



### **Endocrinology**

Bianshly Rivera, M.D.

### **Rheumatology**

Karen Zagar, M.D.  
Tatiana Nagibina, M.D.  
Tatyana Korableva, PA-C

Welcome to Arthritis & Diabetes Center which focuses on performing to the highest standard, **YOUR SATISFACTION**. Our objective is to provide you with one of the best medical experiences that you have ever had.

Enclosed you will find a Patient Information Sheet, a HIPAA Form, a Financial Policy Form, a Disclosure of Personal Health Information Form and a Medical History Form. It is very important to have these forms **filled out in full** and to bring them with you the day of your appointment. We will also need a **photo ID and your insurance card(s)**. All co-pays and deductibles are due at the time of service.

We do realize that the wait to be seen in our office can be quite lengthy. We try to accommodate each person as best as we can. If for any reason you cannot make your appointment with us, please contact our office a minimum of 24 hours before your scheduled appointment as a courtesy to us and to others wanting to be seen.

If you have questions, please do not hesitate to contact our office. Please arrive **15** minutes early for your first appointment, so that we can process the paperwork. If you arrive late, or without the paperwork, **your appointment will be rescheduled to another day**.

Sincerely,

Karen E. Zagar, M.D.

Tatiana Nagibina, M.D.

Bianshly Rivera, M.D.

Tatyana Korableva, PA-C

And The Staff of Arthritis & Diabetes Center

**ARTHRITIS & DIABETES CENTER, INC.**

Physician you are scheduled to see: \_\_\_\_\_

**PATIENT INFORMATION**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Secondary Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Circle One: Marital Status: S M D W Sex: M / F Ethnicity: Hispanic or Non-Hispanic**

**Race: American Indian Asian Black Caucasian Pacific Islander Other**

Primary Language: \_\_\_\_\_ E Mail: \_\_\_\_\_@\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION REQUIRED:**

**PRIMARY INSURANCE COMPANY NAME: \_\_\_\_\_ POLICY#: \_\_\_\_\_**

**SECONDARY INSURANCE (SUPPLEMENT) COMPANY NAME: \_\_\_\_\_**

**POLICY#: \_\_\_\_\_**

**CANCELLATION / NO SHOW POLICY**

**NO SHOW OR SAME DAY CANCELLATIONS WILL BE ASSESSED A \$50 FEE. CANCELLATIONS NEED TO BE MADE PRIOR TO 24 HOURS OF YOUR SCHEDULED APPOINTMENT TIME.**

**X \_\_\_\_\_**

**ASSIGNMENT OF BENEFITS**

**I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS, BE MADE ON MY BEHALF TO ARTHRITIS & DIABETES CENTER, INC FOR ANY EQUIPMENT OR SERVICES PROVIDED TO ME BY THAT ORGANIZATION.**

**X \_\_\_\_\_**

**I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE ADMINISTRATION AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I HEREBY AUTHORIZE MEDICARE TO FURNISH ARTHRITIS & DIABETES CENTER, INC INFORMATION REGARDING MY MEDICARE CLAIMS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT.**

**X \_\_\_\_\_**

## ARTHRITIS & DIABETES CENTER FINANCIAL POLICY

Welcome to Arthritis & Diabetes Center. Please read the following for your financial obligation. You understand and agree that you are responsible and liable for payment of all charges for professional services rendered. If our office is participating with your insurance and accepts assignment, this means that we will accept what your insurance allows for the services performed which is less than our standard billed amount. Based on your plan, our office will collect the designated copay or the co-insurance **estimated** patient responsibility amount at the time of your visit. Once your claim processes through your insurance, the patient responsibility may be more or less than the original **estimated** amount. You will receive a statement in the mail if there is a balance owed by you that will be due upon receipt. If you have a credit, our office will apply that credit to any open patient balances on your account. It is our office policy to hold all credits on your account until all open claims have been processed by your insurance company.

You authorize payment of medical benefits to the physician/care center performing the professional services. In the event your insurance company forwards payment directly to you, you will deliver such payment to the Arthritis & Diabetes Center.

