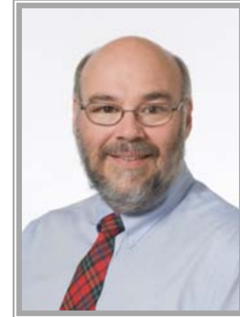
Adonai Diabetes and Endocrinology Center, Inc.
Samuel L. Abbate, MD, CDE
Phone: (907) 357-2332 Fax: (907) 357-2344
Monday -Thursday 7:30am - 5:30pm
help@adecteam.org

Welcome to the Adonai Diabetes and Endocrinology Center!

We are pleased to have the opportunity
to serve you and partner with you
in a shared goal to improve your health.



- **In order to secure an appointment time we require you to complete and return the enclosed forms to the office in person or by fax. Your appointment will be scheduled once all paperwork and outside records have been received.**

  ** *Receipt of records and forms enables you to be moved to an earlier appointment should one become available.* If you need assistance in completing any of the forms, please feel free to call our office at 907-357-2332.

- This packet contains information about our clinic policies and a list of items you should bring to your visits. Please take the time to answer all of the questions on the following pages which will assist us in preparing for your visit.
- We are located at 3331 E. Meridian Park Loop. From the Palmer-Wasilla Highway, head north on Seward Meridian Rd for .4 miles and take the 1st left onto E. Meridian Park Loop. Continue for approximately .2 miles and our office will be on the left.
- All the information you provide is strictly confidential and will not be released without your permission.
- Please know that our rates are considered to be usual and customary as defined by health insurance companies in Alaska. If you are experiencing difficulty paying your bill, we are willing to work with you and invite you to contact our office.

We look forward to meeting with you.

Sincerely,

Samuel L. Abbate MD, CDE

Adonai Diabetes and Endocrinology Center, Inc. – Samuel L. Abbate, MD, CDE

♋ REGISTRATION FORM ♋

Please print your information.

Personal Information

Name: ____ Social Security #: ______________________
(Last) (First) (MI)

Birth Date: (mm/dd/yyyy)________________ Gender: ☐Male ☐ Female Marital Status: __________________

Race*: ___________________ Ethnicity*: ___________________ Language*: ___________________
[*FEDERAL GOVERNMENT REQUESTS THESE ITEMS]

Email: ____

Physical Address: ____

City: ________________________________ State: ______________ Zip: _________________________

Mailing Address: ____

City: ________________________________ State: ______________ Zip: _________________________

Primary Phone (# to call first): _________________________ Other Phone: ______________________________

Employer: _____________________________________ Work Phone: ______________________________

Spouse's Name: _____________________________________ Social Security #: ______________________

Emergency Contact/Relationship: __________________________ / ______________________

↳ Home Phone: _____________________________ Cell Phone: _______________________________

Referred by Physician: ______________________ How did you hear about us? ___________________

Primary Care Provider: ________________________ Preferred Pharmacy: ___________________________

Insurance Information

Person Responsible for the Account: ____
(Last) (First) (MI)

1. ☐ Primary Insurance ☐ Secondary Insurance **Please fill in all policy information!**

Insurance Company: ____

Identification #(Including Alpha Prefix if one): __________________________ Group _________________

Subscribers Name: ____**Birth Date**____________________

Employed by: ____ Work Phone #: _____________________

2. ☐ Primary Insurance ☐ Secondary Insurance **Please fill in all policy information!**

Insurance Company: ____

Identification #(include Alpha Prefix if one): __________________________ Group #: __________________

Subscribers Name: ____ Birth Date: ____________________

Employed by: ____ Work Phone #: _____________________

Assignment and Release

I authorize my insurance benefits to be paid directly to the Doctor. I understand that I am financially responsible for any balance due, including any collection or processing fees. I hereby authorize the doctor to release all information necessary to secure payment of benefit and the use of this signature below on all insurance submissions.

