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



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

Endocrinology

Samuel R. Anderson, M.D.

Ravi S. Dhawale, M.D.

Constantine N. Kroustos, M.D.

Leslie K. Hoffman, M.D.

Sophia Meis, D.O.

Romi Bhasin, M.D.

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Erica Frisch, P.A.

Nikki Piazza, C.N.P.

Locations:

4895 Olentangy River Road Suite 100 Columbus, Ohio 43214

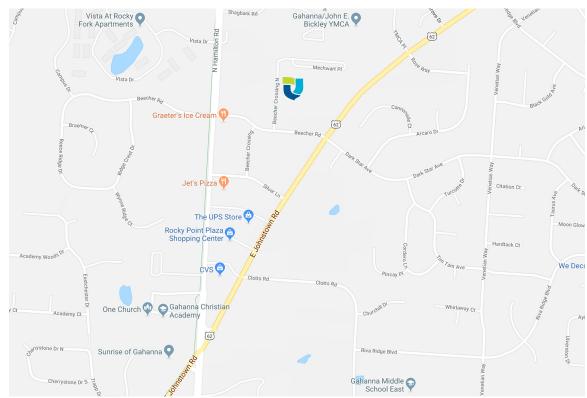
2061 Stringtown Road Grove City, Ohio 43123

1080 Beecher Crossing North Gahanna, Ohio 43230

695 W. Central Avenue Delaware. Ohio 43015

Dear	,		
*	*	ical care, we ask that you complet of your visit. Your appointment is	
Day	Date	Time	

With Romi Bhasin, 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

4. Your insurance card(s)

2. Any medical records

- 5. Your insurance copay
- 3. A current list of all medications and dosage

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



PATIENT DEMOGRAPHIC INFORMATION - ADULT

Please Complete This Entire Form. Thank You!

'oday's Date:// Referred By (<i>If Applicable</i>):									
			PAT	IENT INFORM	IATION	0	FFICE USE (P#):		
LAST NAME:	FIRST NAME:				MIDDLE IN	IITIAL:	DATE OF BIR	TH (<u>mm/dd/yyyy</u>):	
MAILING ADDRESS:		CITY:	ITY:		STATE:	1	ZIP:		
PHYSICAL ADDRESS (<u>If different fr</u>	om mailing	address):	CITY:			STATE:	ZIP:		
HOME PHONE:	CELL PHO	ONE:	I		WORK PHON	E:		EXTENSION:	
E-MAIL ADDRESS:	1	,	USE E-MA	IL ADDRESS FOR	R PATIENT PO	RTAL:	SOCIAL SECURITY	#:	
☐ None ☐ Prefer Not to Disclose			□ Yes □ I	No 🗆 Not Appli	cable				
GENDER: Male				n/Alaskan Nativ n/Other Pacific			lack/African Americ efuse to Report	an 🗆 Hispanic Other	
ETHNICITY: Hispanic/Latin	Non-Hispan	ic/Latin □ Ref	use to Rep		ERRED LANGU ner Language		nglish □ Spanish <i>ecify</i>):		
MARITAL STATUS: ☐ Single	□ Marr	ied □ Sep	arated	□ Divorced	□ Widow	ved			
DO YOU HAVE A CAREGIVER: \Box Y	es 🗆 No	IF YES, NAME	OF CAREG	IVER:			ELEASE PROTECTED YOUR CAREGIVER:		
		1	EMER	GENCY CONT	ACT				
LAST NAME:	FIRST NAM	ΛE:		RELATIONSHIP	(<u>Please speci</u> j	fy):			
HOME PHONE:	CELL PHO	ONE:	Į.		MAY WE RELE	ASE PROT	ECTED HEALTH INFO	DRMATION TO THIS	
()	()		l l	INDIVIDUAL:		□ Yes □ No		
LACT NAME.	FIDST NAS		TIONAL C	<u>`</u>	NTACT #1(OPTIONAL) ELATIONSHIP (Please specify):				
LAST NAME:	FIRST NAM				-				
HOME PHONE:	CELL PHO	ONE:			MAY WE RELE INDIVIDUAL:	ASE PROT	ECTED HEALTH INFO	DRMATION TO THIS	
\ 1	1		EMPLOY				163 110		
EMPLOYER INFORMATION EMPLOYER NAME: EMPLOYER PHONE NUMBER: ()									
EMPLOYMENT STATUS Employ	/ed □ Full	Time 🗆 Part Tin	ne 🗆 Retir	ed 🗆 Self Empl	oyed 🗆 Unem	ployed 🗆	Active Military St	tudent	
INSURANCE INFORMATION (Please present all current insurance cards to the Front Desk)									
I HAVE INSURANCE: Yes No (Self Pay)									
PRIMARY INSURANCE:				SECONDAR	Y INSURANCE	:			
SUBSCRIBER:		RELATION:		SUBSCRIBE	R:			RELATION:	
GENDER: Male Female	e 🗆 Tra	nsgender	□ Unknow	n GENDER:	□ Male □	Female	☐ Transgender ☐	Unknown	
DATE OF BIRTH (<u>mm/dd/yyyy</u>):	SOCIAL SE	CURITY #:			RTH (<u>mm/dd/</u>	<i>(</i> <u>уууу</u>):	SOCIAL SECURITY	Y #:	
CONFIDENTIAL COMMUNICATION (I hereby request to receive confidential communications from COPC in the following manner)									
TELECOMMUNICATIONS —Please leave messages regarding my protected POSTAL COMMUNICATIONS —Please mail my protected health									
health information as follows (<u>Check All That Apply</u>): information to me at (<u>Select Only One</u>):									
☐ Home Phone of Record ☐ Brief ☐ Extended ☐ Mailing Address of Record ☐ Street Address of Record						ord			
□ Cell Phone of Record □ Brief □ Extended					□ Other:				
□ Work Phone of Record □ Brief □ Extended			Street	Street Address City State Zip					
ADVANCE DIRECTIVES									
DO YOU HAVE A LIVING WILL?									
DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?							ovide a copy to the F ovide a copy to the Fi		
PO TOO HAVE A DO NOT KESCOSI	1741 E i			- 140 - 162	uj yes,	picuse pic	ivial a copy to the FI	OH DUSKI	