**PRIVATE PAY:** Full payment is expected when services are rendered if patient is not using health insurance. We accept cash and most major credit/debit cards. Personal checks are not accepted for self-pay patients.

**PPO's & HMO's:** You are responsible for any copays, deductible, co-insurances, and non-covered services.

**\*\*It is the patient's responsibility to verify any required authorizations/referrals are in place prior to their visit\*\***

**Medicare:** We are Medicare providers and accept Medicare assignment. You are responsible for the Medicare yearly deductible, co-insurance, and non-covered services. We will also file your secondary insurance as courtesy. If your secondary insurance does not make payment, you are responsible for this balance. We do not bill tertiary plans; this is the patient's responsibility.

**Medicaid:** We do not participate with ANY Medicaid. The patient is responsible for payment if you have Medicaid. If you have Medicaid as a SECONDARY plan, we will agree to write off the 20 % that the primary plan does not cover after completion of a hardship form with our business office.

**Litigation/Attorney:** Our office does NOT accept Worker's Compensation, Auto/Personal injury cases, nor do we accept Letters of Protection.

You are responsible for keeping our office informed of **any changes in your insurance company or plan**. If you fail to inform us of a change and the wrong insurance is billed, you will be responsible for the balance and billing to the new plan.

It is the policy of our office that a failure to show for a scheduled appointment or same day cancellation will be assessed a \$50 fee. Cancellations need to be made prior to 24 hours of your scheduled appointment time. This is to allow us to accommodate another patient who needs to be seen.

**By signing below, you are stating you understand and agree to all of the above terms and policies:**

**"I understand that I am ultimately responsible for all charges incurred regardless of my existing medical coverage. I accept responsibility for all patient balances due according to the above terms. Should my account become past due, the full balance is due and payable immediately. I will be responsible for all collection and legal costs incurred for collecting the delinquent on my account. "**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Date

# HIPAA Notice of Privacy Practices

[ARTHRITIS & DIABETES CENTER](#)  
[32615 US HWY 19 N., SUITES 2 & 3](#)  
[Palm Harbor, FL 34684](#)  
[727-789-2784](#)

**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## **YOUR RIGHTS**

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply)** – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

**You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information** – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures** – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

## **COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

**Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.**

# HIPAA

## ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the Arthritis & Diabetes Center's Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

\_\_\_\_\_  
Patient Name (Type or Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI**

**ARTHRITIS & DIABETES CENTER  
32615 US HIGHWAY 19 NORTH STE 2 & 3  
PALM HARBOR, FL 34684**

**Information to be Used or Disclosed**

The information covered by this authorization includes: (check one)

All Health Information                       Limited to (e.g. All but my lab results) \_\_\_\_\_

**Purpose of the Disclosure:** Assistance in Care

**Persons Authorized to Use or Disclose the Above Information:** ARTHRITIS & DIABETES CENTER, INC

**Persons to Whom Information May Be Disclosed (e.g. Caregiver, Spouse, Child):** \_\_\_\_\_

\_\_\_\_\_  
(Name of person or organization)

**Expiration Date of Authorization**

This authorization is effective through (check one)  \_\_\_\_/\_\_\_\_/\_\_\_\_ or  NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

\_\_\_\_\_  
Name of patient (Type/Print)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative (if applicable)

\_\_\_\_\_  
Relationship of Patient Representative to Patient (if applicable)

Provided By HCSI



### Endocrinology

Bianshly Rivera, M.D.

### Rheumatology

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#### MEDICAL RELEASE OF INFORMATION

#### RHEUM OR ENDO (CIRCLE ONE)

Date \_\_\_\_\_

Print Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_ Social Security Number(last four) \_\_\_\_\_

TO \_\_\_\_\_

FAX \_\_\_\_\_ PHONE \_\_\_\_\_

I hereby authorize and request you to release any and all information which you may possess relating to my examination and illnesses, including psychiatric and/or psychological information which may be part of my records.

SPECIAL ATTENTION TO:

OFFICE NOTES \_\_\_\_\_

LABORATORY AND BIOPSY REPORTS \_\_\_\_\_

IMAGING \_\_\_\_\_

SPECIAL NOTE: \_\_\_\_\_

**Please forward using this page as your coversheet to:**

32615 US HWY 19N

Suite 2

Palm Harbor, FL 34684

Fax (727) 785-3537 or (727) 499-0647

Phone (727) 789-2784 Attn: \_\_\_\_\_

## CONFIDENTIAL

If you have received this transmittal in error, please notify the sender immediately. The material in this transmission contains confidential information that is legally privileged. This information is intended only for the use of the individual of entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken based on the contents of this transmission is strictly prohibited.





## Endocrinology Patient History Form

Date of first appointment: \_\_\_/\_\_\_/\_\_\_ Birthplace: \_\_\_\_\_  
MONTH DA Y YEAR

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_  
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  F  M  
STREET APT#  
CITY STATE ZIP Telephone: Home (\_\_\_\_) \_\_\_\_\_  
Work (\_\_\_\_) \_\_\_\_\_

**MARITAL STATUS:**  Never Married  Married  Divorced  Separated  Widowed  
Spouse/Significant Other:  Alive/Age \_\_\_\_\_  Deceased/Age \_\_\_\_\_ Major Illnesses \_\_\_\_\_

**EDUCATION** (circle highest level attended):

Grade School College Graduate School Other: \_\_\_\_\_  
Occupation \_\_\_\_\_ Do you work day shift or night shifts ? (Circle)

Referred here by: (check one)  Self  Family  Friend  Doctor  Other Health Professional

Name of person making referral: \_\_\_\_\_

The name of the physician providing your primary medical care: \_\_\_\_\_

Telephone of primary care provider: \_\_\_\_\_

Describe briefly your present symptoms: \_\_\_\_\_

Date symptoms began (approximate): \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Previous treatment for this problem: \_\_\_\_\_

Please list the names of other practitioners you have seen for this problem

\_\_\_\_\_  
\_\_\_\_\_

### PAST MEDICAL HISTORY

Please list your current medical conditions: \_\_\_\_\_

Do you now or have you ever had: (check if "yes")

Cancer (Type: \_\_\_\_\_)

High blood pressure

Neuropathy

Heart disease (Type: \_\_\_\_\_)

Stroke

Kidney stones

Kidney disease (Type: \_\_\_\_\_)

Goiter

History of blood clots

Thyroid disease (Type: \_\_\_\_\_)

Anemia

- Liver disease (Type: \_\_\_\_\_)
- Pancreatic disease (Type: \_\_\_\_\_)
- Diabetes
- High cholesterol
- Retinopathy

## SYSTEMS REVIEW

As you review the following list, please check any of those problems, which are currently affecting you.

Date of last eye exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last bone densitometry (DEXA) \_\_\_\_/\_\_\_\_/\_\_\_\_

### Constitutional

- Recent weight gain amount \_\_\_\_\_
- Recent weight loss amount \_\_\_\_\_
- Fatigue
- Weakness
- Fever

### Eyes

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Tunnel vision
- Dryness
- Itching eyes

### ENT

- Dryness of mouth
- Hoarseness
- Difficulty in swallowing
- Snoring

### NECK

- Neck lumps or nodules
- Neck tenderness

### Cardiovascular

- Pain in chest
- Irregular heart beat
- Rapid heart beat
- High blood pressure
- Heart murmurs

### Respiratory

- Shortness of breath
- Swollen legs or feet
- Cough

### Gastrointestinal

- Nausea
- Constipation
- Increased bowel movements
- Diarrhea
- Heartburn
- Abdominal pain

### Genitourinary

- Decreased libido
- Difficult urination
- Excessive urination
- Getting up at night multiple times to pass urine

#### *For Women Only:*

Are you currently having periods?  Yes  No

Periods regular?  Yes  No

Date of last period? \_\_\_\_/\_\_\_\_/\_\_\_\_

Bleeding after menopause?  Yes  No

Number of pregnancies? \_\_\_\_\_

Number of miscarriages? \_\_\_\_\_

#### *For Men Only:*

- Erectile dysfunction

### Musculoskeletal

- Joint pain
- Muscle weakness
- Muscle tenderness
- Increased in size of ring or show

