Patient Name:_____

Naomi Berrie Diabetes Center

Contact Information:

Home Telephone _____
Work Telephone _____
Other Telephone _____
Home Fax _____
Work Fax _____
E-mail _____

Primary Care MD _____

Address _____
Telephone _____
Fax _____

Pharmacy Name _____
Address _____
Telephone _____
Fax _____

DO NOT WRITE BELOW THIS AREA (FOR PHYISICIAN'S USE ONLY)

Medications:

Insulin _____
Oral Agent _____
Ace Inhibitor _____
Antihypertensive _____
Other _____

Problem List

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Naomi Berrie Diabetes Center
Registration Form

Date: _____

☐ New Patient
☐ Established Patient

Patient Information

Patient Name: (Last,First)	Social Security No. - -	Date of Birth / /	Gender ☐ Female ☐ Male
Street Address:	Apt No.	Marital Status ☐ Single ☐ Married ☐ Divorce ☐ Widowed ☐ Separate	
City/State:	Zip Code:	Email:	
Home Telephone:	Cell Phone:	Work Phone:	
Mother's First Name:	Father's First Name:		

Patient Employer Information

Company Name:	Occupation:	Telephone:
Company Address:	City/State:	Zip Code:

Guarantor-Person Responsible For Payment ** (Leave blank, if same as patient)

Guarantor Name: (Last,First)	Social Security No. - -	Birthdate: / /	Relationship to Patient
Company Name:	Occupation:		
Street Address:	Zip Code:	Telephone:	

Emergency Contact Information

Name: (Last,First)	Relationship to Patient:	Telephone:	Cell Phone:

Primary Care Physician Information

Primary Care Physician Name: DR.	Primary Care Street Address:
Telephone:	Fax:

Insurance Information

Primary Insurance:		ID#	GRP#
Subscriber's Name:	Relationship to Patient:	Date of Birth / /	Social Security No. - -
Secondary Insurance:		ID#	GRP#
Subscriber Name:	Relationship to Patient:	Date of Birth / /	Social Security No. - -

REVISED 8.8.2012

the Naomi Berrie DIABETES CENTER
Columbia University Medical Center

the care until the cure

AUTHORIZATION FOR USE AND DISCLOSURE OF LIMITED HEALTH INFORMATION FOR OUTREACH, EDUCATION AND FUNDRAISING COMMUNICATIONS

I authorize Columbia University Medical Center's Naomi Berrie Diabetes Center to use the following limited health information to contact me with information related to my personal health needs and interests, including:

- NEW SCIENTIFIC ADVANCES
- PATIENT CARE PROGRAMS
- COMMUNITY ACTIVITIES AND EVENTS
- OPPORTUNITIES TO SUPPORT THE NAOMI BERRIE DIABETES CENTER AND COLUMBIA UNIVERSITY MEDICAL CENTER

NOTE: NO DIAGNOSIS OR TREATMENT INFORMATION WILL BE USED OR DISCLOSED.

NAME: _____
ADDRESS: _____
CITY, STATE, ZIP _____
PHONE: _____ EMAIL _____

Columbia University Medical Center fully supports the protection of health information. With the permission of your physician, the staff at the Naomi Berrie Diabetes Center will use this information to contact you to provide information about new scientific advances, care programs, community activities,

Seek to keep you informed about relevant health information by its business associates and requires that they protect the confidentiality of your information and activities at the Naomi Berrie Diabetes Center and Columbia University. Patient lists are not loaned or sold.

Failure to sign this authorization will not affect your treatment, payment or eligibility for benefits in any way. Columbia University strictly limits the use of your information by its business associates and requires that they protect the confidentiality of your information.

This authorization is valid until revoked by the patient or authorized representative. You may revoke this authorization at any time or request to inspect or receive a copy of the protect health information to be used or disclosed by summiting a request in writing to: Privacy Officer, Columbia University Health Sciences, 601 W. 168th Street, Apt. 22, New York, NY 10021 , email HIPPA@Columbia.edu. The revocation will be effective except to the extent that we have already relied on your authorization.

_____ _____

DATE **Signature of PATIENT, PARENT OR GUARDIAN**

Columbia University New York, NY

AUTHORIZATION FOR USE AND DISCLOSURE OF LIMITED HEALTH INFORMATION
COMMUNICATIONS RELATED TO SCIENTIFIC ADVANCES, COMMUNITY EVENTS AND FUNDRAISING

Russ Berrie Medical Science Pavilion, 2nd Floor
1150 St. Nicholas Avenue at 168th Street, New York, NY 10032
Voice/ 212 851-5494 Fax/ 212 851-5493 e-mail/ diabetes@columbia.edu http://nbdiabetes.org

NAOMI BERRIE DIABETES CENTER
INSURANCE AND BILLING INFORMATION

PATIENT NAME:	
INSURANCE PLAN:	ID NO.:

1. If your Berrie Center MD DOES NOT PARTICIPATE in your insurance plan, the Berrie Center's policy is as follows:

    A. Full payment is due at the time of the visit. Payment can be made in the form of cash, check, or major credit card.

    B. We will provide you with a receipt for your paid bill, which you should submit to your insurance company for consideration for reimbursement.

2. If your Berrie Center MD PARTICIPATES in your insurance plan, please be aware that:

    A. If a referral is required, a referral must be issued by your primary care physician before you can be seen at the Berrie Center

        - It is your responsibility to obtain this referral and bring it to your visit.
        - Most referrals are issued for a limited number of visits. You are responsible for making sure you have an up-to-date referral and for obtaining additional referrals as necessary.

    B. If a co-payment is required, this must be paid at the time of service. We cannot bill patients for the co-payment.

    C. Even though your Berrie Center MD participates in your insurance, they may request tests, additional visits, etc. that are not covered by your insurance. As each insurance plan is different, it is your reasonability to know what your particular plan covers. If your insurance does not cover these services, you are responsible for payment for these services.

To My Insurance Carriers:

1. I authorize the release of any medical information necessary to process my insurance claims
2. I authorize and request payment of medical benefits directly to my physicians
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that a photocopy of this form may be used in lieu of the original
5. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles and co-payments on my insurance policy.

I understand and accept the above.

_____ _____

Patient or Representative Signature Date

Please contact Jennifer Arroyo, Practice Manager, at 212-851-5439 with any questions.

ColumbiaDoctors

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:_____

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____

Personal Representative (Print) Personal Representative's Signature

_____

Relationship

For ColumbiaDoctors use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of ColumbiaDoctors Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other _____

_____ _____

Employee Name Date

This form should be placed in the patient's medical record

Revised March 2014

Consent To Treatment at the Naomi Berrie Diabetes Center

Please sign your name below to indicate your consent to treatment.

I hereby authorize and consent Naomi Berrie Diabetes Center to provide necessary medical services for myself or my child. I understand that I may ask any questions. I understand this consent will remain in effect until I revoke it in writing.

Patient's Name:_____ Signature_____
Patient/Legal Guardian Signature: _____Date_____

Patients have a right to and responsibility to:

1. Understand these rights. If necessary, we will supply assistance and an interpreter.
2. Receive treatment without discrimination as to race, religion, sexual orientation, disability or source of payment.
3. Receive considerate and respectful care in a clean and safe environment.
4. Receive emergency care if needed.
5. Be informed of the name and position of the persons rendering care and names and positions of administrative staff.
6. Receive complete information about medical diagnosis, treatment, and prognosis.
7. Receive all the information needed for them to give informed consent including possible risks and benefits.
8. Refuse treatment and be told of the possible consequences of refusing treatment.
9. After a full explanation, have a right to refuse to take part in research.
10. Privacy and confidentiality of all information regarding your care.
11. Participate in decisions regarding your care.
12. Obtain your medical record for which you may be charged a reasonable fee.
13. Receive a receipt for an explanation of all charges.
14. Complain without fear of reprisals. If you are not satisfied, you may address your concerns to the center's administrator.