Signature: ____ Date: ______________________

Adonai Diabetes and Endocrinology Center, Inc. – Samuel L. Abbate, MD, CDE

☙ REGISTRATION FORM ❧

CURRENT MEDICAL PROBLEMS

Please list all medical problems that you have *(Example: diabetes, high blood pressure, etc.);* and anytime you were in the hospital for a medical reason. *(Example: 2001 – pneumonia):*

____
____
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FAMILY MEDICAL HISTORY

Please list all serious medical problems in your family

(Example: Diabetes – mother & brother):

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SURGERY

Please list any surgeries you have had in the past *(Example: 2002 - cataract removal from right eye):*

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ALLERGIES

Please list any medicines, foods or materials you are allergic to and your reaction (Example: penicillin-rash):

____
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____
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____

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you live: ☐ Alone ☐ With family ☐ Roommate(s) Live with: (e.g. wife,children) ___________________

Employment: ☐ Working ☐ Home maker ☐ Retired ☐ Unemployed ☐ Disabled

What hours do you work: ____

Do you drink alcohol? ☐ Yes ☐ No (Type and Amount) ____

Have you ever smoked? ☐ Yes ☐ No Do you currently smoke? ☐ Yes ☐ No

If you have smoked previously, what year did you quit? _________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ____ Date: ______________________

Adonai Diabetes and Endocrinology Center, Inc. – Samuel L. Abbate, MD, CDE

☙ MEDICATION FORM ❧

Please give the information for all medicines that you take:

(*Example: **Medicine**: Metformin **Strength**: 500 mg **How taken**: 2 pills at breakfast; 1 pill at supper)*

Please include: vitamins, supplements and over-the-counter medicines

- Medicine: ____________________ Strength: __________
  How taken: ____
- Medicine: ____________________ Strength: __________
  How taken: ____
- Medicine: ____________________ Strength: __________
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- Medicine: ____________________ Strength: __________
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- Medicine: ____________________ Strength: __________
  How taken: ____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ______________________________ Date: ______________

❦ PRIVATE HEALTH INFORMATION DISCLOSURE ❧

The department of Health and Human Services has established a "Privacy Act" to help insure that personal health care information is protected for privacy. The Privacy Act was also created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient and/or to carry out treatment, payment or health care operations (TPO).

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide services that are in your best interest.

I acknowledge that I have received, or had the opportunity to receive, a full copy of my full rights regarding my personal health information. I understand that I can obtain an additional copy of these rights from this office or on our website at any time.

I have reviewed and understand my rights regarding my personal healthcare information.

Signature: ____ Date: ____________________

Printed Name: ____

ꟷ PRIVATE HEALTH INFORMATION DISCLOSURE ꟷ

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule gives individuals the right to request a restriction on uses of Private Health Information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternate means, such as sending correspondence to the individual's home, work or fax number.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

Note: Use and disclosure for Treatment, Payment and Operations may be permitted without prior consent and in emergency situations.

Communication of my Private Health Information may be handled in the following manner:

☐ Provider may mail information to my home address.

☐ Provider may mail information to my work address.

☐ Provider may leave information on my telephone: ___________________________________

(This may include appointment reminders or information regarding visits or study results.)

☐ Provider may send information to this fax number: __________________________________

☐ Provider may exchange information via this email address: ___________________________

☐ **Provider may send information to (name, relationship and contact information). Be advised you must provide spouses, significant others, children, etc. that you authorize information to be released to or we will not be able to discuss any information with them.**

____

____

Signature: ____ Date: ____________________

Patient Name: _ DOB: _

Adonai Diabetes and Endocrinology Center – Samuel L. Abbate, MD, CDE

PATIENT REMINDERS

Please keep accessible for quick reference

PATIENT VISIT CHECKLIST

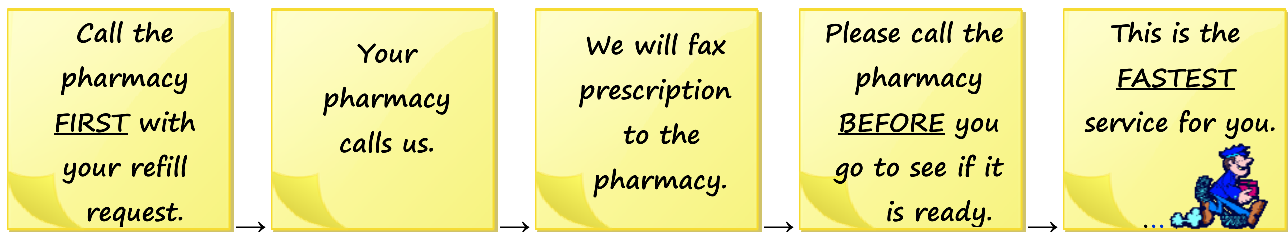
Please bring the following items with you to EVERY visit:

- ✓ All prescription medications
- ✓ All vitamins, supplements, over-the-counter medicines
- ✓ Insurance card(s) / information
- ✓ Written questions for your provider

If you have Diabetes:

- ✓ Blood glucose monitor
- ✓ Home blood glucose records (log book)
- ✓ Meal plan/food log (if asked to keep one)

PRESCRIPTION REFILL PROCESS



Note:

- Whenever possible we will provide samples of medications that are being recommended.