### Integumentary (skin/hair)

- Easy bruising
- Abnormal hair growth

- Rash
- Hair loss
- Facial flushing
- Thick and big stretch marks

### Neurological System

- Headaches
- Dizziness
- Pain of hands and/or feet
- Tremors

### Psychiatric

- Anxiety
- Depression
- Difficulty falling asleep
- Difficulty staying asleep

### Endocrine

- Excessive thirst
- Night sweats
- Excessive sweats at all times
- Feeling cold
- Feeling hot
- Breast discharge
- Breast pain
- Excessive urination

**If you have history of osteopenia or osteoporosis:**

- History of kidney stones  Yes  No
- History of parent with a fractured hip  Yes  No
- History of any bone fractures  Yes  No
- Active dental issues  Yes  No
- History of prolonged steroid use  Yes  No
- Do you take Vitamin D?  Yes  No If you do, what is formulation and dose \_\_\_\_\_
- Do you take Calcium supplements?  Yes  No If you do, what is formulation and dose \_\_\_\_\_
- History of stomach ulcers  Yes  No
- History of sarcoma  Yes  No
- History of parathyroid issues  Yes  No
- History of radiation  Yes  No
- Have you been on any of these medications for treatment of your bones?

Osteoporosis Medications	Length of time	Helped a lot, somewhat not at all	Reactions
Estrogen (Premarin, etc.)			
Alendronate (Fosamax)			
Etidronate (Didronel)			
Raloxifene (Evista)			
Zoledronic Acid (Reclast)			
Calcitonin injection or nasal (Miacalcin, Calcimar)			
Risedronate (Actonel)			
Denosumab (Prolia)			
Romozosumab (Evenity)			
Abaloparatide (Tymlos)			
Teriparatide (Forteo)			

**If you have thyroid gland disease:**

- History of radiation to the neck  Yes  No
  - Family history of thyroid cancer  Yes  No
  - History of prior biopsies of the thyroid  Yes  No
- If yes, please provide date, place and results: \_\_\_\_\_

**If you have diabetes mellitus:**

- Age at diagnosis: \_\_\_\_\_
- Type of diabetes: \_\_\_\_\_
- Medications tried in the past to treat diabetes: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- Do you wear blood sugar monitoring device?  Yes  No If yes, which one? \_\_\_\_\_
- What was your last HbA1c and when? \_\_\_\_\_

## MEDICATIONS

Drug allergies:  No  Yes To what? \_\_\_\_\_

Type of reaction: \_\_\_\_\_

**PRESENT MEDICATIONS** (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of drug	Dose (include strength and # of pills per day)	Reason for Medication (Diagnosis)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
9.		

### SOCIAL HISTORY

Do you drink caffeinated beverages?  Yes  No Cups/glasses per day: \_\_\_\_\_

Do you smoke?  Yes  No  Past – How long ago? : \_\_\_\_\_

Do you drink alcohol?  Yes  No Drinks per week: \_\_\_\_\_

Do you exercise regularly?  Yes  No

Type: \_\_\_\_\_ Hours per week: \_\_\_\_\_

How many hours of sleep do you get at night? \_\_\_\_\_

Do you get enough sleep at night?  Yes  No

Do you wake up feeling rested?  Yes  No

### PREVIOUS SURGERIES:

Type	Year
1.	
2.	
3.	
4.	
5.	
6.	
7.	

### FAMILY HISTORY:

**Do you know of any blood relative who has or had:** (check and give relationship)

Cancer \_\_\_\_\_

Heart disease \_\_\_\_\_

High blood pressure \_\_\_\_\_

Diabetes \_\_\_\_\_

Stroke \_\_\_\_\_

Thyroid disease \_\_\_\_\_

Autoimmune disease \_\_\_\_\_

Genetic conditions \_\_\_\_\_