Phone: (614) 457-7732
Fax: (614) 457-4346

Columbus Endocrinology

Main Office Correspondence Address
4895 Olentangy River Road, Suite 100
Columbus, Ohio 43214

Endocrinology

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Locations:

4895 Olentangy River Road
Suite 100
Columbus, Ohio 43214

2061 Stringtown Road
Grove City, Ohio 43123

1080 Beecher Crossing North
Gahanna, Ohio 43230

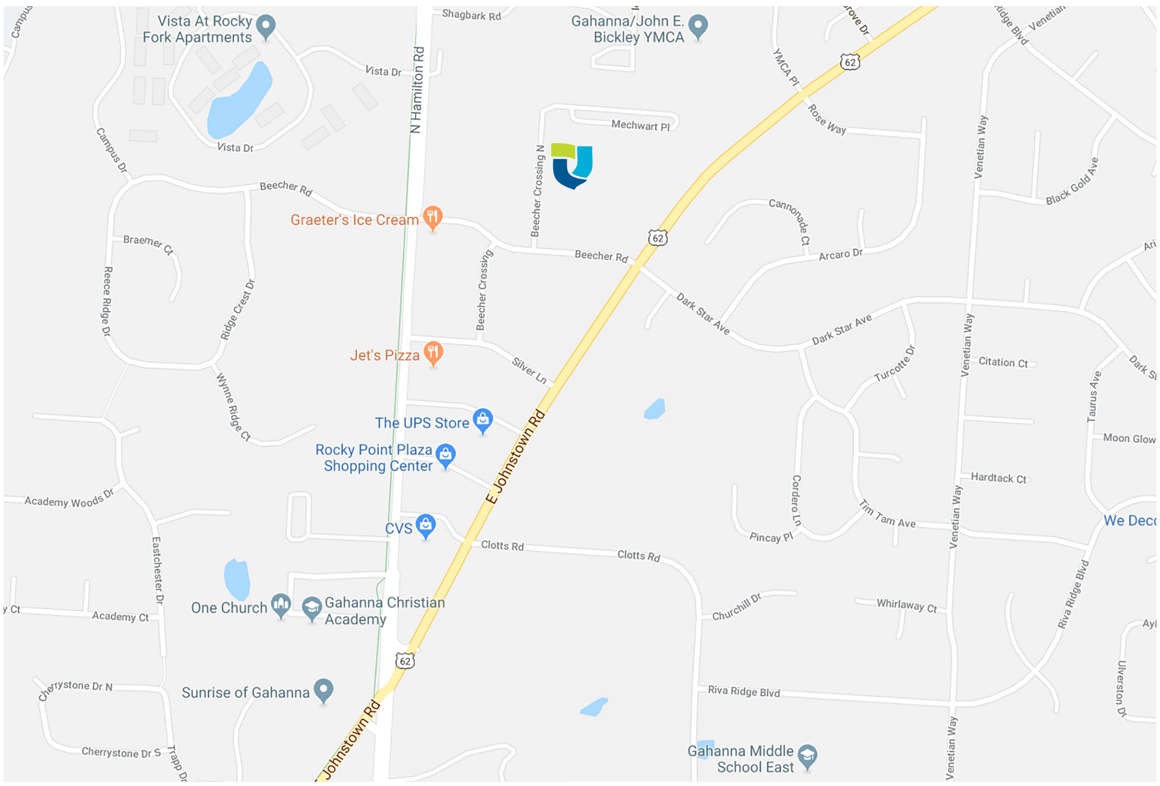
695 W. Central Avenue
Delaware, Ohio 43015

Dear ___________________________,

In an effort to provide efficient comprehensive medical care, we ask that you complete the enclosed forms and bring them with you at the time of your visit. Your appointment is scheduled for:

Day _________________________ Date ____________________ Time __________________

With Laura Butz, M.D. at 1080 Beecher Crossing North, Gahanna, Ohio 43230



I understand and agree that I am also responsible for keeping ALL of my scheduled appointments. ***In the event I am unable to keep a scheduled appointment, I agree to contact the office at least 24 hours (one business day) in advance to cancel. I agree that I am responsible for a late cancelation or missed appointment fee of $50.00.***

Please bring the following information with you to your appointment:

1. The enclosed forms
2. Any medical records
3. A current list of all medications and dosage
4. Your insurance card(s)
5. Your insurance copay

IF DIABETIC, PLEASE BRING YOUR METER OR SUGAR LOGS

Please arrive fifteen minutes prior to your scheduled appointment time. Please contact our office at (614) 457-7732 if you have any questions.

