*

Grunberger Diabetes Institute

Date: ______________

Dear ___________________________,

Welcome! Thank you for choosing the Grunberger Diabetes Institute.

We have you scheduled on ________________________@ ___________________________ with

George Grunberger, MD / Anjana Myneni, MD / Linda Aman, MSN, ANP-BC.

In order to assist us in expediting your appointment, please complete the enclosed forms and bring them with you to your appointment.

<u>Please also bring your:</u>

- **Insurance/Prescription cards**
- **Photo ID**
- **Copies of most recent lab results**
- **List of all current medications**
- **Testing log**
- **Glucose Meter**

Unless an emergency occurs, you can expect us to be on time. We appreciate you being prompt also. If you need to reschedule an appointment, please give us 24 -hour notice.

Do not fast before appointment and please be prepared to provide us with a urine sample.
We are a fragrance free office, please refrain from wearing any scented items prior to and during your appointment.

We have included a map to our office. Please enter the building from the rear and proceed upstairs to suite number 208, which is located at the very end of the hallway on the left side.

We look forward to meeting you! If you have any questions, please don't hesitate to call. We are here to assist you.

Sincerely,

The Staff of Grunberger Diabetes Institute

43494 Woodward Ave., Suite 208 Bloomfield Hills, MI 48302
Phone (248) 335-7740~Fax (248) 338-7979 ~ www.gdi-pc.com

Grunberger Diabetes Institute

Patient Information

Legal Name: (Last, First, MI) ____

Address: _______________________________________City/St/Zip: ______________________________

Phone: (Home) ____________________(Work) ____________________(Cell) _____________________

Social Security #: ____________________ Date of Birth: ___________________ Sex: ______________

Driver License #: ______________________________ Race ______________ Ethnicity ______________

Occupation: _____________________________Employer: __________________________________

E-Mail Address ____

Emergency Contact (**name, phone# and relationship**) _______________________________________

Please give the reason for your visit today? ____

Referring Physician: ____________________________ Phone #: _______________________________

Address: ________________________________City: ______________ State/Zip: _________________

Primary Insurance Information – Insurance Company Name ________________________________

Subscriber Name: (Last, First, MI) ___________________________________ Date of Birth: ________

Insurance ID #: ___________________ Group #: __________________ Employer: _______________

Address if different from the patient: ____

Relationship to patient: _____________________ Copay amount _____________

Secondary Insurance - Insurance Company Name: ____

Subscriber Name: (Last, First, MI) ____________________________________ Date of Birth: ________

Insurance ID #: ___________________Group #: __________________Employer: __________________

Address if different from the patient: ____

Relationship to patient: ___________________________Copay amount: _________

Authorization for Treatment and Assignment of Insurance Benefits

I authorize Grunberger Diabetes Institute (assistants and associates) to provide medical treatment for the above named patient. I consent to examination. I understand the exam results will be provided to me with recommendations. The responsibility for any follow-up exams lies with me and not with George Grunberger, M.D. (assistants and associates). I hereby release my examiner from all responsibility in connection with this exam. I understand that medical treatment is necessary for the patient by George Grunberger, M.D. (assistants and associates). I hereby consent to and authorize the administration of all treatments that may be considered advisable or necessary in the judgment of George Grunberger, M.D. (assistants and associates). No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments. I authorize direct payment of medical benefits to Grunberger Diabetes Institute, P.C., its assistants and associates, for services rendered by its assistants or associates, in person or under supervision. I authorize the release of information required to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I chose to revoke it.

Signature ______________________________ Relation to Patient _________________Date: ________

Grunberger Diabetes Institute

History questionnaire

Name: ______________________________ **Date of Birth**__________

Social History: Marital Status (circle one) S M W D

Have children [no] [yes] # living ___________ # deceased ____________

Exercise [no] [yes] frequency __________________________________

Drink alcohol [no] [yes] amount/ frequency __________________________

Smoke tobacco [no] [yes] packs per day _______________________________

Meal planning: □ Eat healthy □ Follow own diet □ Carb counting □ Special diet

Surgery [no] [yes] Date(s):________________________Reason:______________________________

Hospitalizations [no] [yes] Date(s):_________________Reason:______________________________

Conditions:

Lung disease [no] [yes]

Cancer [no] [yes] Location: _________________

Blood pressure [no] [yes]

Heart problems [no] [yes]

Heart attack [no] [yes]

Irregular heart beat [no] [yes]

Cholesterol [no] [yes]

Depression [no] [yes]

Arthritis [no] [yes]

Gastric reflux [no] [yes]

Sleep apnea [no] [yes]

Diabetic eye disease [no] [yes]

Kidney disease [no] [yes]

Diabetic nerve damage [no] [yes]

Thyroid Disease [no] [yes]

Please give dates for the following

Primary doctor visit ___________

Physical ___________

Foot exam ___________

Diabetes education ___________

Dietician visit ___________

Circulation testing ___________

Bone Density Scan ___________

Nerve testing ___________

Eye exam ___________

Dental exam ___________

Others: ____________________________

Have you recently had: Continuous Glucose Sensor Blood Circulation Study Nerve Conduction Test

Are you interested in: Research Studies (volunteering) Dietitian Diabetes Education Classes

Family history **List family member(s)/relationship**

Diabetes [no] [yes] ____

Thyroid Disease [no] [yes] ____

High Blood Pressure [no] [yes] ____

Stroke [no] [yes] ____

Heart attack /Coronary bypass [no] [yes] ____

Congestive heart failure [no] [yes] ____

Grunberger Diabetes Institute

Review of systems questionnaire

Name: ________________________________ **Date of birth** __________ **Date** __________

Check any that apply:

Constitutional Symptoms

- ☐ Change in appetite
- ☐ Change in weight
- ☐ Difficulty sleeping

Vision

- ☐ Change in vision
- ☐ Severe headaches

Ears / nose / mouth / throat

- ☐ Change in hearing
- ☐ Sinus problems
- ☐ Difficulty swallowing

Cardiovascular

- ☐ Chest pain
- ☐ Swollen ankles

Respiratory

- ☐ Shortness of Breath
- ☐ Frequent Coughs
- ☐ Wheezing

Gastrointestinal

- ☐ Indigestion
- ☐ Heartburn
- ☐ Nausea
- ☐ Abdominal Pain
- ☐ Change in bowels
- ☐ Black / tarry / bloody stools
- ☐ Diarrhea
- ☐ Constipation

Other:____________________________

Genitourinary

- ☐ Painful urination
- ☐ Decreased urine force / flow
- ☐ Vaginal discharge
- ☐ Blood in urine

Musculoskeletal

- ☐ Back pain
- ☐ Pain in joints
- ☐ Stiffness

Skin / breasts

- ☐ Sores that don't heal
- ☐ Changes in skin moles
- ☐ Breast lumps or discharge

Neurological

- ☐ Tingling arms / legs / feet
- ☐ Loss of speech
- ☐ Trouble balancing

Psychiatric

- ☐ Anxious
- ☐ Feeling down, depressed or hopeless
- ☐ Little interest or pleasure in doing things

Endocrine

- ☐ Frequent thirst
- ☐ Frequent urination

Other

- ☐ Seasonal allergies
- ☐ Swollen glands

Grunberger Diabetes Institute

Medication List

Patient Name ____ Date of Birth ___________________________

Pharmacy ______________________ City/Zip __________________ Phone/Fax # __________________________

Medical Supplier ______________________________________ Phone/Fax# ___________________________

Glucose meter type _____________________________________ **Testing Frequency** ____________________

Pump Type ____________________ **Influenza (flu) Date:** ______________ **Pneumonia Date:** __________

Please have your Pharmacy print a copy of your Medication list, include any over the counter vitamins and supplements you may be taking.

Allergies:			
Medication	Dose	Frequency	Prescribing MD

Grunberger Diabetes Institute

MEDICATION HISTORY CONSENT FORM

By signing below I give permission for Grunberger Diabetes Institute to access

my pharmacy benefits data electronically through RxHub. This consent will enable

Grunberger Diabetes Institute to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order

pharmacies, and if so, e-prescribe to these pharmacies.

- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Patient Name (Print)

____

Patient Signature Date

____

Updated 7/2014

Grunberger Diabetes Institute

Patient Health Questionnaire

Name _______________________________

In an effort to give you the best possible care and keep all your practitioners involved please complete the following:

Primary care physician: ____

Address ____Phone #___________________________________

Fax #___________________________________

Cardiologist: (heart)____

Address ____Phone #___________________________________

Fax #___________________________________

Nephrologist: (Kidneys)____

Address ____Phone #___________________________________

Fax # _________________________________

Neurologist: (Nerves)____

Address ____Phone #___________________________________

Fax # _________________________________

Ophthalmologist: (Eyes)____

Address ____Phone #___________________________________

Fax # _________________________________

Podiatrist: (Feet)____

Address ____Phone #___________________________________

Fax # _________________________________

Dentist: ____

Address ____Phone #___________________________________

Other: ____

Address____Phone # _________________________________

Grunberger Diabetes Institute

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Grunberger Diabetes Institute, may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO). Please refer to Grunberger Diabetes Institute Notice of Privacy Practices for more complete description of such uses and disclosures.
I have the right to review the Notice of Privacy Practices prior to signing this consent.
Grunberger Diabetes Institute reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Grunberger Diabetes Institute Office Manager at 43494 Woodward Avenue Ste. 208. With my consent, Grunberger Diabetes Institute may call my home, email, text or other designated location's and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With my consent, Grunberger Diabetes Institute, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements and collections letters. We may use medical information about you to provide you with medical treatment or services. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.
By signing this form, I am consenting Grunberger Diabetes Institute use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Grunberger Diabetes Institute my decline to provide treatment to me.

Information may be released to the following people:

_______________________________ _______________________________ _____________
Signature of Patient/Legal Guardian Name Relationship

_______________________________ _______________________________ _____________
Date Name Relationship

_______________________________ _______________________________ _____________
Print Patient's Name Name Relationship

_______________________________ _______________________________ _____________
Print Name of Legal Guardian Name Relationship

This form will be retained in your medical record.

Updated 7/2014

Grunberger Diabetes Institute

Financial-Office Policy

We are pleased that you have chosen our office. We would like you to be aware of the following policies:

We offer phone and email evaluations. You will be charged based on the level of evaluation unless you were seen in the office within the past week.

We have saved your appointment time for you. We understand that an emergency occasionally occurs, causing you to cancel your appointment. Please let us know as soon as possible. If you miss your appointment or fail to cancel your appointment within 24 hours of your scheduled appointment time, you will be charged a $50.00 fee. If you are running late for your appointment, please call the office. If you are more than 15 minutes late for your appointment, you may be asked to reschedule your appointment.

All prescription renewals will be done on the day of your appointment. If you need a prescription before your next appointment, you will be charged a $5.00 processing for. You may pick it up during regular business hours at no charge. We do not fax prescriptions.

All payments are due at time of service. Patient account balances must be paid within 30 days. We accept cash, checks and credit cards. If your check is returned to the office for any reason, you will be charged a $50.00 fee. be A re-billing charge of $5.00 is added each month to unpaid balances. While filing of insurance claims is a service that we provide, all charges are your responsibility from the date of service, any portion of the bill that is not paid by your insurance is your responsibility and arrangements for prompt payment must be made. It is your responsibility to advise us promptly of insurance changes, failure to do so may result in a charge for additional administrative time required for correction and resubmission of your claims. It is your responsibility to promptly supply your insurance company with any and all information they may request from you. If you are experiencing financial difficulties, please discuss this with our business staff prior to your appointment. Unpaid balances older than 90 days will be referred to a collection agency.

Due to the specialized nature of our practice and the specific needs of our patients the Grunberger Diabetes Institute provides some services that may not be covered by insurance carriers. As a courtesy to you, our office is prepared to submit claims to your insurance company. It is important that you find out which services are covered by your plan before your visit. If your plan requires you to obtain a referral, adequate planning is essential. Referrals must be authorized by your primary care doctor before your appointment can be made. We regret that we are unable to obtain your referral forms for you. If your insurance company requires laboratory specimens be sent to a specific lab, it is your responsibility to know which one. Please make us aware of your plan requirements.

