance | Subscriber's Name | Policy and Group Number |

### Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to provide insurance claims to insurance companies of their agencies (including Medicare), for purpose of filing and payment of receive claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR FEE, ATE THE PROVIDE CURRENT RATE, MAY BE CHARGE on all balances owing to the provider that are past due.

|            |       |
|------------|-------|
| Signature: | Date: |
|------------|-------|

## **Diabetes Thyroid & Endocrine Advanced Care (DTEAC)**

### **Our Financial Policy**

Thank you for choosing us as your endocrine specialist. We are committed to providing you with the best medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

- All patients must complete our information and insurance from before seeing the doctor.
- Full payment is due at the time of service.
- We accept cash, checks or Visa / Master Card / American Express credit cards.
- Returned checks are subject to a \$29.00 service charge.

#### **Healthcare Insurance Plan Obligation:**

Diabetes Thyroid & Endocrine maintains a list of the health care services plans. We have agreed to bill those insurances carriers for services rendered. Authorization from your insurance does not always guarantee payment. The person responsible and our patient shall remain responsible for all the charges, applicable copayment and deductibles. If insurance has not responded to our claims submittal within 60 days, payment for services incurred claim status follow up with the insurance carrier becomes the patient responsibility.

#### **Non-participating Insurance:**

All fees are due in full at the time of service. A receipt is provided which details all services and pay for the visit. A copy of the receipt can be submitted to your insurance carrier for payment.

#### **PPO/HMO/MEDICARE/Traditional Insurance waiver regarding non-covered patients:**

Medicare under section 1862 (A) (1) of the Medicare law and some health insurance plans will only pay 80% of the services that determines to be "Reasonable & Necessary". If Medicare determines that the particular services is not reasonable and necessary under the Medicare programs standards; or your insurance determines that a service were unauthorized or not covered benefit under your plan, Medicare and other insurance plan will deny payment for these services. We believe that according to your insurance or Medicare plan, payment is often denied for the following services.

Copies of medical record

- Certain labs tests
- Out of network referrals
- Physical
- Pre-existing conditions
- Walk in work in appointments

The undersigned and or patient understands & agrees to be personally and fully responsible for covered services. Our practice is committed to providing the best treatment for our patients. There is a \$25.00 fee for missed appointments unless cancelled at least 24 hours in advanced. Please let us serve you better by keeping your appointment. Should collections become necessary, the patient would be responsible for all collection cost and attorneys fee. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read this financial policy. I understand and agree to this financial policy.

|                   |              |
|-------------------|--------------|
| <b>Signature:</b> | <b>Date:</b> |
|-------------------|--------------|

## **Diabetes Thyroid & Endocrine Advanced Care (DTEAC)**

### **Appointment Cancellation / No Show Policy *(Cancelación de Citas / Póliza de Ausencia Sin Aviso)***

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment cancellation policy. This policy enables us to better utilize available appointments for our patients in severe pain needing immediate care. *(Nuestro objetivo es proporcionar atención médica de calidad en el momento oportuno. Para hacerlo hemos tenido que implementar una póliza de cancelaciones de citas y una póliza de ausentarse sin aviso. Esta póliza nos permite utilizar mejor el tiempo de las citas disponibles para nuestros pacientes que necesitan atención médica.)*

#### **Cancellation of an Appointment *(Cancelación de Citas)***

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call 24 hours in advance. Your early cancellation will give another person the possibility to have access to timely medical care. *(Con el fin de ser respetuosos de las necesidades médicas de otros pacientes, por favor sea cortés y llame a nuestra oficina de inmediato si usted no puede asistir a una cita. Esta podría ser reasignada a otro paciente que esté con necesidad de tratamiento. Si es necesario cancelar su cita, requerimos que usted llame con 24 horas de anticipación. Su cancelación anticipada dará a otra persona la posibilidad de tener acceso a la atención médica oportuna)*