Thank you!

Columbus Endocrinology

CENTRAL OHIO PRIMARY CARE

PATIENT DEMOGRAPHIC INFORMATION - ADULT

Please Complete This Entire Form. Thank You!

Today's Date: _____/_____/____ **Referred By *(If Applicable)*: ____________________________**

PATIENT INFORMATION

OFFICE USE (P#):

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH *(mm/dd/yyyy)*:
MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHYSICAL ADDRESS *(If different from mailing address)*:	CITY:	STATE:	ZIP:
HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )	EXTENSION:

E-MAIL ADDRESS: ☐ None ☐ Prefer Not to Disclose	USE E-MAIL ADDRESS FOR PATIENT PORTAL: ☐ Yes ☐ No ☐ Not Applicable	SOCIAL SECURITY #:

GENDER: ☐ Male ☐ Female ☐ Transgender ☐ Unknown	RACE: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Refuse to Report ☐ Other
ETHNICITY: ☐ Hispanic/Latin ☐ Non-Hispanic/Latin ☐ Refuse to Report	PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other Language (*please specify*):

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

DO YOU HAVE A CAREGIVER: ☐ Yes ☐ No	IF YES, NAME OF CAREGIVER:	IF YES, MAY WE RELEASE PROTECTED HEALTH INFORMATION TO YOUR CAREGIVER: ☐ Yes ☐ No

EMERGENCY CONTACT

LAST NAME:	FIRST NAME:	RELATIONSHIP (*Please specify*):
HOME PHONE: ( )	CELL PHONE: ( )	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: ☐ Yes ☐ No

ADDITIONAL CONTACT #1(OPTIONAL)

LAST NAME:	FIRST NAME:	RELATIONSHIP (*Please specify*):
HOME PHONE: ( )	CELL PHONE: ( )	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: ☐ Yes ☐ No

EMPLOYER INFORMATION

EMPLOYER NAME:	EMPLOYER PHONE NUMBER: ( )

EMPLOYMENT STATUS ☐ Employed ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Unemployed ☐ Active Military ☐ Student

INSURANCE INFORMATION

(Please present all current insurance cards to the Front Desk)

I HAVE INSURANCE: ☐ Yes ☐ No *(Self Pay)*

PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:	RELATION:	SUBSCRIBER:	RELATION:
GENDER: ☐ Male ☐ Female ☐ Transgender ☐ Unknown		GENDER: ☐ Male ☐ Female ☐ Transgender ☐ Unknown	
DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:	DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:

CONFIDENTIAL COMMUNICATION

(I hereby request to receive confidential communications from COPC in the following manner)

TELECOMMUNICATIONS –Please leave messages regarding my protected health information as follows (*Check All That Apply*): ☐ Home Phone of Record ☐ Brief ☐ Extended ☐ Cell Phone of Record ☐ Brief ☐ Extended ☐ Work Phone of Record ☐ Brief ☐ Extended	POSTAL COMMUNICATIONS –Please mail my protected health information to me at (*Select Only One*): ☐ Mailing Address of Record ☐ Street Address of Record ☐ Other: ____ Street Address City State Zip

ADVANCE DIRECTIVES

DO YOU HAVE A LIVING WILL?	☐ No	☐ Yes	*(If yes, please provide a copy to the Front Desk)*
DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?	☐ No	☐ Yes	*(If yes, please provide a copy to the Front Desk)*
DO YOU HAVE A DO NOT RESCUSITATE?	☐ No	☐ Yes	*(If yes, please provide a copy to the Front Desk)*

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM

Receipt of Notice of Privacy Practices

I have been offered the HIPAA Notice of Privacy Practices at COPC which outlines my privacy rights and how COPC may use and disclose Protected Health Information about me.

□ Yes □ No □ Offered but Decline Initials: ______

Photograph for Patient Identification

I give my consent to the use of my photograph for identification on my electronic health record. **□ Accept □ Decline Initials: ______**

Telephone Contacts, Monitoring and Recording-this does not include calls related to appointments, billing or health-related information

I hereby consent and agree that: (1) any calls with COPC may be monitored and/or recorded and that COPC (or anyone acting on COPC's behalf) may contact me, from time to time, regarding my Account (including for collections purposes or related to insurance coverage); (2) any and all of COPC's contacts with me may be made via text message or with an automated dialing and announcing or similar device; (3) COPC may contact me at any telephone number I provide to them, whether a residential or business number, a wireless, cellular or mobile number (including a telephone number converted to a mobile/wireless number, or which connects to any type of mobile/wireless device); (4) I have an established business relationship with COPC and that COPC may contact me at the telephone number I provide to them, in any of the ways described above. I understand that, if I accept now, I may opt-out at any time by notifying the COPC EHR Department.

□ Accept □ Decline Initials: ______

Health Information Exchange (HIE)

COPC participates in one or more Health Information Exchanges that share medical information to facilitate improved care through a comprehensive health record. This information is secure and only available to those providers involved in your care delivery. I agree that my COPC provider may allow access to my health information through the Health Information Exchange for treatment or other health care operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying the COPC EHR Department or my physician.

All COPC patients are automatically enrolled in the HIE unless the Opt Out box is checked and initialed. **□ Opt Out Initials: ______**

Confidential Communications

I understand COPC will notify me if COPC is unable to comply with my request for Confidential Communications.

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

Insurance Assignment and Acknowledgement

I understand my insurance carrier can choose to assign benefits to COPC or my Insurance carrier may make a payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly or by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information.

Medicare and Medicaid: *I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.*

I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment. I certify that I will pay to COPC any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to COPC any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by my insurance for my failure to provide the appropriate insurance information for billing.

By signing below, I am acknowledging that I have read and understand the above statements.

______________________	______________________	______________
Patient Printed Name	**Patient Signature**	**Date Signed**
______________________	______________________	______________
Legal Guardian Printed Name (*if applicable*)*	**Legal Guardian Signature (*if applicable*)***	**Date Signed**

***PLEASE PROVIDE A COPY OF LEGAL GUARDIANSHIP COURT PAPERS FOR THE PATIENT'S RECORD.**

HEALTH QUESTIONNAIRE To be completed by patient

Patient Name ______________________________ Today's Date ______________

Referring Physician (if any) ______________________________

Date of Birth ______________ Age ________ Height __________ Weight ________

CHIEF COMPLAINT(S) OR REASON FOR VISIT

Please list, in order of importance, your present health concerns, symptoms, and/or problems you are experiencing.

____

____

____

____

HOSPITALIZATIONS & SURGERIES

Year	Illness / Surgery	Year	Illness / Surgery

PAST MEDICAL HISTORY

Have you ever had any of the following? Leave blank if uncertain

	YES	NO		YES	NO		YES	NO
AIDS or HIV+			Glaucoma			Osteoporosis		
Anemia			Heart Disease			Pneumonia		
Arthritis			Hemorrhoids			Polio		
Asthma			Hepatitis			Rheumatic Fever		
Back Trouble			Hernias			Scarlet Fever		
Bladder infections			High blood pressure			Smallpox		
Bleeding tendency			Hives or eczema			Stroke		
Bronchitis			Infectious mono			Thyroid Disease		
Cancer			Joint pain			Transfusions		
Chickenpox			Kidney Disease			Tuberculosis		
High Cholesterol			Measles / Mumps			Ulcer		
Diabetes			Migraines			Venereal Disease		
Epilepsy			Mitral Valve			Whooping Cough		

Any other disease(s) *Please list:* ______________________________

____

COMMENTS

____

____

____

SOCIAL HISTORY

	YES	NO	
Do you currently smoke?	____	____	Packs per day ____ for _________ years.
Have you ever smoked?	____	____	Quit date __________ Packs per day ____ for _________ years.
Alcohol Use	____	____	Drinks per week ________
Caffeine Use	____	____	Cups per day ________
Illegal Drugs	____	____	If yes, please list ______________________
Exercise	____	____	Type ______________________ Times per week ______
Calcium	____	____	How much? ______________________

Physician Signature ______________________________

Patient Name ____________________ Date of Birth ____________

FAMILY HISTORY (Physician: Note & Date any changes)

Does your family have a history of . . . ?	Yes	No	*Relationship to patient*	*Does your family have a history of . . . ?*	Yes	No	*Relationship to patient*
High Cholesterol	☐	☐	______	Thyroid Disease	☐	☐	______
Diabetes	☐	☐	______	Depression	☐	☐	______
Heart Disease	☐	☐	______	Alcoholism	☐	☐	______
High Blood Pressure	☐	☐	______	Blood Clots / Disorder	☐	☐	______
Stroke	☐	☐	______	Osteoporosis	☐	☐	______
Cancer	☐	☐	______	Migraines	☐	☐	______

Other: ____________________

Please indicate the last time you had the following (list year):