Patient Printed Name	Patient Signature	Date	e Signed
payment. I certify that I will pay to COPC any co-payr any payments that I receive from my insurance carrie amounts not paid by my insurance for my failure to p By signing below, I am acknowledging that I have re	r for services provided to me and/or my deprovide the appropriate insurance information	oendents. I will also be resp on for billing.	
I authorize any holder of medical or other information its intermediaries/carriers, as well as my commercial	insurance carriers any and all information r	equired for claim consider	ation and
Medicare and Medicaid: I certify the information give	en by me in applying for payment under Titi	le XVIII of the Social Securit	ry Act is correct.
Insurance Assignment and Acknowledgement I understand my insurance carrier can choose to assig understand and certify I am financially responsible for well as any applicable co-payments, co-insurance, dec dependents. I am also responsible for providing up-to	r all health care service charges that are pa ductibles and/or charge for non-covered se	id to me directly or by my i	nsurance carrier as
Release of Protected Health Information in Eme I understand that my protected health information m		appropriate in an emergen	cy situation.
Confidential Communications I understand COPC will notify me if COPC is unable to		nmunications.	
All COPC patients are automatically enrolled in the HIE un	less the Opt Out box is checked and initialed.	□ Opt Oເ	ıt Initials:
Health Information Exchange (HIE) COPC participates in one or more Health Information I comprehensive health record. This information is secu COPC provider may allow access to my health informa operations. This is a voluntary agreement. I understan	re and only available to those providers inv tion through the Health Information Excha ad that I may opt-out at any time by notifyir	olved in your care delivery. nge for treatment or other ng the COPC EHR Departme	I agree that my health care ent or my physician.
		□ Accept □ Decline	Initials:
Telephone Contacts, Monitoring and Recording- I hereby consent and agree that: (1) any calls with CO may contact me, from time to time, regarding my Acc COPC's contacts with me may be made via text messa me at any telephone number I provide to them, wheth telephone number converted to a mobile/wireless num business relationship with COPC and that COPC may counderstand that, if I accept now, I may opt-out at any	PPC may be monitored and/or recorded and ount (including for collections purposes or r ge or with an automated dialing and annouser a residential or business number, a wire nber, or which connects to any type of mobontact me at the telephone number I provice.	that COPC (or anyone action related to insurance covera uncing or similar device; (3) less, cellular or mobile num ile/wireless device); (4) I had the to them, in any of the wo	ng on COPC's behalf ge); (2) any and all c COPC may contact aber (including a ave an established
I give my consent to the use of my photograph for iden	•	□ Accept □ Decline	
Photograph for Patient Identification			
тогества неакт туотпакон авоас те.	□ Yes □ I	No 🗆 Offered but Decline	Initials:
I have been offered the HIPAA Notice of Privacy Practi Protected Health Information about me.	ces at COPC which outlines my privacy righ	ts and how COPC may use o	and disclose
Receipt of Notice of Privacy Practices			

Legal Guardian Signature (if applicable)*

Date Signed

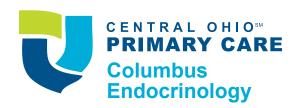
*PLEASE PROVIDE A COPY OF LEGAL GUARDIANSHIP COURT PAPERS FOR THE PATIENT'S RECORD.

