A. Rodman Barber, MD, FACE
Board Certified: Endocrinology

Venkatarama S. Donepudi, MD, FACE
Board Certified: Endocrinology

Ian Orozco, MD, FACE
Board Certified: Endocrinology

Michelle Woods, PA-C
Board Certified

311 Ninth Avenue Drive NE
Hickory, North Carolina 28601
Phone: (828) 322-7338 Fax: (828) 304-6319

Enclosed are forms for you to complete prior to your appointment. Please bring these completed forms with you at your first visit. Please complete FRONT AND BACK of all pages.

You will need to call our office and confirm this appointment 3 business days prior to your appointment date or your appointment will be cancelled.

A minimum of 48 hours notice is required to cancel your appointment with us. A $25 cancellation fee will be billed to you if you fail to cancel your appointment.

We ask that you not wear perfumes, scented lotions or aftershave cologne to your appointments.

We will file charges to your insurance company. Please bring your insurance information with you. If your insurance plan requires authorization from a specific physician to see a specialist please call them at least 2 weeks prior to your appointment to obtain this or your insurance company will not pay for this visit and you will be responsible for payment on the day of your visit. As a courtesy, we will file to your secondary insurance but if payment is not received 30 days after we file to your secondary insurance, we will bill the amount owed to you.

If you are being seen for a thyroid condition, please obtain any records on thyroid imaging studies and/or thyroid biopsies done in the recent past and either ask your physician to send the results to us in advance of your visit or bring them with you to your initial consultation. If possible, please bring the actual films and not just the report.

If you are diabetic, please bring your glucose meter and blood sugar logbook to every visit.

Thank you for choosing Piedmont Endocrinology.

PIEDMONT ENDOCRINOLOGY

Directions to Piedmont Endocrinology
311 Ninth Avenue Drive NE
Hickory, NC 28601-3829

From Interstate 40:
Taking Exit 125, turn North (Left if coming from Hildebran/Morganton area, Right if coming from Conover/Statesville area) onto Lenoir-Rhyne Boulevard SE. Follow Lenoir-Rhyne Boulevard until you reach the intersection of 1st Ave and Tate Boulevard. At this intersection take a Left onto 1st Avenue SE, and then take a Right at the next traffic light onto Hwy 127 North (2nd St NE). You will go through five traffic lights. You will see Kingston Residence, Allergy & Asthma Associates, and Shook & Tarlton Building on the right. Turn right at Salsarita's onto 9th Ave Dr NE. Our building is the second on your left. Go to the second drive for Patient Parking.

Coming Hwy 321 Southbound (Boone):
Coming South on HWY 321 you will turn left at the stoplight intersection where you see Raceway and CVS Pharmacy. You will need to get in left hand lane at second stoplight turn left onto 12th Avenue NW. Follow 12th Avenue NW until you reach the end at the stoplight. You will take a left onto 6th Street NW. At the third traffic light you will take a right onto 2nd Street NE (Hwy 127 North.) Watch for Pure Service Station, Panera Bread and Salsarita's on your left, slowing to turn at Salsarita's onto 9th Ave Dr NE. Our building is the second on your left. Go to the second drive for Patient Parking.

Coming Hwy 321 Northbound (Charlotte, Mountainview):
Stay on 321 until you get to Hwy 127. Exit here and turn right going north. Go straight over I-40 and into downtown. Continue about 4 miles. You will pass Fire Station on left and Frye Regional Medical Center also on Left (one block over). You will see Kingston Residence, Allergy & Asthma Associates and Shook & Tarlton on your right. Turn right at Salsarita's onto 9th Ave Dr NE. Our building is the second on your left. Go to the second drive for Patient Parking.

From Hwy 127 North:
Follow Hwy 127 North through the Bethlehem community, crossing Lake Hickory. Continue into Hickory as the street (Hwy 127) becomes 2nd Street NE. Watch for Pure Oil Station, Panera Bread and Salsarita's, slowing to turn at Salsarita's onto 9th Ave Dr NE. Our building is the second on your left. Go to the second drive for Patient Parking.