Participant Self-Assessment of Diabetes Management

Name: _____

Date: _____

Date of Birth: ___/___/___ Age: _____ Gender: ❑ F ❑ M

Ethnic Background: ❑ White/Caucasian ❑ Black/African American ❑ Hispanic
❑ Native American ❑ Middle-eastern

What is your language preference: ❑ English Other_____

Address: _____
Street City ST Zip

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:_____/_____
List relatives with diabetes: _____

3. Do you take diabetes medications? ❑ Y (check all that apply below) ❑ N
❑ Diabetes pills ❑ Insulin injections ❑ Other
❑ Symlin injections ❑ Combination of pills and injections
About how often do you miss taking your medication as prescribed? _____

4. Do you have other health problems? ❑ Y ❑ N
Please list other 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? _____

continued

8. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
How many people live in your household? _____

9. How are they related to you? _____

10. From whom do you get support for your diabetes? ❑ Family ❑ Co-workers
❑ Health care providers ❑ Support group ❑ No one

11. Do you have a meal plan for diabetes? ❑ Y ❑ N
If yes, please describe: _____
_____

About how often do you use this meal plan? ❑ Never ❑ Seldom ❑ Sometimes
❑ Usually ❑ Always
Do you read and use food labels? ❑ Y ❑ N
Do you have any diet restrictions: ❑ Salt ❑ Fat ❑ Fluid ❑ None ❑ Other _____
Give a sample of your meals for a typical day:
Time: _____ Breakfast: _____
Time: _____ Lunch: _____
Time: _____ Dinner: _____
Time: _____ Snack: _____
Time: _____ Snack: _____

12. Do you: do your own food shopping? ❑ Y ❑ N Cook your own meals? ❑ Y ❑ N
How often do you eat out? _____

13. Do you drink alcohol? ❑ Y ❑ N Type: _____
How many per day _____ per week _____ occasionally _____
Do you use tobacco: ❑ cigarette ❑ pipe ❑ cigar ❑ chewing ❑ none
❑ quit—how long ago _____

14. Do you exercise regularly? ❑ Y ❑ N Type: _____
How Often: _____
My exercise routine is: ❑ easy ❑ moderately intense ❑ very difficult ❑ intense

15. Do you test check your blood sugars? ❑ Y ❑ N
Blood sugar range: _____ to _____
How often: ❑ Once a day ❑ 2 or more/day ❑ 1 or more/Week ❑ Occasionally
When: ❑ Before breakfast ❑ 2 hours after meals ❑ Before bedtime
What is your target blood sugar range? _____ _____

continued

16. In the last month, how often have you had a low blood sugar reaction:
❑ Never ❑ Once ❑ One or more times/week
What are your symptoms? _____
How do you treat your low blood sugar? _____

17. Can you tell when your blood sugar is too high? ❑ Y ❑ N
What do you do when your sugar is high? _____

18. Check any of the following tests/procedures you have had in the last 12 months:
❑ dilated eye exam ❑ urine test for protein ❑ dental exam ❑ foot exam—self
❑ foot exam—health care professional ❑ 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 ❑ dental problems
❑ numbness/tingling/loss of feeling in your feet ❑ high blood pressure ❑ high cholesterol
❑ sexual problems ❑ depression

21. 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 have any special cultural or religious observancespractices or beliefs that influence how you care for your diabetes? ❑ Y ❑ N Please describe
_____

26. Do you use computers: to ❑ email ❑ look for health and other information

27. 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

continued

I struggle with making changes in my life to care for diabetes: ❑ agree ❑ neutral ❑ disagree

28. How do you handle stress? _____

_____

29. What concerns you most about your diabetes? _____

_____

30. What is hardest for you in caring for your diabetes? _____

_____

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

_____

_____

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

_____

33. **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

EDUCATOR ASSESSMENT SUMMARY: _____

_____

_____

_____

_____

_____

Education Needs/Education Plan: ❑ Diabetes disease process ❑ Nutritional Management ❑ Physical Activity ❑ Medication Use ❑ Monitoring ❑ Acute Complications ❑ Psychosocial Adjustment ❑ Chronic Complications ❑ Behavior Change Strategies ❑ Health Promotion

Date: _____ Educator Signature: _____

Date: _____ Educator Signature: _____