# 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**

**Donna Hamill, DNP, NP-C, BC-ADM / Amy Tobin, DO**

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

**Please also bring your:**

- 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 are more than 15 minutes late for your appointment your appointment may need to be rescheduled. If you need to reschedule an appointment, please give us the courtesy of 24 hour notice. Cancellations within 24 hours of appointment or not showing for appointment will result in $50 charge.

Do not fast before appointment and please be prepared to provide us with a urine sample.

We have included a map to our office. Please enter the building from the back and proceed upstairs to Suite 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

# Grunberger Diabetes Institute

**Patient Information**

Legal Name: (Last, First, MI) _____

Address: _____City: _____St/Zip: _____

Phone: (Home) _____(Work) _____(Cell) _____

Date of Birth: _____ Sex: _____

Ethnicity/race: American Indian / Hispanic or Latino / Asian / Black or African American / White / Pacific Islander

Occupation: _____Employer: _____

E-Mail Address _____

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

_____

**Please give the reason for your visit today** _____

Referring Physician: _____ Phone #: _____

**Primary 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: _____

**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 Grunberger Diabetes Institute. 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 had children [no] [yes]

Exercise [no] [yes] frequency/type _____

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

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

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

Major Surgery [no] [yes] Date(s):_____Reason:_____

Recent Hospitalizations [no] [yes] Date(s):_____Reason:_____

**Conditions:**

| | | |
|---|---|---|
| Diabetic eye disease | [no] | [yes] |
| Diabetic nerve damage | [no] | [yes] |
| Kidney disease | [no] | [yes] |
| High blood pressure | [no] | [yes] |
| Elevated Cholesterol | [no] | [yes] |
| Fatty Liver Disease/Fibrosis | [no] | [yes] |
| Heart Attack | [no] | [yes] |
| Heart failure | [no] | [yes] |
| Irregular heart beat | [no] | [yes] |
| Thyroid disease | [no] | [yes] |
| Depression | [no] | [yes] |
| Sleep apnea | [no] | [yes] |
| Gastric reflux | [no] | [yes] |
| Cancer | [no] | [yes] |
| Location: _____ | | |
| Arthritis | [no] | [yes] |
| Lung Disease | [no] | [yes] |

**Please give dates for the following**

Primary doctor visit: _____

Physical: _____

Foot exam: _____

Diabetes education: _____

Dietician visit: _____

Circulation testing: _____

Nerve testing: _____

Bone Density Scan: _____

Eye exam: _____

Dental exam: _____

Other tests: _____

_____

_____

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

**Are you interested in:** Nutrition 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] | _____ |



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# Grunberger Diabetes Institute

**Review of Systems Questionnaire**

**Name**: _____ **Date of birth** _____ **Date** _____

Check any that apply:

*Constitutional Symptoms*
□ Change in appetite
□ Weight loss/Weight gain (please circle)
□ Difficulty sleeping

*Vision*
□ Change in vision

*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 (please circle)
□ Diarrhea
□ Constipation
□ Other:_____

*Genitourinary*
□ Painful urination
□ Decreased urine force / flow (please circle)
□ Vaginal discharge
□ Blood in urine
□ Incontinence

*Musculoskeletal*
□ Back pain
□ Joint pain
□ Stiffness

*Skin / breasts*
□ Sores that don't heal
□ Changes in skin moles
□ Breast lumps or discharge

*Neurological*
□ Tingling arms / legs / feet (please circle)
□ Speech difficulty
□ Trouble balancing
□ Severe headaches

*Psychiatric*
□ Anxious
□ Feeling down, depressed or hopeless

*Endocrine*
□ Frequent thirst
□ Frequent urination

*Other*
□ Seasonal allergies

# Grunberger Diabetes Institute

**Patient Health Questionnaire**

Name: _____ Todays Date : _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle number 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 a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such a 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 | 0 | 1 | 2 | 3 |
| | add columns | + | + | |
| Doctor use only | TOTAL: | | | |

| | | |
|---|---|---|
| 10. 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 | _____ |



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# Grunberger Diabetes Institute

**Medication List**

Patient Name _____ Date of Birth_____

Pharmacy _____Phone & Fax #_____

Address, City & State _____

Medical Supplier _____Phone & Fax#_____

**Glucose meter/sensor 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 are taking.**

| Allergies: | | | |
|---|---|---|---|
| | | | |
| Medication | Dose | Frequency | Prescribing MD |
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# 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 Signature Patient Name (please print clearly)

_____

Date

# Grunberger Diabetes Institute

**Patient Health Questionnaire**

Name _____ Date of Birth _____

In an effort to give you the best possible care and keep all your practitioners involved please complete the following ***(please provide their first AND last names):***

Primary care physician: _____

Cardiologist: (heart)_____

Nephrologist: (Kidneys)_____

Neurologist: (Nerves)_____

Ophthalmologist: (Eyes)_____

Podiatrist: (Feet)_____

Dentist: _____

Other: _____



**PATIENT CONSENT FOR USE AND DISCLOSURE**

# Grunberger Diabetes Institute
## 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 any time. 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, Bloomfield Hills, MI 48302. 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 professionals 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:

_____ _____

Name Relationship

_____ _____

Name Relationship

***OR***

_____ I DO NOT authorize the release of my medical information.

_____ _____ _____

Signature of Patient/Legal Guardian Patient's Name (please print) Date

***This form will be retained in your medical record but must be updated yearly.***

# Grunberger Diabetes Institute

**Financial-Office Policy (please read carefully)**

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

We have saved your appointment time exclusively for you. Our policy is to charge $50 for missed appointments that were not canceled more than 24 hours in advance. These charges will be your responsibility and billed directly to you. 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 $10 processing fee. We do not fax prescriptions. Per insurance guidelines, doctors may bill your insurance for telephone calls.

All co-payments and deductibles are due at time of service. This arrangement is part of your contract with your insurance company. 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 fee.

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. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of the claim. Most insurance companies have time filing restrictions; if a claim in not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains. 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.

***We currently do not participate with ANY Medicaid programs. If you have Medicaid, either Primary OR Secondary, we will not be able to see you at Grunberger Diabetes Institute. If you fail to disclose that you do have Medicaid you will be responsible for any charges that you incur and you will be dismissed from our practice.***

Due to the specialized nature of our practice and the specific needs of our patients 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

| Patient Signature | Patient Name (please print clearly) | Date |
|---|---|---|



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# Grunberger Diabetes Institute

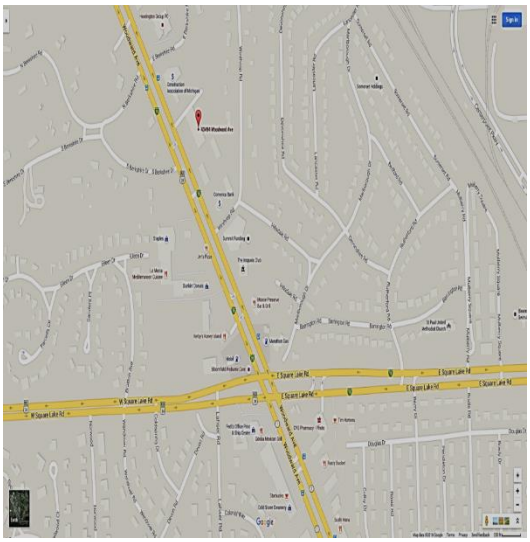
Please be advised of additional fees you may incur when the following documents are prepared on your behalf by Grunberger Diabetes Institute.

**These fees are not billable through your insurance carrier. These are all upon your request.**

Fees are for one item per each date of service and due prior to being picked up, mailed or faxed. If mailing, additional mailing fees may apply. Fees are subject to change. Thank you for your understanding. This form will be retained in your medical record.

| | |
|---|---|
| Appeal letter | $50 (starting at) |
| Disability, FMLA, Dept of Trans., etc. | $30 (starting at) |
| Patient Assistance Forms | $30 (starting at) |
| Travel Letter | $15 |
| Copy of Lab Documents | $10 |
| Rx refills outside of office visit | $10 |
| Rush Fee | $10 |

Signature of Patient/Legal Guardian _____ Print Patient's Name _____ Date _____



Map

Please park in the back 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.

Front of building



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☐ ALL PATIENTS DIAGNOSED WITH DIABETES ☐ ALL PATIENTS AGE 50 AND OLDER

# Peripheral Arterial Disease Questionnaire – Grunberger Diabetes Institute

**Patient Name:** _____ Date of Birth:____/____/____ Age ____ Today's Date:____/____/____

Do you see a Cardiologist? ____Yes ___No Name of Cardiologist_____

Have you ever had the blood pressure tested in your ankle before? No Yes Approximately when _____/_____
(This is called an Ankle Brachial Index – ABI) month/ year

**(Please complete and discuss with the Doctor, Physician Assistant, or Nurse Practitioner)**

| | | | |
|---|---|---|---|
| What is your present age range? | 49 or less **0** | 50-64 **5** | 65 or older **10** |
| 1. Do you currently smoke, or have you quit smoking in the past? | Never **0** | Quit at age _____ **5** | Yes Current **10** |
| Please answer and circle Yes or No to the following questions | | | |
| 2. Do you have diabetes? Have you had your annual diabetic eye exam? ___N ___Y When ___/___/___ | No **0** | | Yes **10** |
| 3. Do you have high blood pressure or take medication for your blood pressure? | No **0** | | Yes **3** |
| 4. Do you have high cholesterol or are you taking cholesterol medication? | No **0** | | Yes **3** |
| 5. Have you ever had a __heart attack or a __stroke? | No **0** | | Yes **5** |
| 6. Have you ever had surgery, angioplasty, or stenting on an artery of the __neck, __abdomen (aorta), __kidney, __heart or __leg? | No **0** | | Yes **5** |
| 7. When walking, do your legs ache, feel fatigued, tingle, cramp up, feel heavy or painful? | No **0** | | Yes **5** |
| 8. Do you experience any pain at rest in your lower __leg(s) or __feet? | No **0** | | Yes **1** |
| 9. Do you experience foot or toe pain that often disturbs your sleep? | No **0** | | Yes **1** |
| Add up the points from each circled answer in the second and third column | __**0**__ | _____ | _____ |
| Total Score: Add up the total for the second and third columns | | _____ | |

**Scoring:**

| | |
|---|---|
| 0 – 9 | Unlikely problems with peripheral arterial disease |
| 10 – 15 | Questionable: Your physician can help determine if this may be of concern |
| 15 or more | Likely benefit from a painless, non-invasive test for peripheral arterial disease |

10. Do you have chronic kidney disease (CKD)? No Yes
11. Do you have end stage renal disease (ESRD) or on Dialysis? No Yes
12. Has a relative (mother, father, sibling, grandparent) had an Abdominal Aortic Aneurysm (AAA) No Yes

**The American Diabetes Association (ADA), Kidney Disease Improving Global Outcomes (KDIGO), American Heart Association (AHA), American College of Cardiology (ACC), and American College of Physicians (ACP) recommend if you score 15 or more on the questions above that you should have a test for circulation in your legs known as the Ankle Brachial Index – ABI.**

Patient Signature _____ Reviewed by Doctor / PA / NP _____



*PLEASE TAKE EXTRA QUESTIONNAIRES HOME TO SHARE WITH FAMILY AND FRIENDS*

# Do You Need a Test for CVI? Grunberger Diabetes Institute

***Chronic Venous Insufficiency (CVI) is a serious circulatory problem in which the leg veins cannot pump enough blood back to your heart. It affects over 25 million Americans, most over the age of 40. It is estimated that at least 20 to 25 million Americans have varicose veins. Symptoms of CVI include varicose veins, skin problems, leg and ankle swelling, tight calves, and legs that feel heavy, tired, restless, or achy. Factors that can increase the risk of CVI include pregnancy, obesity, smoking, standing or sitting for long periods of time and not getting enough exercise. Answers to these questions will determine if you are at risk for CVI and if a vascular exam will help us better assess your vascular health status.***

Name:_____ Date:_____/_____ /_____
(PLEASE PRINT CLEARLY)

| | ***Circle "Yes" or "No":*** | | **Test for Venous Disease** |
|---|---|---|---|
| 1. | Are your legs __swollen, __painful, __red or warm to the touch (__R/__L/__B)? (CIRCLE ALL THAT APPLY) | Yes | No | ☐ |
| 2. | Have you had a blood clot in a vein that caused inflammation, pain or irritation? (__R/__L/__B) | Yes | No | ☐ |
| 3. | Do you have varicose veins (veins that are enlarged or swollen and raised above the surface of the skin) in the legs (__R/__L/__B) | Yes | No | ☐ |
| 4. | Have you had a __Deep Vein Thrombosis (DVT) in the past and are experiencing __Pain, __swelling, __changes in skin color or __non-healing ulcers (__R/__L/__B)? (CIRCLE ALL THAT APPLY) | Yes | No | ☐ |
| 5. | Do your legs feel heavy, tired, restless or achy (__R/__L/__B)? | Yes | No | ☐ |
| 6. | If you push on your swollen foot, ankle or leg for 10 seconds and release, does your fingerprint leave a dimple (__R/__L/__B)? | Yes | No | ☐ |
| 7. | If your feet, ankles and legs are swollen, does the skin look stretched or shiny (__R/__L/__B)? | Yes | No | ☐ |
| 8. | Do you have an ulcer on the inside of your ankle (__R/__L/__B)? | Yes | No | ☐ |
| 9. | Do you have dark brown pigment changes in your lower legs (__R/__L/__B)? | Yes | No | ☐ |
| 10. | Have you ever been told to wear compression stockings on your legs because of: __Swelling in your legs, __pitting edema, __venous insufficiency (__R/__L/__B) (CIRCLE ALL THAT APPLY) | Yes | No | ☐ |
| 11. | Are you still wearing the compression stockings? | Yes | No | |
| 12. | Have you ever had a test for Chronic Venous Insufficiency (CVI) before? If you said yes, when was your last test? _____/_____ MONTH / YEAR | Yes | No | |

Patient Signature:_____

Physician / PA / NP Signature:_____ Date:_____/_____ /_____ ☐
__George Grunberger, M.D. __Anjana Myneni, M.D. __Linda Aman, MSN, ANP-BC



CVI quesetion