Piedmont Endocrinology
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Hickory, NC 28601
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PATIENT INFORMATION

Patient Name:_____
Last First Middle Maiden
Address:_____

Zip Code:_____ City:_____ State:_____ Sex: Female Male

Home Phone:_____ Work Phone:_____ Ext:_____ Cell Phone:_____

Date of Birth:_____ Social Security Number:_____ Marital Status: Married Single Widowed

Email address: _____

Patient's Employer:_____ Employment: Full Part Self Empl. Unempl. Retired

Referred By Doctor:_____ Phone:_____

In case of an emergency please contact: _____ Relationship: _____
Home Phone: _____ Work Phone _____ Cell Phone _____

May we leave messages related to your care with above or on answering machine? Yes No

RESPONSIBLE (OR INSURED) PARTY INFORMATION

Responsible Party Name:_____
Last First Middle Maiden
Patient Relationship to the Responsible Party: Self Spouse Child Other

Address (if different from above):_____

Zip Code:_____ City:_____ State:_____ Sex: Female Male

Home Phone:_____ Work Phone:_____ Ext:_____ Cell Phone:_____

Date of Birth:_____ Social Security Number:_____

Responsible Party's Employer:_____ Employment: Full Part Self Empl. Unempl. Retired

COMPLETE THIS SECTION IF YOU HAVE MEDICARE (Required by Medicare beginning 2011)

Ethnicity (choose one): Hispanic or Latino Not Hispanic or Latino

Race (choose all that apply):
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White
Other Race

PLEASE BE SURE TO COMPLETE ENTIRE NEW PATIENT PACKET FRONT AND BACK WHICH INCLUDES 8 PAGES

PIEDMONT ENDOCRINOLOGY CONSULTATION (1)

NAME_____ _____ _____ **Date of Birth:**_____ **Age:**_____
Last First Initial

On the two lines below, please describe the problem for which you are seeing the doctor:

_____

_____

MEDICATIONS YOU ARE NOW TAKING

(Include prescription medications, antacids, aspirin, supplements, vitamins, health products, or laxatives):

Name of Medicine	Dose/ strength	When taken	To treat what	Year begun	Prescribed by

(PLEASE DO NOT WRITE IN THIS BOX)
History of the purpose of the consultation (HPI)

PIEDMONT ENDOCRINOLOGY CONSULTATION (2)

NAME_____ _____ _____ **Date of Birth**:_____
Last First Initial

Please list your health problems

CURRENT MEDICAL PROBLEMS
(DISEASES FOR WHICH YOU TAKE MEDICINE):

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

SURGERIES
(LIST ANY SURGERIES YOU HAVE HAD):

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

List drugs you are **Allergic** to and reactions: _____

SOCIAL HISTORY:

Marital status? _____ Children: None____; or (give sex and age in years) _____

Have you used tobacco?
Yes___ No___ If yes, what kind? (Cigarettes, cigars, smokeless, pipe)? _____How much? _____
For how long? _____ (years). If you have quit, what year did you quit? _____

Do you drink alcohol?
Yes___ No___
If yes, amount and type of alcohol used each week: _____

Have you used "recreational" drugs (marijuana, heroin, crack) in the past?
Yes___ No___
If yes, what? _____

How many ounces of caffeine do you drink every day (coffee, cola, tea, energy drinks)? _____ounces

PIEDMONT ENDOCRINOLOGY CONSULTATION (3)

NAME_____ _____ _____ **Date of Birth**:_____
Last First Initial

Present weight: _____ pounds
What is the most you ever weighed (not pregnant):_____ pounds
Has your weight changed in the past year? Yes_____ No_____ If yes: Gained _____pounds Lost _____pounds
Reason for weight gain or loss:_____

Do you have trouble sleeping? Yes___ No___ If yes, what is the problem? _____

Highest education level you completed: ____ GED ____ High school ____ College ____ Graduate school

What are your hobbies, recreational activities? _____

What is your current job?_____Your past jobs:_____

If you served in the military service, give branch_____ and years
_____

Average number of hours you sleep each day ____ hours

Do you get exercise or do heavy work each week? Yes___ No___ If yes, you do ____hours each week

Are you are on a restricted diet? Yes___ No___ If yes, what do you restrict?

FAMILY HEALTH HISTORY:

(Such as heart disease, High blood pressure, stroke, cancer, diabetes, thyroid disease, mental illness)

Relationship to you	Age if still living	If not alive, age person died	Diseases person has or had and cause of death if deceased
Grandparents			
Mother			
Father			
Brother			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			
Sister			

REVIEW OF THE SYSTEMS

EYES, EARS, NOSE, THROAT (CHECK YES OR NO FOR ALL LISTED)

Lightheadedness ..... Yes_____ No_____
Hoarseness ..... Yes_____ No_____
Wear glasses or contacts ..... Yes_____ No_____
Blurred vision and glasses don't help ..... Yes_____ No_____
Double vision ..... Yes_____ No_____
Trouble hearing..... Yes_____ No_____

STOMACH, INTESTINES & LIVER (CHECK YES OR NO FOR ALL LISTED)

Frequent nausea ..... Yes_____ No_____
Have frequent or unexplained vomiting ..... Yes_____ No_____
Stomach or abdominal pain ..... Yes_____ No_____
Loose bowels most of the time ..... Yes_____ No_____

