



DIABETES & ENDOCRINOLOGY  
CENTER OF OHIO, INC

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*Is scheduled for an appointment with:*

*Dr. Polly Reddy*

*\_\_\_\_\_ Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday*

*\_\_\_\_\_ at \_\_\_\_\_ AM/PM*

- Please plan to arrive 10 minutes prior to your scheduled appointment time to allow for paperwork processing and check-in procedures.*
- If you are unable to arrive by your scheduled appointment time, it may be necessary to reschedule your appointment.*
- A current insurance card and photo identification must be presented at check-in.*

*In order to expedite the check-in process, please complete the attached paperwork prior to your appointment. You may fax your completed paperwork to (614)764-1707 or you may mail it to:*

*DECO, Inc.  
7281 Sawmill Rd., Ste 100  
Dublin, Ohio 43016*

*If you have any questions regarding this paperwork or your visit, please contact our office at*

*614.764.0707*

*We are here to assist you Monday – Friday from 8:30am – 4:30pm*

*Our staff will be happy to assist you Monday – Friday 9:00am-4:30pm*

*614.764.0707*

*614.764.1707 Fax*



*Dr. Polly Reddy received her medical degree from the University of Miami in Miami, Florida. She then completed her Internal Medicine Residency as well as Endocrinology & Metabolism Fellowship at Henry Ford Health System in Detroit, Michigan. She is Board Certified in Endocrinology and Internal Medicine by the American Board of Internal Medicine. She is a Professional Member of the American Diabetes Association (ADA) and the American Association of Clinical Endocrinologists (ACE).*

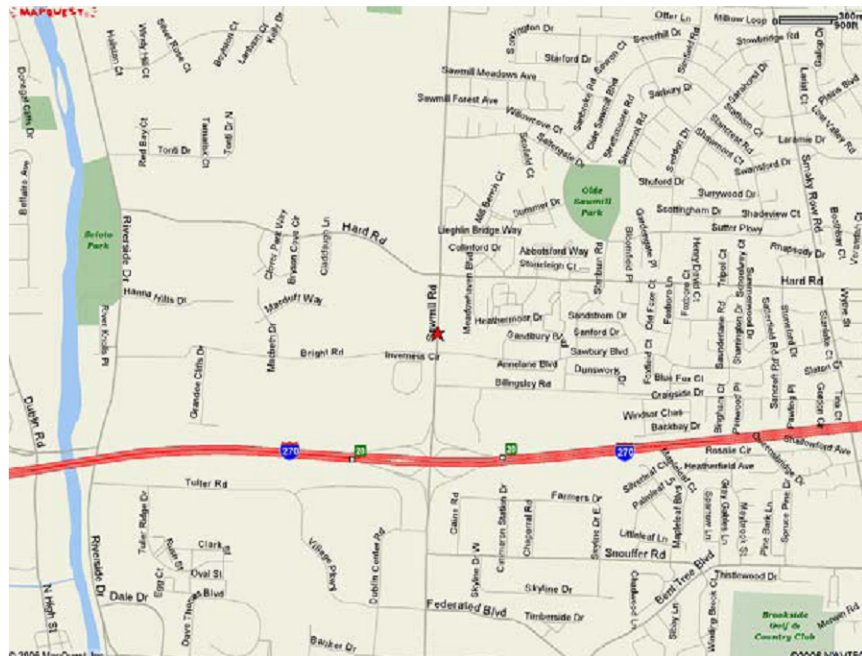
*Polly Reddy MD*

*Our office is conveniently located in Northwest Columbus at:  
7281 Sawmill Rd – Suite 100 (Driveway off Bright Rd.)*

*Dublin, Ohio 43016*

*From I-270, Exit Sawmill Rd. – Head North on Sawmill  
Turn left on Bright/ Sawbury Rd.*

*We are the first driveway on the right, 1st building on the left.*



### Patient Registration

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Martial Status\_\_ S\_\_M\_\_ D\_\_ W

Address \_\_\_\_\_ Sex \_\_M\_\_F

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home phone# (\_\_\_\_) \_\_\_\_\_ Cellular Ph# (\_\_\_\_) \_\_\_\_\_

Ok to leave detailed message? \_\_\_\_Yes \_\_\_\_No

E-mail address \_\_\_\_\_

### Employment Information

\_\_Employed \_\_Disabled \_\_Unemployed \_\_Retired \_\_Self Employed \_\_Student

Employer Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

St \_\_\_\_\_ Zip \_\_\_\_\_ Employer Ph# \_\_\_\_\_ Ext. \_\_\_\_\_

### Pharmacy Information

Pharmacy Name \_\_\_\_\_ Ph# (\_\_\_\_) \_\_\_\_\_

Pharmacy Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

### Mail Order Pharmacy

Pharmacy Name \_\_\_\_\_ Ph# (\_\_\_\_) \_\_\_\_\_

Pharmacy Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

### Emergency Contact Information

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Ph# ( \_\_ ) \_\_\_\_\_ Cell Ph# ( \_\_ ) \_\_\_\_\_

Insurance Information

**Primary Insurance Carrier**

Insurance Company . \_\_\_\_\_

Claims Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Customer Service Phone# (\_\_\_\_) \_\_\_\_\_

Insured Party's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured Party's Date of Birth \_\_\_\_\_ Insured Party's SS# \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Secondary Insurance Carrier**

Insurance Company \_\_\_\_\_

Claims Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Customer Service Phone# ( \_\_ ) \_\_\_\_\_

Insured Party's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured Party's Date of Birth, \_\_\_\_\_ Insured Party's SS# \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group# \_\_\_\_\_

**\*\*\*\*\*Assigned of Insurance Benefits\*\*\*\*\***

**I hereby authorize direct payments of medical benefits to Diabetes & Endocrinology Center of Ohio, Inc for services rendered by them in person or under their supervision. I understand that by signing this form, I am financially responsible for payment of any balances due.**

**\*\*\*\*\*Consent to Treatment\*\*\*\*\***

**I hereby authorize treatment by the physician and staff as they deem medically necessary for conditions they have diagnosed.**

**\*\*\*\*\*HIPAA Notification\*\*\*\*\***

**I hereby acknowledge that Diabetes aS Endocrinology Center of Ohio, Inc. has offered me a copy of the HIPAA Privacy Policy. I have \_\_\_accepted \_\_\_declined a copy.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Failure to complete all information may result in patient being billed directly for services.**

Patient History Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_ S \_ M \_ D \_ W Occupation \_\_\_\_\_

History of Present Illness- What are you being seen for? \_\_\_\_\_

**Current Medication(s)**

**Please list all prescribed medications along with any over the counter or herbal medications**

Medication	Strength /Dose	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Please attach a separate sheet if additional space is needed.)

**Allergies or Sensitivities to Medications (example: Penicillin- Rash)**

\_\_No Known Drug Allergies

Name of Medication	Reaction
_____	_____
_____	_____

**Surgeries & Hospitalization**

**Please list all surgeries & hospitalizations**

Hospitalization	Year	Reason	Surgery	Year
__ Y __ N	_____	_____	_____	_____
__ Y __ N	_____	_____	_____	_____
__ Y __ N	_____	_____	_____	_____
__ Y __ N	_____	_____	_____	_____

**Social History**

- Do you currently smoke? \_\_Yes \_\_No If yes, how many packs per day? \_\_\_\_\_
- Do you drink alcohol? \_\_Yes \_\_No If yes, how often? \_\_\_\_\_
- Do you use street/recreational drugs? \_\_Yes \_\_No
- Are you on a special diet? \_\_Yes \_\_No If yes, please explain. \_\_\_\_\_
- Do you exercise? \_\_Yes \_\_No If yes, please explain. \_\_\_\_\_

# Patient & Family Medical History

Please indicate family history by marking Yes or No.

Please indicate any medical problems that you are being followed for under Patient Medical Problems'.

## Patient Medical Conditions

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

## Family Medical Conditions

Diabetes \_\_\_Type 1 \_\_\_Type 2      \_\_\_Yes \_\_\_No  
Thyroid Disorders                      \_\_\_Yes \_\_\_No  
Pituitary Disorders/Tumors         \_\_\_Yes \_\_\_No  
Coronary Artery Disease             \_\_\_Yes \_\_\_No  
Congestive Heart Failure             \_\_\_Yes \_\_\_No  
Hypertension                            \_\_\_Yes \_\_\_No  
High Cholesterol                        \_\_\_Yes \_\_\_No  
Cancer/Type: \_\_\_\_\_             \_\_\_Yes \_\_\_No  
Stroke                                      \_\_\_Yes \_\_\_No

**Please list all current physicians. Please be sure to include as much information as possible to allow our physicians to communicate their findings.**

### Referring Physician

Name \_\_\_\_\_ Practice Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Phone# (\_\_\_\_) \_\_\_\_\_ Fax# (\_\_\_\_) \_\_\_\_\_

### Primary Care Physician

Name \_\_\_\_\_ Practice Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Phone# (\_\_\_\_) \_\_\_\_\_ Fax# (\_\_\_\_) \_\_\_\_\_

### Additional Physicians

Name \_\_\_\_\_ Practice Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # (\_\_\_\_) \_\_\_\_\_ Fax# (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Practice Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Phone#(\_\_\_\_) \_\_\_\_\_ Fax# (\_\_\_\_) \_\_\_\_\_

I certify that the information given on this questionnaire is filled out to the best of my ability. I understand that the staff of DECO, Inc. will review my history with me at the initial exam.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Office Financial Policy

### Insurance Information

As a courtesy to our patients, we will file claims to your primary and secondary insurance. Please note, your health insurance is a contract between you and your insurance company so it is your responsibility as the patient to make sure our physicians are covered under your plan. All insurance companies do not carry the same benefits so the services rendered to you in this office may or may not be covered. It is the patients' responsibility to know what is covered and if you need a referral.

1. A valid insurance card must be presented at each visit. If you do not have an insurance card with you it will be necessary to either reschedule the appointment or the patient can pay out of pocket at the time of the visit.

2. Copay is due at the time of service. If you do not have the copay amount your appointment may be rescheduled.

3. In order to successfully file a claim with your insurance company, you must provide all the requested information on the patient demographics form. This includes:

- A. subscriber's name
- B. subscriber's date of birth
- C. subscriber's social security number

### No Show or Canceling of Appointments

We understand that emergencies may arise that prevent you from canceling your appointment in a timely manner (at least 24 hours notice). However, if you have 5 No Show/Late Cancel appointments within 1 year, you will be charged a \$25.00 fee.

### Self Pay Patients

All patients without insurance must pay for the visits at the time of service.

### Statements

Mailed to the patient approximately every 30 days. A statement will be mailed to the patient once payment or further information regarding the visit has been received from your insurance company.

### Payment Arrangements

Under special circumstances payment arrangements can be made with our billing office. If upon receipt of statement you are unable to pay the entire amount of your bill, a payment plan can be discussed. The following guidelines have been set in place to ensure proper and timely payment.

- 1. payment arrangements will not exceed 6 months from date of service, unless approved by the practice administrator
- 2. failure to uphold scheduled payments will result in a voided agreement and full payment will be due immediately
- 3. all payment agreements will officially be signed and dated

Any questions or concerns you may have can be addressed by our Practice Administrator Miranda, at 614-764-0707.

I have read and fully understand the above policy.

\_\_\_\_\_  
Patient or Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
DECO Representative Signature

\_\_\_\_\_  
Date