KENTUCKY DIABETES ENDOCRINOLOGY CENTER

1760 Nicholasville Road Suite 502 Lexington, KY 40503
859-278-2232

Lyle Myers, MD Wendell Miers, MD Rebecca Tweardy, PA-C Jacqui Baker, PA-C

Dear:_____

Welcome to our practice. We are looking forward to meeting you and assisting in your medical care.

Your first visit has been scheduled on _____ at _____.

PLEASE ARRIVE 15-20 MINUTES EARLY TO BEGIN THE CHECK-IN PROCESS.

It is not necessary that you fast prior to your appointment. You can expect your visit to take approximately 1 hour. If blood work or any special procedures are required, additional time may be necessary. Please feel free to ask questions.

Complete all the information requested in the enclosed forms prior to your visit and bring them with your driver's license, or other photo identification, and insurance cards. Be sure to answer ALL QUESTIONS on the front and back of each form.

FAILURE TO BE PREPARED WILL RESULT IN DELAYS AND YOU COULD POSSIBLY BE ASKED TO RESCHEDULE.

Please bring all medications you are currently taking and any recent testing or scan reports. If you have any laboratory tests completed in the past 3 months, bring a copy of these lab results at the time of your appointment. You may ask your referring physician to fax the results directly to us at 859-278-1543. If we do not have recent lab results there may be a delay in your visit.

KENTUCKY DIABETES ENDOCRINOLOGY CENTER, PSC

Account_____ Date_____

Patient Information

Last Name_____ First Name_____ Middle____

Street Address_____ Apt #_____

City_____ State_____ Zip_____

Home Phone (____)_____ Cell Phone (____)_____ Email_____

Date of Birth_____ Age_____ Sex: () M () F Race: () White () Black () Other

SSN_____ Marital Status: () Single () Married () Divorced () Widow

Employment Status: () Employed () Disabled () Retired Retirement Date_____

Employer_____ Phone# (___) _____

Address_____ City _____

State____ Zip _____Job Title_____ () Full time/ () Part Time

Referring Physician_____ Phone # (____) _____

Emergency Contact_____ Relationship_____

Day Phone (____) _____ Evening Phone (____) _____

Insurance Information

Primary Insurance _____ Employer_____

Policy # _____ Group# _____

Name of insured (as it appears on card) _____ DOB_____

SSN_____ Relationship to patient: () Self () Spouse () Parent () Guardian

Secondary Insurance _____ Employer_____

Policy # _____ Group# _____

Name of insured (as it appears on card) _____ DOB_____

SSN_____ Relationship to patient: () Self () Spouse () Parent () Guardian

Third Insurance _____ Employer _____

Policy # _____ Group# _____

Name of insured (as it appears on card) _____ DOB _____

SSN _____ Relationship to patient: () Self () Spouse () Parent () Guardian

Responsible Party

Please complete the section below if someone **other** than the patient is responsible for payment

Name _____ Date of Birth _____ SSN _____

Street Address _____ City _____ ST _____ Zip _____

Phone (___) _____ Employer _____ JobTitle _____

Employer's Address _____ City _____

State _____ Zip _____ Business Phone (___) _____

Other Information

How did you hear about our Practice? _____

If you have an answering machine, may we leave a message that contains medical information? () Yes or () No

Insurance Authorization and Assignment

I authorize the release of any medical or personal information necessary to process insurance claims, and do request payment of insurance be made to the **Kentucky Diabetes Endocrinology Center, PSC**. I understand that payment of insurance co-pays and any balances due are required at the time of service.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

Tricare/ChampVA Patients ONLY

Please be advised that our physicians are enrolled with Tricare, but are not participating providers as that relates to accepting Tricare allowable fees, We accept (and by federal law we are allowed to charge) 115% of the Tricare allowable fees. We will file Tricare claims for you however the Tricare check and Explanation of Medical Benefits Form (EOMB) will be mailed to you. When making payment on your account, you MUST include the Tricare EOMB with your payment so that we can calculate the 115% change and adjust off the remaining amount. Your signature below indicated that you have read and understand this procedure.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

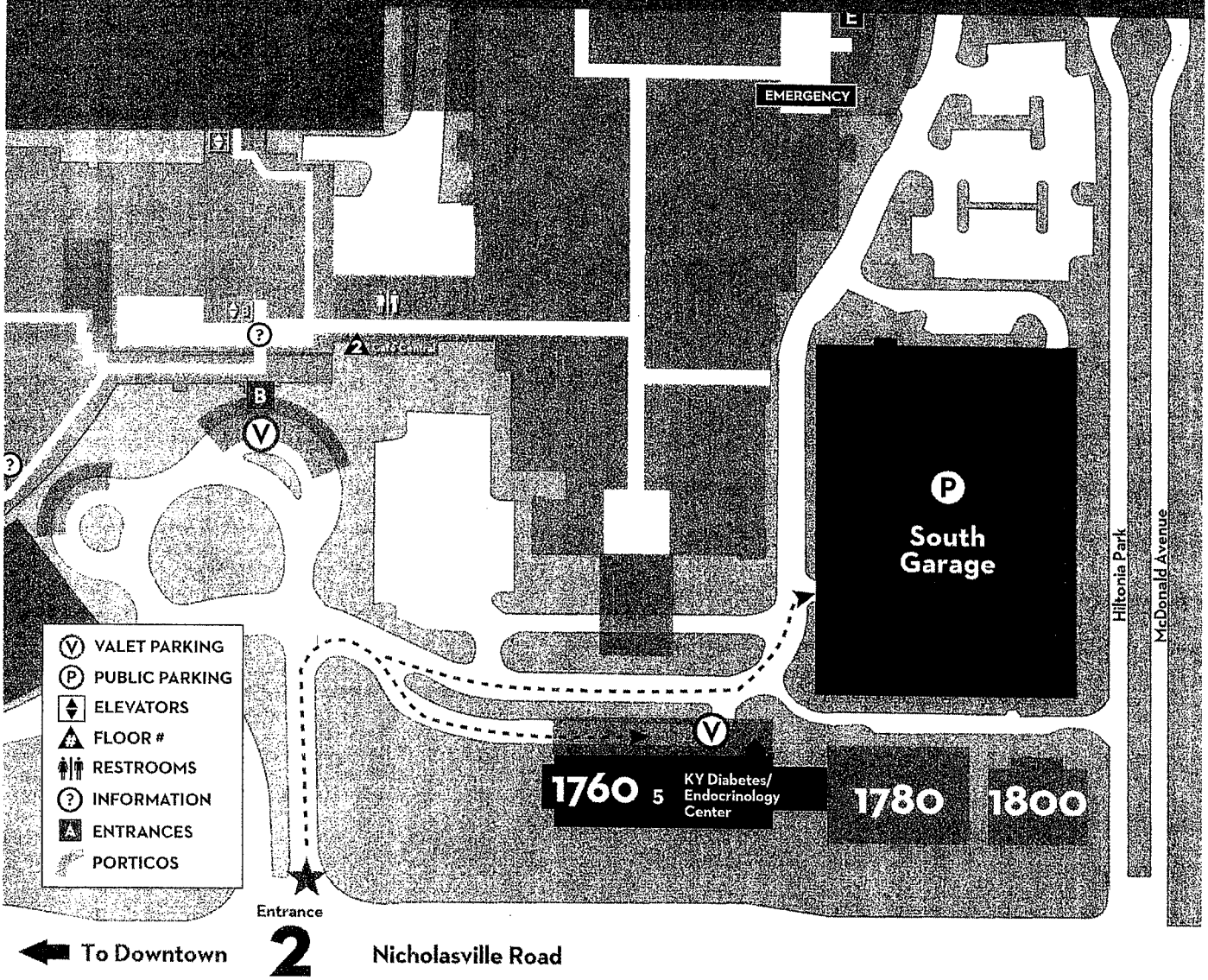
BAPTIST HEALTH
LEXINGTON

BaptistHealthLexington.com

KY DIABETES ENDOCRINOLOGY CENTER

1760 Nicholasville Road, Suite 502

859.260.6828



SELF PARKING

Use Entrance 2 onto campus and make the first right. Continue forward at the split (bearing right takes you under the portico to Valet Parking), and continue toward the South Garage.

Take the lobby elevator to the 5th floor. Depending on the elevator you take, Kentucky Diabetes Endocrinology Center will be either straight ahead or slightly to the left in Suite 502.

FREE VALET PARKING

Monday - Friday, 7:00 a.m. - 6:00 p.m.

Use Entrance 2 onto campus and make the first right. Bear right at the split and go under the portico to Valet Parking.

Take the lobby elevator to the 5th floor. Depending on the elevator you take, Kentucky Diabetes Endocrinology Center will be either straight ahead or slightly to the left in Suite 502.

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1760 NICHOLASVILLE ROAD SUITE 502
LEXINGTON, KENTUCKY 40503

FINANCIAL POLICY

PLEASE READ CAREFULLY TO AVOID ANY MISUNDERSTANDINGS

Upon arrival to our office, please give us any updated information on your insurance, address or other demographics. Please give us this information at check in. You will be asked for the information on your encounter to signify that the information we do have is correct. We will ask to scan your driver's license and insurance card to avoid any problems in filing your claim for you. **Please come prepared**. If you do not have your information, you will be considered a self pay patient or you may have to be rescheduled.

We participate with the following insurances listed below. If your insurance is not listed below, please call your insurance carrier if you have a question about out of network benefits. ***You are responsible for any bill or portion of a bill that is not paid by your insurance carrier. We do not make contractual adjustments if we are not a participating provider.***

We participate with:

Medicare, Anthem, Aetna, Bluegrass Family Health, Beech Street, Bluegrass Health Network, CHA, Cigna, Cooperative Care, Coventry, Healthsmart, Humana (Kentucky plans only), Interplan, Kentucky Health Cooperative MultiPlan, NPPN, OneHealth Network, PHCS, and United Healthcare. The ***Medicare replacement policies*** we currently participate with are Anthem Medicare Advantage, Humana HMO, Humana Choice Care and United Healthcare. Please call our office if you have any questions about Medicare replacement policies.

Some insurance carriers require a referral from a primary care physician. ***It is your responsibility to obtain that referral and bring it with you to your appointment.*** We cannot see you without the required referral and will have to reschedule your appointment. Failure to obtain a referral may result in denial of your claim in which case you will be responsible for payment in full

Copays, deductibles, coinsurance and previous balances are due at the time of service. You may be asked to reschedule if you fail to pay any previous balance due. Please come prepared to make the necessary payments. We accept cash, checks, Discover, Visa, MasterCard and American Express. There ***is a $75.00 fee for <u>each</u> returned check. Additionally, there is a $10.00 fee for failure to make your copay at time of service.*** If you have any questions about what may be due, please contact the Business Office at 859-278-2232 option 8.

If you have Medicare ***only***, you are expected to pay your 20% coinsurance at time of service.

Diabetes Education is ***not always*** covered by insurance companies. If it is not, you are responsible for the charge. Education is a part of our program and we strongly recommend that you attend. Please call your insurance company to verify whether or not this is a covered benefit for you.

Any unpaid insurance balances over 90 days will be your responsibility. At this time, you will need to collect from your insurance carrier. We will be happy to help you appeal any claim, or refer you to the Kentucky Department of Insurance. ***If payment is not received within 100 days of your date of service, your account will be turned over to a collection agency. You will then be responsible for your balance plus a collection fee equal to 30% of your balance due. When you receive a statement that is marked Final Notice, you have 10 days to pay your balance. If not paid, all future appointments will be cancelled.***

Contact regarding your account may be via mail, telephone, wireless telephone, text or email. This may include the use of pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication from the practice or its agents including collection agencies.

The patient is ultimately responsible for any unpaid balances whether it is from a primary or secondary insurance. Secondary insurances will be only filed once.

Appointment Cancellation Policy: If you must change or cancel your appointment, please notify us at least **24 hours** in advance so that we may reassign your appointment slot. Repeated failure , anytime you miss two consecutive appointments or fail to give us ample notification, will result in a **$25.00 charge** which will not be paid by your insurance carrier. You will need to pay the charge plus any other copay or balance before being seen again.

I have read and understand the above financial policies. I agree to honor my financial responsibilities for my medical care provided by Kentucky Diabetes Endocrinology Center.

Signature: _____

Legal Guardian or Agent for Patient: _____

Date: _____

3/15

Review of Systems:

Patient Name: _____

Please circle any of the following symptoms that you have had in the recent past. In each category, if you have not had any of the symptoms, circle none. If you have had other symptoms, write them in.

General Fevers Chills Sweats Anorexia Fatigue Weakness Malaise Weight loss Sleep disorder **none**

Eyes Vision loss – 1 eye Double Vision Eye irritation Vision loss both eyes Blurring Eye Pain Halos Discharge Light sensitivity **none**

ENT Ringing in the ears Ear discharge Earache Decreased Hearing Nasal Congestion Nosebleeds Hoarseness Sore throat **none**

CV: Difficulty breathing at night Near fainting Chest pain or discomfort Heart racing or skipping Fatigue Lightheadedness Palpitations Shortness of breath on exertion Swelling of hands or feet Fainting Difficulty of breathing while lying down Leg cramps with exertion Bluish discoloration of lips and nails Weight gain **none**

Respiratory Sleep disturbances due to breathing Cough Shortness of breath Coughing up blood Chest discomfort Wheezing Excessive sputum Excessive snoring **none**

GI Excessive appetite Loss of appetite Indigestion Vomiting blood Nausea Vomiting Yellowish skin color Gas Abdominal pain Abdominal bloating Hemorrhoids Diarrhea Change in bowel habits Constipation Dark tarry stools Bloody stools **none**

Female GU Foul urinary discharge Blood in urine Urinary frequency Inability to empty bladder Urinary urgency Kidney pain Painful urination Trouble starting urinary stream Night time urination Genital sores Inability to control bladder Lack of sexual drive Heavy periods Missed periods Unusual urinary color Other abnormal vaginal bleeding Pelvic pain **none**

Male GU Dysuria Hematuria Discharge Urinary Frequency Urinary Hesitancy Nocturia Incontinence Genital Sores Decreased Libido Erectile Dysfunction **none**

Musculoskeletal Muscle cramps Joint pain Joint swelling Presence of joint fluid Back pain Muscle weakness Arthritis Gout Loss of strength Muscle aches **none**

Derm Excessive perspiration Night sweats Suspicious lesions Changes in nail beds Dryness Poor wound healing Unusual hair distribution Skin cancer Itching Changes in color of skin Flushing Rash **none**

Neuro Difficulty with concentration Poor balance Headaches Disturbances in coordination Numbness Inability to speak Falling down Tingling Brief paralysis Visual disturbances Seizures Weakness Sensation of room spinning Tremors Fainting Memory loss Excessive daytime sleeping **none**

Psych Sense of great danger Anxiety Suicidal thoughts Mental problems Depression Thoughts of violence Frightening visions or sounds **none**

Endo Cold intolerance Heat intolerance Excessive urination Excessive thirst Weight change **none**

Heme Enlarged lymph nodes Bleeding Skin discoloration Abnormal bleeding Fevers **none**

Allergy Persistent infections Hives or rash Seasonal allergies HIV exposure **none**

Patient Medical History

Please Fill Out and Bring With You to Your First Appointment

Name:_____
Date:_____

1. What problem are you having that you scheduled this appointment ?_____

2. How long have you had this problem ?_____

3. Please list all MEDICATIONS you are currently taking, including any over-the -counter medications or home remedies you use. Please list the drug name, dosage, and quantity and how often you take the medication.
Example : Glucophage, 500mg., 2, twice a day.

4. Drug Allergies: List all medications to which you are allergic and the kind of symptoms that you experience._____

5. What OPERATIONS have you had? (Please list approximate dates)_____

6. List any other HOSPITALIZATIONS you have had. (Please list approximate dates)_____

7. What SERIOUS INJURIES or ILLNESSES have you had? (Please list approximate dates)_____

8. Please list all DOCTORS that you are currently seeing. _____

9. How long does it take for you to reach our office from your home._____

FAMILY HISTORY

Pleas fill out chart on your immediate family only (parents, brothers, and/or sisters). Please check any conditions that they may have/had.

Name	Relationship	Age	Living Y/N	Diabetes Y/N	High Blood Pressure	High Cholesterol	Heart Problems	Cancer	Other