Constipation most of the time ..... Yes_____ No_____

PIEDMONT ENDOCRINOLOGY CONSULTATION (4)

NAME_____ _____ _____ **Date of Birth**:_____
Last First Initial

LUNGS AND HEART (CHECK YES OR NO FOR ALL LISTED)

Short of breath even with little effort ..... Yes_____ No_____
Heart murmur ..... Yes_____ No_____
Wake up at night with shortness of breath ..... Yes_____ No_____
Positive skin test for tuberculosis ..... Yes_____ No_____
Pain, discomfort, or tightness in chest ..... Yes_____ No_____
Persistent cough ..... Yes_____ No_____
Palpitations or racing of the pulse ..... Yes_____ No_____
Swelling of the legs or ankles ..... Yes_____ No_____
Severe pain in the calves while walking or running ..... Yes_____ No_____

KIDNEYS & BLADDER (CHECK YES OR NO FOR ALL LISTED)

Kidney stone ..... Yes_____ No_____
Constant feeling of a need to urinate ..... Yes_____ No_____
Trouble or hesitancy in getting urine flow going ..... Yes_____ No_____

MUSCLES, JOINTS & SKELETON (CHECK YES OR NO FOR ALL LISTED)

Had fractures of bones ..... Yes_____ No_____
Severe or unusual muscle cramps ..... Yes_____ No_____
Stiff joints ..... Yes_____ No_____
Painful muscles ..... Yes_____ No_____
Swollen joints ..... Yes_____ No_____

NERVOUS AND PSYCHIATRIC (CHECK YES OR NO FOR ALL LISTED)

Unusual weakness of muscles ..... Yes_____ No_____
Numbness of part of body ..... Yes_____ No_____ If yes, which part?_____
Paralysis in or loss of use of part of body ..... Yes_____ No_____ If yes, which part?_____
Pass out, fainting or loss of consciousness ..... Yes_____ No_____
Unusual shaking or trembling ..... Yes_____ No_____
Depressed ..... Yes_____ No_____
Considering suicide ..... Yes_____ No_____
Attempted suicide ..... Yes_____ No_____ If yes, by what means?_____
Memory failing ..... Yes_____ No_____

ENDOCRINE (CHECK YES OR NO FOR ALL LISTED)

Big problem with heat or hot weather ..... Yes_____ No_____
Big problem with cold or cold weather ..... Yes_____ No_____
Excessive perspiration ..... Yes_____ No_____
Trouble swallowing ..... Yes_____ No_____
Tender thyroid or pain in the front of your neck ..... Yes_____ No_____
Excessive appetite ..... Yes_____ No_____
Poor appetite ..... Yes_____ No_____
Exhaustion or fatigue most of the time ..... Yes_____ No_____
Reduced libido or a poor sex drive ..... Yes_____ No_____
Breast discharge ..... Yes_____ No_____
Excessive body or facial hair ..... Yes_____ No_____
Problem with acne ..... Yes_____ No_____

PIEDMONT ENDOCRINOLOGY CONSULTATION (5)

NAME_____ _____ _____ **Date of Birth**:_____
Last First Initial

MEN ONLY (COMPLETE IF THIS APPLIES)

Prostate trouble .....Yes_____ No_____
Swelling, pain, tenderness, or a lump on testicles .....Yes_____ No_____
Inability to sustain an erection/problems with sexual function .....Yes_____ No_____

WOMEN ONLY (COMPLETE IF THIS APPLIES)

Have you ever been pregnant .....Yes_____ No_____
If yes:
Number of times you have been pregnant ____
Number of miscarriages or abortions you have had ____
Number of children you delivered ____
Number of living children you have ____
Age periods began: ____years
Had tubes tied .....Yes_____ No_____
Had a hysterectomy .....Yes_____ No_____
Had ovaries removed .....Yes_____ No_____
Date last period began ____/____/_____
Periods are about every ____ weeks and last about____ days
Periods are abnormally heavy .....Yes_____ No_____
Bleeding between periods .....Yes_____ No_____
Contraceptive use: .....