As a courtesy to other patients and to our staff, we request that you silence your cell phone and refrain from answering your cell phone while in the office.

Thank you for understanding and adhering to these policies. We look forward to serving you.

Sincerely, The staff of Grunberger Diabetes Institute

By signing below, you agree to abide by these policies.

(Patient - Print Name) ______________________ **Signature** ___________________**Date**_________

Updated 7/2014

Grunberger Diabetes Institute

43494 Woodward Ave, Suite 208
Bloomfield Hills, MI 48302

PLEASE BE ADVISED-

Payment will be required for, but not limited to the following services:

Fees are for one item per each date of service

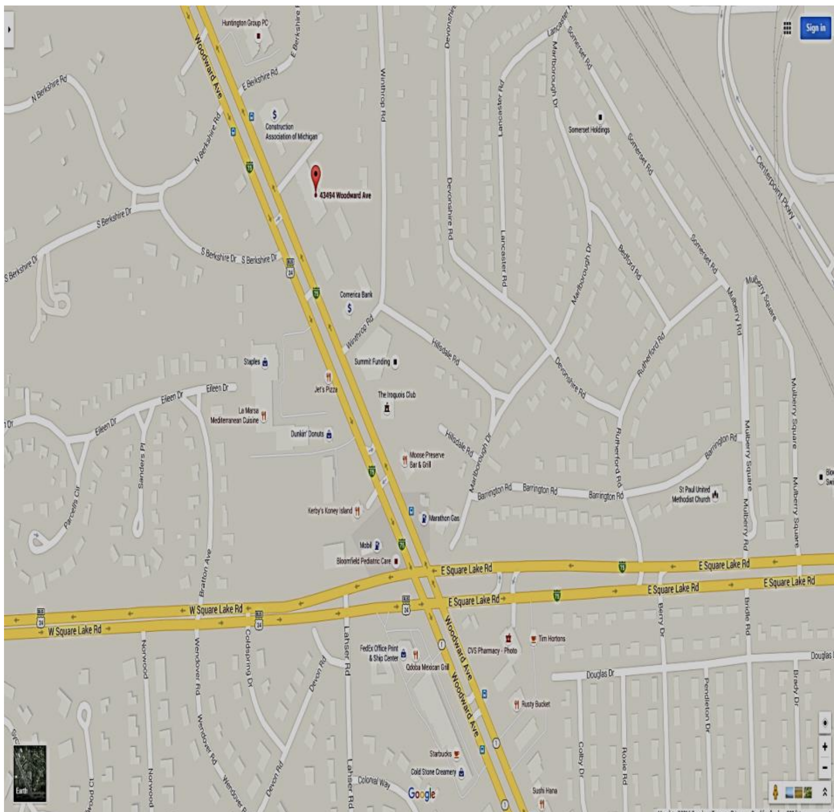
Service	Fee
Narrative Letter	$50
Disability form, FMLA, Endo quarterly, etc. (Fee varies-starting at)	$25
Travel Letter	$15
Letter of Medical Necessity/Physician Order	
Custom	$100
Form –Initial/follow-up	$80/$70

Service	Fee
Progress Notes	$25
Preauthorization	$25
Appeal letter – starting at	$50
Patient Assistance Forms	$25
Glucose Logs	$5
Copy of Lab Documents	$10
Rx refills	$5
Rush Fee	$10
Fax	$5

Total: ______

Shipping and Handling (cost plus $5.00)
Payment will be required prior to picking up, mailing or faxing. If mailing, additional mailing fees may apply. Fees are subject to change. Thank you for your understanding.

Name: _________________________________ **Date**: ___________________



Please park in the rear of the building, enter through the two glass doors and take the stairs or elevator to the second floor. Turn left at top of stairs; we are in Suite 208.

Updated 7/2014