Samples may not always be available and cannot be provided on an ongoing basis. We will assist you with identifying programs to help you get the needed medications, should you have difficulty paying for them.

APPOINTMENT CANCELLATIONS

At avoid late cancellation charges:
Call no later than 24 hours prior
to your appointment to cancel or reschedule.
The office number is 357-2332.
Call this number anytime day or night.

Signature: ______________________________ Date: ________________

Patient Name: _ DOB: _

Adonai Diabetes and Endocrinology Center, Inc. – Samuel L. Abbate, MD, CDE

☙ PATIENT RIGHTS AND RESPONSIBILITIES ❧

Care Provided:

- We strive to provide high quality consultation reports that address the symptoms and concerns of our patients. The results of the clinical evaluation, laboratory studies and radiology reports will be shared with your primary care provider. We will schedule a follow-up visit with you to review the laboratory and radiology results. At that time, we will start or evaluate the treatment plan.
- We do not provide primary care to patients.
  This is a medical subspecialty practice, so all patients are required to have a primary care provider. If you do not have a primary care provider, we will offer you the names of local providers.
- We do not provide acute or chronic pain management.
  If these medical services are needed we will make appropriate referrals.
- We will make referrals to other providers as necessary to provide you with the care you require. *We will assist you in making those appointments or you may do so yourself.*
- **All care is provided in person. Laboratory results will not be provided over the telephone in place of an office visit.**

Missed Appointments:

- We will call to confirm your appointment 1-2 business days prior to your appointment. If we are unable to reach you, we will leave a message (when possible).
- **If you fail to keep your appointment <u>or</u> do not cancel more than 24 hours prior to the appointment, a $100.00 fee will be charged directly to you and not your insurance company.**
- If you fail to keep your appointments 3 times, these will be grounds for termination of the doctor-patient relationship.

Co-Pays, Deductibles and Fees:

- **ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.**
- **A $25.00 LATE FEE WILL BE ADDED TO ACCOUNTS NOT PAID IN FULL BY 60 DAYS**
- **A 25% SERVICE CHARGE WILL BE ASSESSED TO ALL ACCOUNTS THAT ARE SENT TO COLLECTIONS.**

Medical Records Requests:

- We will make every effort to fulfill requests for medical records in 1-2 business days.
- If you have already received a copy of your records and you request an additional copy, a $25.00 service fee will be charged.

I have read and understand these policies and agree to abide by them.

Signature: ____ Date: _____________________

Patient Name: _ DOB: _

ꕥ PATIENT RIGHTS AND RESPONSIBILITIES ꕥ

Healthcare is a partnership between patients and their providers.

The best outcomes are achieved when we work closely together in a trusting relationship.

Patient's Rights:

1. Be seen in a timely manner.
2. Be treated with respect.
3. Participate in all medical decisions and selection of treatments.
4. Be aware of possible complications and side-effects of recommended treatments.
5. Have written instructions describing your care plan.
6. Receive prompt attention for urgent and emergent medical conditions.
7. Receive prompt and appropriate referral for needed services.
8. Respect for the privacy of your personal health information.

Patient's Responsibilities:

1. Keep and be on time for appointments.
2. Treat all care team members with respect.
3. Follow treatment recommendations and treatment plans.
4. Immediately report all treatment complications and if treatments are stopped.
5. Read and implement written instructions.
6. Seek attention at urgent care and emergency facilities if this is office is closed or is not the best place to receive the needed care.
7. Follow recommendations for referrals to other providers.
8. Complete necessary forms for compliance with privacy regulations and for release of information.

I have read and understand my rights and responsibilities and agree to comply with them.

Signature: ____ Date: _______________