HOW TO MAKE THE MOST OUT OF YOUR FIRST VISIT

1. Bring the enclosed forms fully completed
2. Be sure to complete the list of medications you are taking, including the doses and frequency of prescription (or bring the bottles)
3. Bring your Driver’s License (or other form of ID)
4. Bring all your insurance cards

DIRECTIONS FROM SHREVEPORT (I-49 & I-20):
Travel on I-20 East to Exit 18A toward Common Street/Line Ave; merge onto Southern Avenue and take the Line Avenue Exit. Turn left onto Jordan Street; take the 1st right onto Irving Place; 1560 IRVING PLACE is on the right.

DIRECTIONS FROM BOSSIER CITY:
Take I-20 West take the Louisiana Ave exit, EXIT 18D, toward Common Street; Keep right to take the Louisiana Ave ramp; Turn slight right onto Louisiana Ave; Turn left onto Jordan Street; Take the 1st right onto Irving Place; 1560 IRVING PLACE is on the right.
Diabetes Assessment and Management Center of Shreveport, LLC
REGISTRATION FORM

<table>
<thead>
<tr>
<th>Primary Care Physician:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
</tbody>
</table>

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Patient’s last name:</th>
<th>First:</th>
<th>Middle:</th>
<th>Marital status:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is this your legal name?</th>
<th>If not, what is your legal name?</th>
<th>Former name:</th>
<th>Birth date:</th>
<th>Age:</th>
<th>Sex:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td>☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Social Security no.:</th>
<th>Home phone no.:</th>
<th>Cell phone no.:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Occupation:</th>
<th>Employer:</th>
<th>Employer phone no.:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Chose clinic because/referred to clinic by (Please choose one option):</th>
<th>[Doctor’s name]</th>
<th>[Choose an item]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Other family members seen here:</th>
<th>[Other patients]</th>
</tr>
</thead>
</table>

**INSURANCE INFORMATION**

(Please give your insurance card to the receptionist.)

<table>
<thead>
<tr>
<th>Person responsible for bill:</th>
<th>Birth date: (Birthday)</th>
<th>Address (if different): (Address)</th>
<th>Home phone no.: (Phone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Responsible party]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is this person a patient here?</th>
<th>Is this patient covered by insurance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupation:</th>
<th>Employer:</th>
<th>Employer address:</th>
<th>Employer phone no.:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Please indicate primary insurance:</th>
<th>[Choose an item]</th>
<th>Other: [Other insurance]</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Subscriber’s name:</th>
<th>Subscriber’s S.S. no.:</th>
<th>Birth date: (Birthday)</th>
<th>Group no.: (Group #)</th>
<th>Policy no.: (Policy #)</th>
<th>Co-payment: ($[Co-pay])</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Name]</td>
<td>[SS#]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s relationship to subscriber:</th>
<th>[Choose an item]</th>
<th>Other: [Relationship to subscriber]</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of secondary insurance (if applicable):</th>
<th>Subscriber’s name:</th>
<th>Group no.: (Group #)</th>
<th>Policy no.: (Policy #)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Secondary Insurance]</td>
<td>[Name]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s relationship to subscriber:</th>
<th>[Choose an item]</th>
<th>Other: [Relationship to subscriber]</th>
</tr>
</thead>
</table>

**IN CASE OF EMERGENCY**

<table>
<thead>
<tr>
<th>Name of local friend or relative (not living at same address):</th>
<th>Relationship to patient:</th>
<th>Home phone no.:</th>
<th>Work phone no.:</th>
</tr>
</thead>
</table>

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Diabetes Assessment and Management Center of Shreveport, LLC or insurance company to release any information required to process my claims.

<table>
<thead>
<tr>
<th>Patient/Guardian signature</th>
<th>Date</th>
</tr>
</thead>
</table>
# Diabetes Assessment & Management Centers

## PARTICIPANT SELF ASSESSMENT OF DIABETES MANAGEMENT

**Name:** __________________________________     **Date:**__________________________________________

**Date of Birth:** ___/___/___    **Age:** _____    **Gender:** [F] [M]

**Ethnic Background:** [White/Caucasian] [Black/A-A] [Hispanic] [Native American] [Middle-eastern]

**What is your language preference:** [English] [Other] ______________________

**Address:**

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>ST</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>________</td>
<td>______</td>
<td>____</td>
<td>_____</td>
</tr>
</tbody>
</table>

**Phone:** Home (_____) __________________ Work: (_____) __________________ Mobile: (_____) _________________

1. **What type of diabetes do you have?** [Type 1] [Type 2] [Pre-diabetes] [GDM] [Don’t Know]

2. **Year/Age of Diabetes Diagnoses:** ______/_____

3. **Do you take diabetes medications?** [Y] [N]  
   **Please list:** Diabetes pills  Insulin injections  Byetta injections  Symlin injections  
   **Combination of pills and injections:**

4. **Do you have other health problems?** [Y] [N]  
   **Please list other medical conditions:** ___________________________________________________________

5. **Do you take other medications?** [Y] [N]  
   **Please list other medications:** _______________________________

6. **What is the last grade of school you have completed?** _______________________________________________

7. **Are you currently employed?** [Y] [N]  
   **What is your occupation?** ________________________________

8. **Marital Status:** [Single] [Married] [Divorced] [Widowed]  
   **How many people live in your household?** __
   **How are they related to you?** __________________________________________________________

9. **From whom do you get support for your diabetes?** [Family] [Co-workers] [Healthcare providers] [Support group] [No-one]

10. **Do you have a meal plan for diabetes?** [Y] [N]  
    **If yes, please describe:** __________________________

11. **About how often do you use this meal plan?** [Never] [Seldom] [Sometimes] [Usually] [Always]

12. **Do you drink alcohol?** [Y] [N]  
    **Type:** ______   **How many _____ per day _____ per week _____ occasionally_____ __________

13. **Do you exercise regularly?** [Y] [N]  
    **Type:** ______   **How Often:**

14. **Do you check your blood sugars?** [Y] [N]  
    **Blood sugar range:** ______ to ________  
    **How often:** [Once a day 2 or more/day] [1 or more/Week] [Occasionally]

15. **What is your target blood sugar range?** _________________

16. **In the last month, how often have you had a low blood sugar reaction:** [Never] [Once] [One or more times/week]

17. **Check any of the following tests/procedures you have had in the last 12 months:**
   - dilated eye exam
   - urine test for protein
   - foot exam--self
   - foot exam--healthcare professional
   - dental exam
   - blood pressure
   - weight
   - cholesterol
   - HgA1c
   - flu shot
   - pneumonia shot
19. In the last 12 months, have you: used emergency room services [ ] been admitted to a hospital [ ]
   Was ER visit or hospital admission diabetes related? [Y] [N]

20. Do you have any of the following: eye problems [ ] kidney problems [ ] numbness/tingling/loss of feeling in your feet [ ] dental problems [ ] high blood pressure [ ] high cholesterol [ ] sexual problems [ ] depression [ ]

22. Have you had previous instruction on how to take care of your diabetes? [Y] [N] How long ago:

22. In your own words, what is diabetes?

23. How do you learn best: Listening [ ] Reading [ ] Observing [ ] Doing [ ]

24. Do you have any difficulty with: hearing [ ] seeing [ ] reading [ ] speaking [ ]
   Explain any checked: __________________________________________________________

25. Do you use computers: to email [ ] look for health and other information [ ]

26. Please state whether you agree, are neutral or disagree with the following statements:
   I feel good about my general health: agree [ ] neutral [ ] disagree [ ]
   My diabetes interferes with other aspects of my life: agree [ ] neutral [ ] disagree [ ]
   My level of stress is high: agree [ ] neutral [ ] disagree [ ]
   I have some control over whether I get diabetes complications or not: agree [ ] neutral [ ] disagree [ ]
   I struggle with making changes in my life to care for my diabetes: agree [ ] neutral [ ] disagree [ ]

27. How do you handle stress?

28. What concerns you most about your diabetes?

29. What is hardest for you in caring for your diabetes?

30. What are your thoughts or feelings about this issue (e.g., frustrated, angry, guilty)?

31. What are you most interested in learning from these diabetes education sessions?

32. Pregnancy and Fertility:
   Are you: Pre-menopausal [ ] Menopausal [ ] Post-Menopausal [ ] N/A [ ]
   Are you pregnant? [Y]--When are you expecting? [ ]
   [N]--Are you planning on becoming pregnant? __________
   Have you been pregnant before? [Y] [N] Do you have any children? [Y]--Ages: ______ [N]
   Are you aware of the impact of diabetes on pregnancy? [Y] [N]
   Are you using birth control? [Y]--please specify _____________________________ [N]

*Please do not write below this line*

CLINICIAN ASSESSMENT SUMMARY:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Education Needs/Education Plan: Diabetes disease process [ ] Nutritional Management [ ] Physical Activity [ ]
Using Medications [ ] Monitoring [ ] Preventing Acute Complications [ ] Preventing Chronic Complications [ ]
Behavior Change Strategies [ ] Risk Reduction Strategies [ ] Psychosocial adjustment [ ]

