Diabetes and Thyroid Center of Fort Worth, PLLC

Darren Lackan, MD, PA, FACE, ECNU **Chris Bajaj, DO, PA, FACE, ECNU**
Anjanette Tan, MD, FACE, ECNU **Sara Matani, MD**

Welcome to the Diabetes and thyroid Center of Fort Worth. The purpose of this letter is to describe our philosophy on patient care and explain clinic policies.

Most endocrinology disorders are chronic problems. These include diabetes, osteoporosis, disorders of the thyroid, pituitary, adrenal, sex hormones, etc… Adequately treating these disorders requires a team approach. The leader of this team is you. We expect you to take control of your disease and we are here to teach you how. If you want to learn about your disease, how to take control of it and learn how to make important changes to your lifestyle, you have come to the right place.

The clinic policies are simple and are in place to provide the best and most efficient patient care possible.

- For your first visit, please bring with you all important medical records, or call your primary care physician in advance to fax all pertinent records to our office. **Your visit will be rescheduled if we don't' have the records for your visit.**
- **Please bring all of your medications and supplements or a detailed list to all of your appointments.**
- **For the first visit, please arrive at least 30 minutes early to complete all forms.**
- **Diabetic patients** must bring your glucometer or glucose log book, and carbohydrate counting sheets (if applicable) to all visits. Without these, changes cannot be made and you may be rescheduled.
- **Late arrivals** will be rescheduled to the next available appointment.
- **We value your time,** but due to individualized care we provide to every patient, we sometimes run behind schedule. Please be assured that we will spend the time needed to provide you with the best care possible.
- **Please notify us 24 hours in advance if you need to cancel or reschedule an appointment. A $25 charge may be incurred if you cancel without a 24 hours' notice.** If you miss more than two appointments without giving 24 hours' notice, you may be discharged from the clinic.
- **We ask that every patient has a primary care physician (PCP). General health questions should be addressed by your PCP.** If you need a PCP, please ask our staff or a list of recommended physicians.
- Returning patients need to have labs performed at least 10 days prior to your appointment. Labs will be discussed at appointments only. **Results will not be discussed over the phone.** If labs are done in between visits, we recommend **signing up for Next MD Patient Portal.** This is a secure portal that we can communicate your results with you.
- **For prescription refills,** please call your pharmacy at least 48 hours in advance. The pharmacist will fax our office a request for your refill. **Refills will be called in within 48 hours after receiving the request.**

We look forward to helping you achieve better health. Our staff is here to help, so if there are ever any questions or concerns, please do not hesitate to call.

Diabetes and Thyroid Center of Fort Worth, PLLC

Darren Lackan, MD, PA, FACE, ECNU ✠ Chris Bajaj, DO, PA, FACE, ECNU

Anjanette Tan, MD, FACE, ECNU ✠ Sara Matani, MD

New Patient Registration Form (Please Print)

Today's Date:

Patient Information

Patient's Last Name: First: Middle:			☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status (circle one) Single / Mar. / Div. / Sep. / Wid.
Nickname:	Former Name:	Birth Date: / /	Age:	Sex: ☐ M ☐ F
Street Address:	City:	State:	Zip Code:	
Social Security #:	Home Phone #: ( )	Cell Phone #: ( )		
Occupation:	Employer:	Employer Phone #: ( )		
Referred to clinic by:	☐ Dr.			

Guarantor Information

☐ Check if same as patient information

Person Responsible for bill:	Birth Date: / /	Address (if different):	Home Phone #: ( )
Is this person a patient here? ☐ Yes ☐ No			
Social Security #:	Employer:	Employer Address:	Employer #: ( )
Is this patient covered by insurance? ☐ Yes ☐ No			

Patient Portal

The Patient Portal is internet based and used at a personal computer. The Patient Portal is a secure way to:

- Send secure messages to your doctor
- View test results
- Request appointments
- Renew Medication

NEXTGEN® Patient Portal

Please provide your email address below to obtain access to the Patient Portal.

Email Address: Signature:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone #: ( )	Work Phone #: ( )

Diabetes and Thyroid Center of Fort Worth, PLLC

HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Today's Date: _____

Reason for visit: _____

SOCIAL

Marital Status: [Single] [Married] [Widowed] ____/____/_____ [Divorced] ____/____/_____

Occupation: [Retired] [Active] _____

Do you: (Please circle No or Yes and explain if Yes)

Get Exercise	[No]	[Yes]	⇒	_____Hours per week Type of exercise: _____
Use Illegal drugs	[No]	[Yes]	⇒	_____
Use Alcohol	[No]	[Yes]	⇒	Ounces per day: _____
Use Tobacco	[No]	[Yes]	⇒	_____Packs per day for ____years _____current

PAST MEDICAL

What medications are you currently taking (including supplements and vitamins)? Please list dose and frequency.