#### **No Show Policy *(Póliza de Ausencia Sin Aviso)***

A “No Show” is someone who misses an appointment without calling 24 hours in advance to cancel. “No Shows” inconvenience those individuals who need access to medical care in a timely manner, as well as the physician. A failure to show up at the time of a scheduled appointment will be recorded in the patients chart as a “No Show”. Any “No Show” will result in a fee of \$25.00. If a patient accumulates 3 “No Shows”, he or she may be asked to leave the practice. *(Un “No Show” es una persona que pierde una cita sin llamar con 24 horas de anticipación para cancelar. “No Shows” incomodan las personas que necesitan tener acceso a la atención médica de manera oportuna, así como al médico. El hecho de no presentarse a la hora de una cita programada será registrado en el historial clínico del paciente como un “No Show”. Cualquier “No Shows” resultará en un cargo de \$25.00. Si un paciente acumula 3 “No Shows” él o ella se le puede pedir que deje la práctica.)*

#### **Late Cancellations *(Cancelaciones De Última hora)***

Late cancellations will be considered as a “No Show”. Exceptions will be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed as a cancellation fee. *(Cancelaciones de última hora serán consideradas como un “No Show”. Las excepciones se harán solo en circunstancias extraordinarias. Las cancelaciones realizadas con más de 24 horas antes de su cita, no se les aplicarán un cargo por cancelación.)*

If you have any questions regarding this policy, please let one of our staff know and we will gladly help to clarify any questions you may have. We thank you in advance for your cooperation and understanding. *(Si tiene alguna pregunta sobre esta póliza, por favor, déjele saber a uno de nuestros empleados y estaremos encantados de ayudarlo a aclarar cualquier duda que pueda tener al respecto. Le agradecemos de antemano por su cooperación y comprensión.)*

I understand this policy and authorize Diabetes Thyroid & Endocrine Advanced Care to assess cancellation and no show fee according to the above outlined policy. *(Entiendo esta póliza y autorizo a Diabetes Thyroid & Endocrine Advanced Care a evaluar la cancelación y “No Show” de acuerdo con la póliza descrita más arriba.)*

|                   |              |
|-------------------|--------------|
| <b>Signature:</b> | <b>Date:</b> |
|-------------------|--------------|

(Signature of insured or authorized patient or parent of a minor)

**Diabetes Thyroid & Endocrine Advanced Care (DTEAC)**

|                             |                            |    |                                      |
|-----------------------------|----------------------------|----|--------------------------------------|
| Last Name <i>(Apellido)</i> | First Name <i>(Nombre)</i> | MI | Birth Date <i>(Fecha Nacimiento)</i> |
|-----------------------------|----------------------------|----|--------------------------------------|

**Medication List**

*(Lista de Medicamentos)*

| Medication Name<br><i>(Nombre del Medicamento)</i> | Strength/Dosage<br><i>(Dosis)</i> | Direction to use<br><i>(Uso)</i> | Reason<br><i>(Razón)</i> |
|----------------------------------------------------|-----------------------------------|----------------------------------|--------------------------|
| 1.                                                 |                                   |                                  |                          |
| 2.                                                 |                                   |                                  |                          |
| 3.                                                 |                                   |                                  |                          |
| 4.                                                 |                                   |                                  |                          |
| 5.                                                 |                                   |                                  |                          |
| 6.                                                 |                                   |                                  |                          |
| 7.                                                 |                                   |                                  |                          |
| 8.                                                 |                                   |                                  |                          |
| 9.                                                 |                                   |                                  |                          |
| 10.                                                |                                   |                                  |                          |

**Please list any other medications including over the counter medications**

*(Por favor anote cualquier otro medicamento, incluyendo medicamentos de venta libre)*

**Preferred Pharmacy:**

**Surgical Procedures**

*(Procedimientos Quirúrgicos)*

| Surgical Procedure<br><i>(Procedimiento Quirúrgico)</i> | Date<br><i>(Fecha)</i> |
|---------------------------------------------------------|------------------------|
| 1.                                                      |                        |
| 2.                                                      |                        |
| 3.                                                      |                        |
| 4.                                                      |                        |
| 5.                                                      |                        |

|                                                                                        |              |
|----------------------------------------------------------------------------------------|--------------|
| <b>Signature:</b><br>(Signature of insured or authorized patient or parent of a minor) | <b>Date:</b> |
|----------------------------------------------------------------------------------------|--------------|