Date: ______________________________  Clinician Signature: __________________________________
DiAMC Patient History Form

Please Print Clearly-Use back of page if needed

Name: ___________________________________ Date: _________________________

Please circle any conditions that apply to you:  Tobacco Y  N  Alcohol Y  N

- Asthma
- Bleeding Disorders
- COPD
- Diabetes
- Fainting
- Heart Disease
- Gastrointestinal Problems
- Kidney Disease
- Thyroid Disease
- Musculoskeletal Problems
- Psychological Issues
- Seizures
- Sleeping Disorders
- Stroke

Please list any other problems: _______________________________________________________

Allergies: ____________________________ Previous Surgeries: _____________________________

Family Health Problems: Mother: ________________ Father: ____________________________

Please list your medications below:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
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<tbody>
<tr>
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(If additional space is needed, please use the back of page)
CONSENT/AUTHORIZATION FOR TREATMENT

1. I consent to and acknowledge the risk of the following services including but not limited to Venipuncture (drawing blood); Glucose monitoring; Retinograph (pictures taken of my retina); Urine testing for protein; Physical exam including monofilament foot exam and measurement of ABI (ankle brachial index) using segmental blood pressures and a Doppler (computer aided stethoscope) with production of PVR (pulse volume recording); Diabetes education and Medication counseling.

2. I acknowledge full responsibility for the payment of such services and agree to pay my bills in full AT TIME OF SERVICE unless other arrangements are made. By signing this consent I assign all rights, title and interest and authorize direct payment to DiAMC of any insurance benefits or benefits under the Social Security Act for the services. DiAMC will assist in billing my insurance company but I am financially responsible for charges not collected by this assignment. I authorize DiAMC to bill my insurance or third party and receive payment from them directly.

3. I acknowledge that to the extent necessary to determine liability for payment or to obtain reimbursement, DiAMC may disclose my records to any person, Social Security Administration, insurance or benefit payer, health care service, or plan which may be liable for all or any of the charges. Furthermore DiAMC may disclose my records to other treating providers, audit committees for the purpose of quality improvement, and applicable state and federal agencies.

4. My signature acknowledges that I have been given the right to ask questions and receive information about any services and I voluntarily sign this consent. This authorization shall remain valid for a period of one year unless I revoke it in writing. A photocopy or faxed copy shall be deemed as valid as the original.

Signed: _________________________________ Date: ____________________________
(Patient, Parent, Guardian)

Signed: _________________________________
(Relationship to Patient)
HIPAA CONSENT

This consent form allows Diabetes Assessment & Management Centers (DiAMC) to use and disclose information about me protected under Health insurance portability and accountability act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

DiAMC has informed me of the center's privacy practices, which protects my health information from disclosure without my written permission unless it is disclosed for treatment, payment, or health care operations.

I understand that the terms of notice of privacy practices may change and that I may obtain revised notices by mail or by an update on the DiAMC website.

I understand that I have the right to request, now and in the future, how protected health information is used or disclosed to carry out treatment, payment and health care operations. I understand that while DiAMC is not required to agree to my requested restrictions, if DiAMC does agree, it is bound by that agreement.

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that the service may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information.

I understand that DiAMC may refuse me further service if I revoke the consent. Please indicate authorized representative below if desired.

Signature______________________________ Date ____________________

Authorized release to:________________________________________________________
Shared Medical Visit Waiver Privacy is something almost everyone is concerned about when they come for shared visits. Information revealed during an individual appointment is normally considered confidential, but this confidentiality may be lost by revealing the same information in a group setting. Family members and others may be present during these shared visits. During shared visits, you have the opportunity to listen to discussions between your doctors and other patients of theirs and to ask questions about your own medical condition. Medical information provided in response to another patient’s questions may not be appropriate for all patients. Your doctor will advise you about the recommended treatment for your condition. By signing below you agree that Diabetes Assessment and Management Center of Shreveport, LLC (DiAMC) shall not be liable for any financial or other damages resulting from any breach of confidentiality committed by other members of the group. Along with DiAMC’s commitment to maintain the privacy of its patients, you also agree to protect each other’s privacy by not identifying other patients or discussing their health problems outside of the group setting. I understand that my insurance company will be billed for this appointment. I am aware of my responsibility to pay my co-pay and other costs my insurance does not cover for any services provided in the course of the visit.

___________________________________  ________________________
Print Name                                                                 Date

___________________________________
Patient’s Signature