_____

_____

_____

_____

_____

_____

Have you had previous surgeries? Please list any below:

_____

_____

_____

Problems for which you have seen a physician or have been treated for: (use back of page if necessary)

Diabetes	[No]	[Yes]	⇒	Type _____ Year _____ Treatment _____
Cancer	[No]	[Yes]	⇒	Type _____ Year _____ Treatment _____
Nodule/Tumor	[No]	[Yes]	⇒	Location _____ Year _____ Treatment _____
Cholesterol	[No]	[Yes]	⇒	Meds _____ Side Effects? _____
Stroke	[No]	[Yes]	⇒	Year _____ Treatment _____
Blood Pressure	[No]	[Yes]	⇒	Year _____ Medications _____
Heart Problem	[No]	[Yes]	⇒	Year _____ Treatment _____
Eye Disease	[No]	[Yes]	⇒	Diabetic? _____ Year _____ Treatment _____
Kidney Disease	[No]	[Yes]	⇒	Diabetic? _____ Year _____ Treatment _____
Foot Infections	[No]	[Yes]	⇒	Diabetic? _____ Year _____ Treatment _____
Thyroid Disease	[No]	[Yes]	⇒	Type _____ Year _____ Treatment _____
Others	[No]	[Yes]	⇒	_____

Do you have any allergies/reactions? {please list reaction}

_____

_____

FAMILY

Do any of your blood relatives have or have had any of these diseases or do any other problems run in the family:

Diabetes	[No]	[Yes]	⇒	Type: _____
Cancer	[No]	[Yes]	⇒	Location: _____
Tumor/lesion	[No]	[Yes]	⇒	Location: _____
Heart Problem	[No]	[Yes]	⇒	_____
TB	[No]	[Yes]		
Thyroid Disease	[No]	[Yes]	⇒	Type: _____
High Blood Pressure	[No]	[Yes]	⇒	_____
Stroke	[No]	[Yes]		

Diabetes and Thyroid Center of Fort Worth, PLLC
Darren Lackan, MD, PA, FACE, ECNU ✠ Chris Bajaj, DO, PA, FACE, ECNU
Anjanette Tan, MD, FACE, ECNU ✠ Sara Matani, MD

REVIEW OF SYSTEMS

Completed by: [Patient] [Family Member _____] on: ____/____/_____

Name: _____ [Male] [Female] Age: _____ DOB: _____

Please check any of the following that apply:

Constitutional Symptoms *Have you noticed recently?* ☐ Weight Gain ☐ Fatigue ☐ Weight Loss ☐ Malaise	**Skin** *Do you have?* ☐ Hives ☐ Rash ☐ Itching ☐ Skin Lesions
Ears-Nose-Mouth-Throat *Have you recently had?* ☐ Sinus Pressure ☐ Eye Pain ☐ Sore Throat	**Eyes** *Have you recently had?* ☐ Visual Changes ☐ Peripheral Vision Loss
Respiratory *Do you have?* ☐ Cough ☐ Wheezing ☐ Shortness of Breath	**Cardiovascular** *Do you have?* ☐ Chest Pain ☐ Leg Pain with Walking ☐ Palpitations ☐ Swollen Ankles
Gastrointestinal *Do you have?* ☐ Abdominal Pain ☐ Nausea ☐ Change in Stools ☐ Diarrhea ☐ Constipation ☐ Loss of Appetite	**Endocrine** *Do you have?* ☐ Cold Intolerance ☐ Excessive Hair Growth ☐ Heat Intolerance ☐ Excessive Thirst ☐ Brittle Hair/Nails ☐ Excessive Hunger
Musculoskeletal *Do you have?* ☐ Back Pain ☐ Joint Pains ☐ Muscle Weakness	**Allergies/Immune** *Do you have?* ☐ Seasonal Allergies ☐ Food Allergies
Psychology *Do you feel?* ☐ Anxious ☐ Depressed	**Hematology/Lymphatic** *Do you?* ☐ Bruise Easily ☐ Swollen Glands

Diabetes and Thyroid Center of Fort Worth, PLLC
Darren Lackan, MD, PA, FACE, ECNU ✪ Chris Bajaj, DO, PA, FACE, ECNU
Anjanette Tan, MD, FACE, ECNU ✪ Sara Matani, MD

NEXTGEN® Patient Portal

The Patient Portal is internet based and used at a personal computer.