**Diabetes Thyroid & Endocrine Advanced Care (DTEAC)**

**PLEASE INDICATE THE HEALTH HISTORY OF YOUR FAMILY MEMBERS**

| FAMILY MEMBER<br>(Mother, Father, Sister, Brother, etc.) | GOOD                  | POOR                  | DECEASED              | CAUSE OF DEATH |
|----------------------------------------------------------|-----------------------|-----------------------|-----------------------|----------------|
| 1.                                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |                |
| 2.                                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |                |
| 3.                                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |                |
| 4.                                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |                |
| 5.                                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |                |
| 6.                                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |                |

**PLEASE INDICATE THE HEALTH HISTORY OF YOUR FAMILY MEMBERS**

|                   | <u>ME</u>             | <u>OTHER</u>          |                      | <u>ME</u>             | <u>OTHER</u>          |
|-------------------|-----------------------|-----------------------|----------------------|-----------------------|-----------------------|
| HEART DISEASE     | <input type="radio"/> | <input type="radio"/> | HIGH BLOOD PRESSURE  | <input type="radio"/> | <input type="radio"/> |
| STROKE            | <input type="radio"/> | <input type="radio"/> | CANCER               | <input type="radio"/> | <input type="radio"/> |
| GLAUCOMA          | <input type="radio"/> | <input type="radio"/> | DIABETES             | <input type="radio"/> | <input type="radio"/> |
| THYROID DISEASE   | <input type="radio"/> | <input type="radio"/> | EPILEPSY/CONVULSIONS | <input type="radio"/> | <input type="radio"/> |
| BLEEDING DISORDER | <input type="radio"/> | <input type="radio"/> | KIDNEY DISEASE       | <input type="radio"/> | <input type="radio"/> |
| MENTAL ILLNESS    | <input type="radio"/> | <input type="radio"/> | OSTEOPOROSIS         | <input type="radio"/> | <input type="radio"/> |
| GOUT              | <input type="radio"/> | <input type="radio"/> | HIV/AIDS             | <input type="radio"/> | <input type="radio"/> |
| GI DISORDER       | <input type="radio"/> | <input type="radio"/> | HEPATITIS            | <input type="radio"/> | <input type="radio"/> |
| ANEMIA            | <input type="radio"/> | <input type="radio"/> | ASTHMA               | <input type="radio"/> | <input type="radio"/> |
| DOUBLE VISION     | <input type="radio"/> | <input type="radio"/> | SEXUAL DYSFUNCTION   | <input type="radio"/> | <input type="radio"/> |
| MIGRAINES         | <input type="radio"/> | <input type="radio"/> | DEPRESSION           | <input type="radio"/> | <input type="radio"/> |
| GALLSTONES        | <input type="radio"/> | <input type="radio"/> | DIZZINESS            | <input type="radio"/> | <input type="radio"/> |
| GOITER            | <input type="radio"/> | <input type="radio"/> | LEG PAIN             | <input type="radio"/> | <input type="radio"/> |
| INDIGESTION       | <input type="radio"/> | <input type="radio"/> | CONSTIPATION         | <input type="radio"/> | <input type="radio"/> |
| RECTAL BLENDING   | <input type="radio"/> | <input type="radio"/> | FAINTING SPELLS      | <input type="radio"/> | <input type="radio"/> |
| FORGETFULNESS     | <input type="radio"/> | <input type="radio"/> | HOARSENESS           | <input type="radio"/> | <input type="radio"/> |
| ABDOMINAL PAIN    | <input type="radio"/> | <input type="radio"/> | COLITIS              | <input type="radio"/> | <input type="radio"/> |

|                                                                                        |              |
|----------------------------------------------------------------------------------------|--------------|
| <b>Signature:</b><br>(Signature of insured or authorized patient or parent of a minor) | <b>Date:</b> |
|----------------------------------------------------------------------------------------|--------------|

### **Diabetes Thyroid & Endocrine Advanced Care (DTEAC)**

|                                                                                                                           |                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ETHNICITY:</b><br>(Please chose one)                                                                                   | <b>RACE:</b><br>(Please chose one)                                                                                                                                                                                                                                        |
| <input type="radio"/> Hispanic or Latino<br><input type="radio"/> Not Hispanic or Latino<br><input type="radio"/> Unknown | <input type="radio"/> American Indian or Alaska Native<br><input type="radio"/> Asian<br><input type="radio"/> Black or African American<br><input type="radio"/> Native Hawaiian or Other Pacific Islander<br><input type="radio"/> White<br><input type="radio"/> Other |

|                            |               |
|----------------------------|---------------|
| <b>Preferred Language:</b> | <b>Email:</b> |
|----------------------------|---------------|

#### **ARE YOU ALLERGIC TO ANY MEDICATIONS?**

|                                                                                 |
|---------------------------------------------------------------------------------|
| <input type="radio"/> Yes - Please indicate : _____<br><input type="radio"/> No |
|---------------------------------------------------------------------------------|

#### **PHARMACY INFORMATION FOR ELECTRONIC PRESCRIPTIONS**

|                                                                              |      |         |  |
|------------------------------------------------------------------------------|------|---------|--|
| Pharmacy Name                                                                |      | Phone # |  |
| Address                                                                      | City | State   |  |
| Do You Have A Mail Order? <input type="radio"/> Yes <input type="radio"/> No |      |         |  |
| Which One?                                                                   |      | Phone # |  |

|                                                                                                                             |                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <b>ARE YOU OR WERE YOU A SMOKER?</b><br><input type="radio"/> Yes - How many packs a day? _____<br><input type="radio"/> No | <b>DO YOU DRINK ALCOHOL?</b><br><input type="radio"/> Yes<br><input type="radio"/> No |
|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|

|                                                                                                           |
|-----------------------------------------------------------------------------------------------------------|
| <b>Are you on aspirin or blood thinner (COUMADIN)?</b> <input type="radio"/> Yes <input type="radio"/> No |
|-----------------------------------------------------------------------------------------------------------|

#### **WOMENS**

|                                                                                                        |                                                                                |
|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Day of your last menstrual cycle? _____<br><input type="radio"/> Normal <input type="radio"/> Abnormal | Cramps?<br><input type="radio"/> Yes <input type="radio"/> No     Where: _____ |
|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|

## **Diabetes Thyroid & Endocrine Advanced Care (DTEAC)**

### **Acknowledgment and Consent for Purpose of Treatment, Payment and Healthcare Operations**

In connection with the medical services that I am receiving from Diabetes Thyroid & Endocrine Advanced Care (DTEAC), I hereby authorize the group to disclose any/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

- a. Any third party payer covering medical services of the patient;
- b. Other healthcare professionals and institutions involved in the delivery of health care to the patient;
- c. The proponent of any legally sufficient subpoena or in response to a court order;
- d. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care sendees and payment for such services;
- e. Pharmacies; and
- f. Other parties as otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further acknowledge that I have received a copy of the practice's privacy notice and had an opportunity to ask questions concerning the Notice of Privacy Practices.

|                                                                                            |                      |
|--------------------------------------------------------------------------------------------|----------------------|
| <b>Signature:</b><br><br>(Signature of insured or authorized patient or parent of a minor) | <b>Date:</b><br><br> |
|--------------------------------------------------------------------------------------------|----------------------|

## Diabetes Thyroid & Endocrine Advanced Care (DTEAC)

|                               |                              |    |
|-------------------------------|------------------------------|----|
| Last Name ( <i>Apellido</i> ) | First Name ( <i>Nombre</i> ) | MI |
|-------------------------------|------------------------------|----|

Please check all that apply:

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li><input type="radio"/> Fatigue</li> <li><input type="radio"/> Changes in sleep</li> <li><input type="radio"/> Unexplained weight loss</li> <li><input type="radio"/> Excessive alcohol intake</li> <li><input type="radio"/> Headaches</li> <li><input type="radio"/> Change in goiter</li> <li><input type="radio"/> Trouble swallowing</li> <li><input type="radio"/> Hypertension</li> <li><input type="radio"/> Anorexia</li> <li><input type="radio"/> Vomiting</li> <li><input type="radio"/> Pancreatitis</li> <li><input type="radio"/> Subtotal or total gastrectomy</li> <li><input type="radio"/> Inflammatory bowel disease</li> <li><input type="radio"/> Low body weight</li> <li><input type="radio"/> Polydipsia (excessive thirst)</li> <li><input type="radio"/> Renal insufficiency</li> <li><input type="radio"/> Abnormal menstrual cycle. (____) per year.</li> <li><input type="radio"/> Hair Changes</li> <li><input type="radio"/> Nervousness</li> <li><input type="radio"/> Confusion</li> <li><input type="radio"/> Muscle weakness</li> <li><input type="radio"/> Osteopenia / Osteoporosis</li> <li><input type="radio"/> Previous fracture</li> <li><input type="radio"/> H/O Hypogonadism</li> <li><input type="radio"/> H/O Hyperparathyroidism</li> <li><input type="radio"/> Growth hormone deficiency</li> <li><input type="radio"/> Swelling</li> <li><input type="radio"/> Lymphoma</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Energy Changes</li> <li><input type="radio"/> Unexplained weight gain</li> <li><input type="radio"/> Smoking</li> <li><input type="radio"/> Changes in eyes</li> <li><input type="radio"/> Goiter</li> <li><input type="radio"/> Neck pressure</li> <li><input type="radio"/> Palpitations</li> <li><input type="radio"/> Shortness of breathe</li> <li><input type="radio"/> Nausea</li> <li><input type="radio"/> Constipation</li> <li><input type="radio"/> Peptic ulcer disease</li> <li><input type="radio"/> Malabsorption syndromes</li> <li><input type="radio"/> Cirrhosis</li> <li><input type="radio"/> Polyuria (excessive urination)</li> <li><input type="radio"/> Nephrolithiasis</li> <li><input type="radio"/> Cramps. Where? _____</li> <li><input type="radio"/> Marfan's Syndrome</li> <li><input type="radio"/> Decreased Concentration</li> <li><input type="radio"/> Tremors</li> <li><input type="radio"/> Bone pain</li> <li><input type="radio"/> Rheumatoid arthritis</li> <li><input type="radio"/> Temperature intolerance</li> <li><input type="radio"/> H/O Hyperthyroidism</li> <li><input type="radio"/> Vitamin D deficiency</li> <li><input type="radio"/> Diabetes mellitus</li> <li><input type="radio"/> Multiple myeloma</li> <li><input type="radio"/> Leukemia</li> </ul> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                        |              |
|----------------------------------------------------------------------------------------|--------------|
| <b>Signature:</b><br>(Signature of insured or authorized patient or parent of a minor) | <b>Date:</b> |
|----------------------------------------------------------------------------------------|--------------|

## **Diabetes Thyroid & Endocrine Advanced Care (DTEAC)**

### **Disclosure of Medical Information Form (DMI)**

*(Formulario de Divulgación de la Información Médica)*

|                             |                            |    |                                             |
|-----------------------------|----------------------------|----|---------------------------------------------|
| Last Name <i>(Apellido)</i> | First Name <i>(Nombre)</i> | MI | <b>Birth Date</b> <i>(Fecha Nacimiento)</i> |
|-----------------------------|----------------------------|----|---------------------------------------------|

\_\_\_\_\_ YES – I authorize to release information of my medical status to a family member. *(SI – Autorizo a divulgar información de mi estado de salud a un miembro de la familia).*

\_\_\_\_\_ NO – I do not authorize to release information of my medical status to a family member or anyone else. *(NO – No autorizo a divulgar información de mi estado de salud a un miembro de la familia o cualquier otra persona).*

|                                                                                        |              |
|----------------------------------------------------------------------------------------|--------------|
| <b>Signature:</b><br>(Signature of insured or authorized patient or parent of a minor) | <b>Date:</b> |
|----------------------------------------------------------------------------------------|--------------|

# AUDIT-C QUESTIONNAIRE

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Date of Visit \_\_\_\_\_

1. Within the past year, how often did you have a drink of alcohol?

- ☐ a. Never
- ☐ b. Monthly (e.g. Special occasions/Rare)
- ☐ c. 2-4 times a month (e.g. 1x on weekend - "Fridays only" or "every other Thursday")
- ☐ d. 2-3 times a week (e.g. weekends – Friday-Saturday or Saturday-Sunday)
- ☐ e. 4 or more times a week (e.g. daily or most days/week)

2. Within the past year, how many standard drinks containing alcohol did you have on a typical day?

- ☐ a. 1 or 2
- ☐ b. 3 or 4
- ☐ c. 5 or 6
- ☐ d. 7 to 9
- ☐ e. 10 or more

3. Within the past year, how often did you have six or more drinks on one occasion?

- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

Scoring:

A total of 5+ indicates increasing or higher risk drinking

An overall total score of 5 or above is AUDIT-C positive.