Adult: 12/2/15, 1/27/16, 3/22/16 Page 2 of 2

Legal Guardian Printed Name (if applicable)*

HEALTH (QUEST	IONN	AIRE	To be completed by	patient				
Patient Name	e						_ Today's Date		
Referring Physician (if any) Age				Height	We	eight			
CHIEF COM	DI AINT	6) OB B	EASON	I EOD VISIT					
CHIEF COM	-	-			acorne evr	mntome (and/or problems you a	ro ovnori	oncina
riease iisi, ii	i order or	ппропа	nce, yo	ui present neath coi	icerris, syr	прилів, а	and/or problems you a	ire experi	ending.
HOSPITALIZ	ZATIONS	& SHID	SEDIES	.					
Year				2	Year	Illn	ace / Surgary		
rear	iliness	/ Surger	У		rear	IIII16	ess / Surgery		
PAST MEDIC	CAL HIST	ΓORY							
			followin	g? Leave blank if un	certain				
		YES		<u> </u>		NO		YES	NO
AIDS or HIV	/+	1	''	Glaucoma	120	110	Osteoporosis	1,5	110
Anemia				Heart Disease			Pneumonia		
Arthritis				Hemorrhoids			Polio		
Asthma				Hepatitis			Rheumatic Fever		
Back Troub				Hernias			Scarlet Fever		
Bladder infe				High blood pressu	ure		Smallpox		
Bleeding ter	ndency			Hives or eczema			Stroke		-
Bronchitis Cancer				Infectious mono Joint pain			Thyroid Disease Transfusions		
Chickenpox	,	-		Kidney Disease			Tuberculosis	_	
High Choles				Measles / Mumps	<u> </u>		Ulcer		<u> </u>
Diabetes	0.0101						Venereal Disease		
Epilepsy				Migraines Mitral Valve			Whooping Cough		
	iaaaaa/a	\ Dlagge	L liet.						<u>. </u>
Any other d	isease(s) Please	e iist						
COMMENT	S								
·									
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SOCIAL HIS		-1 -0	YES						
Do you curr	•				ay to	or	years.		
Have you e		ked?					oer day for		years
Alcohol Use									
Caffeine Us									
Illegal Drug	S			It yes, pleas	e list		 -		
Exercise				lype			Times pe	er week ₋	
Calcium				How much?					
DI								-	
Physician S	signature							Page	e 1 of 2

Patient Name			_ Date of Birth				
FAMILY HISTORY (Physician: Note & Da	to any changes)						
, ,		es your family have	a history of 2	Relationship to patient			
Yes No	relationship to patient	so your raining mavo	Yes No	reductioning to patient			
High Cholesterol	Thy	yroid Disease					
Diabetes	De	pression					
Heart Disease		oholism					
High Blood Pressure		od Clots / Disorder	$\sqcup \sqcup$				
Stroke		teoporosis					
Cancer	Mig	graines	$\sqcup \sqcup$				
Other:							
Please indicate the last time you had the follo	wing (list year):						
Flu vaccine	Tetanus shot		Hepatitis shot				
TB test	Pneumonia shot						
Stool blood test	Bone density			noidoscopy			
Eye exam	Cholesterol test		Prostate specific a	antigen			
FOR WOMEN ONLY							
Age at onset of menstrual period							
Do you use birth control? Y N Type		Nur	mber of pregnancies	5			
Number of live births Number of	of abortions Numb	per of miscarriages					
Year of last Mammogram	_ Results						
Year of last Pap Smear Results							
DRUG ALLERGIES							
Medications You Are Taking:		Dosage		Times / Day			
Medications fou Are faking.		Dosage		Times / Day			
Over-the-counter Medications, Vitamins and Supplements:							
I have personally reviewed this history form with the	ne natient						
	s Endocrinology						



Main Office:

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Fax: 614-457-4346

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.

<u>Columbus Endocrinology Acknowledgment Form</u> 4895 Olentangy River Road Ste 100 • Columbus • Ohio • 43214

By signing below you agree to the terms of this policy and	d acknowledge that you have received a copy:
Printed Name:	D.O.B:
Signature:	Date: