Welcome to Our Practice

New Patient Paperwork

All new patient paperwork must be completed prior to your appointment. This allows our Clinicians adequate time to review your medical history and prepare for your visit.

- If your paperwork has been completed and submitted prior to your appointment, please plan to arrive 15 minutes before your scheduled appointment time.
- If your paperwork has not been sent in prior to your visit, you must arrive 30 minutes early to ensure our Team can update your chart.

Please note: If new patient paperwork is not completed at the time of your appointment, your appointment will need to be rescheduled.

Referral Requirements

If your insurance requires a referral, it must be received by our office prior to your scheduled appointment. If a required referral has not been received, your appointment may need to be rescheduled until the referral is obtained.

Insurance Information

Please bring a copy of your photo I.D and current insurance card with you to your visit. Please be advised that our practice does not accept Medicaid.

Labs/Imaging

Please bring a copy of your most recent lab wok with you to your visit. Thyroid patients, please also bring a recent copy of your U/S.

Appointment Cancellation Policy

We understand that schedules can change. If you need to cancel or reschedule your appointment, we kindly request at least 48 hours' notice. Providing adequate notice allows us the opportunity to offer that appointment time to another patient who may be waiting for care.

We appreciate your cooperation with these policies, as they help us provide the best possible care and maintain timely access for all of our patients.

If you have any questions before your visit, please do not hesitate to contact our office.

We look forward to meeting you and partnering with you in your healthcare.

Sincerely,

The GDE Care Team

App Day:_____

App Time:_____

2026 GDI Financial Policy

Appointment and Cancellation Policy

Your appointment time has been reserved specifically for you. We understand that emergencies may arise and require you to cancel; however, we ask that you notify our office as soon as possible. Appointments that are missed or canceled with less than 48 hours' notice will incur a $50.00 missed appointment fee. Please note, after hours and weekend hours are not included in this timeframe as our office is closed.

If you anticipate arriving late, please contact the office promptly. Patients who arrive more than 10 minutes late may be required to reschedule their appointment and may incur a $50 fee.

Prescription Policy

Prescription renewals are processed during scheduled appointments. If a prescription refill is requested prior to your next appointment, a $10.00 processing fee will apply. Prescriptions may be picked up during regular business hours at no charge. Please note that we do not fax prescriptions.

Billing and Payment Policy

All co-payments, deductibles, and outstanding balances are due at the time services are rendered. Patient account balances must be paid in full within 30 days. We accept cash, checks, and credit cards. Credit card payments are subject to a 3.95% processing fee. Returned checks will incur a $50.00 fee.

Unpaid balances will be assessed a $5.00 monthly rebilling fee. While we are happy to submit insurance claims as a courtesy, all charges remain the patient's responsibility from the date of service. Any portion not covered by insurance is the patient's responsibility, and arrangements for prompt payment must be made.

Patients are responsible for notifying our office of any insurance changes in a timely manner. Failure to do so may result in additional administrative charges related to claim correction and resubmission. Patients are also responsible for providing their insurance carrier with any information requested. Accounts with balances outstanding for more than 90 days may be referred to a collection agency. If you are experiencing financial hardship, please discuss this with our business staff prior to your appointment.

Insurance and Referral Policy

Due to the specialized nature of our practice and the individualized needs of our patients, the Grunberger Diabetes Institute provides certain services that may not be covered by all insurance plans. As a courtesy, we will submit claims to your insurance carrier; however, it is your responsibility to verify coverage prior to your visit. Please note, we do not participate with Medicaid.

If your insurance plan requires a referral, it must be obtained and authorized by your primary care provider before your appointment can be scheduled. Unfortunately, we are unable to obtain referrals on your behalf. Additionally, if your insurance carrier requires laboratory services to be performed at a specific facility, it is your responsibility to be aware of and communicate this requirement to our office.

Thank you for your understanding and cooperation with these policies. We appreciate the opportunity to care for you and look forward to serving you.

Sincerely, The staff of Grunberger Diabetes & Endocrinology

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

This form will be retained in your medical record.

Grunberger Diabetes & Endocrinology

Patient Information

Legal Name: (Last, First, MI) _____

Address: _____ City: _____ St/Zip: _____

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

Date of Birth: _____ Sex: _____

Occupation: _____ Employer: _____

E-Mail Address _____

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

_____

Referring Physician (first AND last name): _____ Phone #: _____

PCP (first AND last name): _____ Phone #: _____

Address: _____ Fax #: _____

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: _____

Authorization for Treatment and Assignment of Insurance Benefits

I authorize Grunberger Diabetes & Endocrinology 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 Grunberger Diabetes & Endocrinology. I hereby release my examiner from all responsibility in connection with this exam. I hereby consent to and authorize the administration of all treatments that may be considered advisable or necessary in the judgment of Grunberger Diabetes & Endocrinology. 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 & Endocrinology, 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 & Endocrinology

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 [never] [currently] packs per day _____

[past use] duration _____ date stopped _____

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]
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: _____
_____
Location: _____

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]	_____

Grunberger Diabetes & Endocrinology

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 & Endocrinology

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 for ALL doctors you are listing):***

Primary care physician: _____

Cardiologist: (Heart)_____

Nephrologist: (Kidneys)_____

Neurologist: (Nerves)_____

Ophthalmologist: (Eyes)_____

Podiatrist: (Feet)_____

Dentist: _____

OB/Gyn: _____

Grunberger Diabetes & Endocrinology

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

Grunberger Diabetes & Endocrinology

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Grunberger Diabetes & Endocrinology, may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO). Please refer to Grunberger Diabetes & Endocrinology 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 & Endocrinology 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 & Endocrinology, Office Manager at 43494 Woodward Avenue Ste. 208, Bloomfield Hills, MI 48302. With my consent, Grunberger Diabetes & Endocrinology 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 & Endocrinology, 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 & Endocrinology 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 & Endocrinology 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 & Endocrinology

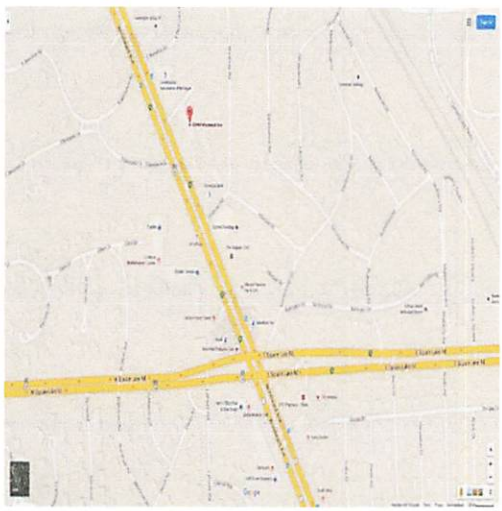
Please be advised of additional fees you may incur when the following documents are prepared on your behalf by Grunberger Diabetes & Endocrinology.

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