# Social Needs Screening Tool

## HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?<sup>1</sup>  
☐ Yes  
☐ No
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)<sup>2</sup>  
☐ Bug infestation  
☐ Mold  
☐ Lead paint or pipes  
☐ Inadequate heat  
☐ Oven or stove not working  
☐ No or not working smoke detectors  
☐ Water leaks  
☐ None of the above

## FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.<sup>3</sup>  
☐ Often true  
☐ Sometimes true  
☐ Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.<sup>3</sup>  
☐ Often true  
☐ Sometimes true  
☐ Never true

## TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?<sup>1</sup>  
☐ Yes  
☐ No

## UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?<sup>4</sup>  
☐ Yes  
☐ No  
☐ Already shut off

## CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?<sup>5</sup>  
☐ Yes  
☐ No

## EMPLOYMENT

8. Do you have a job?<sup>6</sup>  
☐ Yes  
☐ No

## EDUCATION

9. Do you have a high school degree?<sup>6</sup>  
☐ Yes  
☐ No

## FINANCES

10. How often does this describe you? I don't have enough money to pay my bills.<sup>7</sup>  
☐ Never  
☐ Rarely  
☐ Sometimes  
☐ Often  
☐ Always

## PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?<sup>8</sup>  
☐ Never (1)  
☐ Rarely (2)  
☐ Sometimes (3)  
☐ Fairly often (4)  
☐ Frequently (5)
12. How often does anyone, including family, insult or talk down to you?<sup>8</sup>  
☐ Never (1)  
☐ Rarely (2)  
☐ Sometimes (3)  
☐ Fairly often (4)  
☐ Frequently (5)



13. How often does anyone, including family, threaten you with harm?<sup>a</sup>

- ☐ Never (1)  
☐ Rarely (2)  
☐ Sometimes (3)  
☐ Fairly often (4)  
☐ Frequently (5)

14. How often does anyone, including family, scream or curse at you?<sup>a</sup>

- ☐ Never (1)  
☐ Rarely (2)  
☐ Sometimes (3)  
☐ Fairly often (4)  
☐ Frequently (5)

### ASSISTANCE

15. Would you like help with any of these needs?

- ☐ Yes  
☐ No

### SCORING INSTRUCTIONS:

For the housing, food, transportation, utilities, child care, employment, education, and finances questions: Underlined answers indicate a positive response for a social need for that category.

For the personal safety questions: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.

Sum of questions 11–14: \_\_\_\_\_

Greater than 10 equals positive screen for personal safety.

### REFERENCES

1. [https://www.va.gov/HOMELESS/Universal\\_Screener\\_to\\_Identify\\_Veterans\\_Experiencing\\_Housing\\_Instability\\_2014.pdf](https://www.va.gov/HOMELESS/Universal_Screener_to_Identify_Veterans_Experiencing_Housing_Instability_2014.pdf)
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# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)

|                                                                                                                                                                             | Not at all | Several days | More than half the days | Nearly every day |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------------|-------------------------|------------------|
| 1. Little interest or pleasure in doing things                                                                                                                              | 0          | 1            | 2                       | 3                |
| 2. Feeling down, depressed, or hopeless                                                                                                                                     | 0          | 1            | 2                       | 3                |
| 3. Trouble falling or staying asleep, or sleeping too much                                                                                                                  | 0          | 1            | 2                       | 3                |
| 4. Feeling tired or having little energy                                                                                                                                    | 0          | 1            | 2                       | 3                |
| 5. Poor appetite or overeating                                                                                                                                              | 0          | 1            | 2                       | 3                |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down                                                                          | 0          | 1            | 2                       | 3                |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television                                                                                    | 0          | 1            | 2                       | 3                |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0          | 1            | 2                       | 3                |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way                                                                                            | 0          | 1            | 2                       | 3                |

FOR OFFICE CODING 0 +      +      +     

=Total Score:     

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult  
at all

☐

Somewhat  
difficult

☐

Very  
difficult

☐

Extremely  
difficult

☐