The Patient Portal is a secure way to:

- Send secure messages to your doctor
- View test results
- Request appointments
- Renew Medication

If you would like to sign up for the Patient Portal, please provide your email address below.

Email Address: _____

6844 Harris Parkway, Suite 300 • Fort Worth, Texas 76132
P: 817-263-0007 • F: 817-263-1118 • www.DTC-FW.com

Diabetes and Thyroid Center of Fort Worth, PLLC
Darren Lackan, MD, PA, FACE, ECNU ✪ Chris Bajaj, DO, PA, FACE, ECNU
Anjanette Tan, MD, FACE, ECNU ✪ Sara Matani, MD

Patient Name: _____ DOB: _____

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

WHO TO CONTACT

I hereby give permission to Diabetes and Thyroid Center of Fort Worth, PLLC to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name		Relationship	
Name		Relationship	
Name		Relationship	
Name		Relationship	

☐ I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition(s).

HOW TO CONTACT

Communication by Phone / Text Message

Home Phone: ( )		Work/Cell Phone: ( )	
☐	Ok to leave message with detailed information	☐ ☐	Approve to leave message with detailed information Approve to send text messages with detailed information

Written Communication

☐	Approve to send mail to my home address:
☐	Approve to send to my Email address:

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient or Parent/Guardian Signature:_____ Date: _____

DIABETES AND THYROID CENTER OF FORT WORTH
Darren Lackan, MD, PA, FACE, ECNU Chris Bajaj, DO, PA, FACE, ECNU
Anjanette Tan, MD, FACE, ECNU Sara Matani, MD

NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

This notice describes the practices of Diabetes and Thyroid Center of Fort Worth (DTC) and that of its physicians with respect to your protected health information created while you are a patient at DTC. DTC physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, DTC physicians may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at DTC. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at DTC.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of DTC, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction;
- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to Diabetes and Thyroid Center of Fort Worth, 7801 Oakmont Blvd., Suite 101, Fort Worth, TX, 76132.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at DTC.
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations, and As Otherwise Allowed By Law

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories

We will use your health information for treatment.
For example: We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at DTC. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at DTC.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.
For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.

Business associates: There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Communications for treatment and health care operations:
We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fundraising: We may contact you as part of a fundraising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative, and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative, and law enforcement purposes.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state, or local law.

For More Information or to Report a Problem
If you have questions or would like additional information, you may contact Enterprise Medical Management at 866 4597818. If you believe your privacy rights have been violated, you can file a complaint with Enterprise Medical Management or the Secretary of Health and Human Services. There will be no retaliation for filing a complaint

Diabetes and Thyroid Center of Fort Worth, PLLC

Darren Lackan, MD, PA, FACE, ECNU Chris Bajaj, DO, PA, FACE, ECNU

Anjanette Tan, MD, FACE, ECNU Sara Matani, MD

ACKNOWLEDGEMENT OF THE RECEIPT OF DIABETES AND THYROID CENTER OF FORT WORTH (DTC)
NOTICE OF HEALTH INFORMATION PRACTICES

ACKNOWLEDGEMENT

The Health Insurance Portability and Accountability Act (HIPAA)is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. DTC is furnishing you with the attached notice, which provides information about how DTC and its physicians may use and/or disclose protected information about you for treatment, payment, healthcare operations and as otherwise allowed by the law. By signing this form, you acknowledge that you have received a copy of Notice of Health Information Practices.

Initial: _____

CONSENT TO TREAT

I hereby authorize employees and agents, including physicians of this medical office, to render routine medical care to the patient indicated on this form, and to fulfill the orders of the physicians including consultants, associates and assistants of the physician's choice. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Initial: _____

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to DTC and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to DTC. I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of DTC, if any. I also understand that interest may be charged at a rate of 11% per annum for accounts over 60 days old. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Initial: _____

FOR MINORS

If the patient is a minor:

I consent for _____ to authorize evaluation and treatment for my child named herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

Initial: _____

GOVERNING LAW AGREEMENT

I (we), the patient or patient's representative and DTC, including employees and agents of DTC, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choices of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Initial: _____

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____