Flu vaccine ______ Tetanus shot ______ Hepatitis shot ______

TB test ______ Pneumonia shot ______ Rubella vaccine______

Stool blood test ______ Bone density______ Colonoscopy/sigmoidoscopy ______

Eye exam ______ Cholesterol test ______ Prostate specific antigen ______

FOR WOMEN ONLY

Age at onset of menstrual period ______ Date of last menstrual period ______

Do you use birth control? Y ☐ N ☐ Type ______ Number of pregnancies ______

Number of live births ______ Number of abortions ______ Number of miscarriages ______

Year of last Mammogram ______ Results ____________

Year of last Pap Smear ______ Results ____________

DRUG ALLERGIES ____________________

Medications You Are Taking:	Dosage	Times / Day

Over-the-counter Medications, Vitamins and Supplements:

____

____

I have personally reviewed this history form with the patient ____________________

Date ______ **Columbus Endocrinology**

CENTRAL OHIO℠
PRIMARY CARE
Columbus
Endocrinology

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THYROID BIOPSY INSTRUCTIONS

Please discontinue use of any of the following medications or blood thinners **5-7 days prior to appointment:**

Aspirin
Clopidogrel (Plavix)
Ibuprofen (Advil, Motrin)
Naproxen (Aleve, Naprosyn)
Warfarin (Coumadin)
Xarelto (Rivaroxaban)
Eliquis (Apixaban)
Lovenox (Enoxaparin)
Pradaxa (Dabigatran)

If you are taking any of the above medications or blood thinners, please contact your prescribing doctor to verify that it is OK to stop taking this medication for five to seven days prior to your appointment.

**It is OK for you to take Tylenol*
**No fasting is necessary*

Office Policy for Columbus Endocrinology

Patient Information:
As a patient it is your responsibility to tell the staff if and when something has changed with the following:
***Address *Contact Information *Phone Number *Insurance Policy *Insurance Cards *Co-Pays**

Appointments:
All patients are responsible for scheduling, remembering, and keeping their appointments. Although we will attempt to remind you of your appointment with a reminder call, this is only a courtesy. A missed appointment or failure to notify the office within 24 hours of the cancellation can result in a fee billed directly to you. If an appointment is broken without a 24-hour notice, or the patient does not call to cancel and misses the appointment, the office reserves the right to charge a fee. If you are a late arrival to your scheduled appointment, you may be asked to reschedule at the discretion of the provider.

*A follow- up missed appointment fee will be $25. *A second follow-up missed appointment fee will be $50. *A new patient missed appointment fee will be $50.
You are only allowed three no-shows. After the third occurrence, it will be an automatic dismissal from the practice.

If you have Diabetes, please bring your blood glucose logs and meter.

All co-pays are due at the time of service. This is an insurance regulation policy that is made with you and your policy holder. It is our role as a physician's office to honor this agreement. If a co-pay cannot be paid, you may be asked to reschedule your appointment.

If you have an outstanding balance, we ask that you call our billing department (614) 326-2672 to set up a payment plan. You can also call into the office to make payments (614) 457-7732. If you are being seen for an appointment and no payment activity is actively being made, you will be required to make some sort of payment at your visit.

Scheduling: For any patients who are already established in our office, we do not allow you to change physicians. However, all patients will be scheduled for follow up with an Advanced Practice Provider.

Prescriptions and Prescription Refills:
We do not accept auto-fax or calls from your pharmacy for refills. However, we do accept refill request from your pharmacy through the computer (e-request). You can request refills at your visit, or we ask that you use MyChart or call the refill line. Please do not leave refill requests on the nurse line. For all prescription refills please allow 48-72 hours (2-3 business days). Our physicians do attempt to send in prescriptions sooner than that, but it is not guaranteed.

Please plan for the weekend/holidays

When you call in for a refill, please be prepared to tell the staff the following:
***Name of medication *Dosage *Times per day the medication is taken *Quantity**
***The pharmacy to which it should be sent to – Including the phone number and location**

Test Results:
Please allow 7-10 business days to receive your test results. If your labs are normal and you are on the patient portal, they will be posted to your portal. If you go to an outside lab, please allow more time, as it takes us longer to receive the results. If you have gone to an outside lab and have not heard from our office within 2 weeks after having your labs drawn, please contact the office to make sure we received them.

In the event of a medical EMERGENCY after hours, please call the office and select the prompt for the doctor on call.

Columbus Endocrinology Acknowledgment Form

4895 Olentangy River Road Ste 100 . Columbus . Ohio . 43214

By signing below you agree to the terms of this policy and acknowledge that you have received a copy:

Printed Name:____ D.O.B:___________________

Signature:____ Date:____________________