OTHER PROBLEMS (CHECK YES OR NO FOR ALL LISTED)

Pain in feet .....Yes_____ No_____
Rash now or often .....Yes_____ No_____
Chronic itching .....Yes_____ No_____
Anemic .....Yes_____ No_____
Swollen lymph glands .....Yes_____ No_____

PATIENT: PLEASE DO NOT WRITE BELOW HERE

Date reviewed _____/_____/ _____ by _____

A. Rodman Barber, MD, FACE
Venkatarama S. Donepudi, MD, FACE
Ian J. Orozco, MD, FACE
Michelle Woods, PA-C

PIEDMONT ENDOCRINOLOGY CONSULTATION

NAME_____ _____ _____ Date of Birth:_____
Last First Initial

PIEDMONT ENDOCRINOLOGY

Authorization for Release of Medical Records

Patient Name:_____ DOB:_____

Piedmont Endocrinology, PA, receives all of our patients on a consulting basis by physician referral only. It is our practice to send office notes, diagnostic and lab results from each visit to the referring physician and/or any other physician that you request in an effort to provide accurate and concise communication regarding your care here. By signing below, you agree and authorize the release of our office notes, diagnostic and lab results to the physician who referred you to our practice. We will not re-release any medical records we receive from other physicians.

Signature:_____ Date:_____

Please list any persons and their relationship you authorize Piedmont Endocrinology, PA to disclose any of your protected health information to (i.e. family members, physicians, physician offices, etc).

_____ _____
_____ _____
_____ _____

Signature:_____ Date:_____

You may update this release at any time by filling out a new form. You may revoke this release at anytime by submitting your request in writing to Piedmont Endocrinology at the address above

Consent for Records Release to Health Insurer(s)

As a specialist, we are often required to release medical information to your health insurance in order for them to process claims. By signing below, you agree and authorize the release of our office notes, diagnostic and lab results that may be requested by your health insurer to your health insurer. We will not re-release any medical records we receive from other physicians.

Signature:_____ Date:_____

PIEDMONT ENDOCRINOLOGY

Patient Financial Responsibility

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services rendered.

- Prompt payment allows us to control costs. Outstanding accounts cost both you and the practice time and money; therefore, you will be required to establish financial arrangements for payment of their account.
- It should be noted that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your carrier, and to ensure your carrier remits payment for your account.
- All insurance co-payments are due and payable at the time of service prior to being seen. There are no exceptions.
- As a courtesy to you, we will file claims with your insurance company. Once your insurance company has processed your claim, you are responsible for any balance due. If the insurance company later provides additional payments on your claim you will receive any appropriate refund promptly.
- Once your insurance company has processed your claim, you will receive a statement for services, which is due and payable within thirty days of the statement date. If your payment is late, or if you have not made financial arrangements, we will mail you a reminder notice indicating a problem with your account. It is imperative that you contact us immediately upon receipt of such notice.
- It is your responsibility to understand your plan guidelines regarding providers and hospitals that your plan is contracted with because employers do occasionally change their insurance plans, even if they do not change insurance companies.
- For your convenience, we accept Visa, MasterCard, check, or cash in payment for services. Please do not send cash in the mail. There is a $25 service charge for checks that are returned.
- If you are experiencing a set of financial circumstances beyond your control, please call our practice and we will be happy to make special payment arrangements.
- Failure to adhere to the above policies could result in your account being turned over to an outside collection agency. Any fees associated with this will be your responsibility.
- There is an administration fee of up to $35 or in accordance with applicable law, payable in advance, for you to receive a copy of your medical records. This fee may be waived if your records are sent directly to another physician. This fee does not apply to records sent to your insurance company.
- It is important that we have accurate insurance information for all our patients. It is likely that you will be asked to show your current card on each visit. If you fail to provide your card, you will be required to pay that day any anticipated charges for the visit. If you are able to provide the card at a later time, we will refund any covered fees and file with your insurance company.
- In order to provide quality care, it is crucial that we have current contact information, including insurance information. If you are unable to provide this, we will not continue to provide healthcare services for you.

Piedmont Endocrinology firmly believes that a good doctor/patient relationship is based upon understanding and open communication. Our staff has been instructed to make every effort to assist you in managing your account. We hope to avoid any disagreement over payment for professional services by clearly defining our policies at the onset. If you have any questions concerning this policy or need any assistance with your account in the future, please contact us immediately.

I have read the above financial agreement and agree to abide by the terms set forth in it.

Signed:_____ Date: _____

Patient, Parent or Guardian

Please print your name here:_____

INSURANCE INFORMATION

Leave this section blank if you bring your card(s) with you.

Primary Insurance Company:_____ Eff. Date:_____ Phone:_____

Claims Address:_____ Zip Code:_____ City:_____ State:_____

Contract or ID #:_____ Subscriber's Name:_____

Subscriber's Date of Birth:_____ Patient Relationship to Subscriber: Self Spouse Child Other

Group Name:_____ Group Number:_____

Co-Payment Amount: $_____ or Deductible $_____ Has Deductible Been Met This Year?_____

Secondary Insurance Company:_____ Eff. Date:_____ Phone:_____

Claims Address:_____ Zip Code:_____ City:_____ State:_____

Contract or ID # :_____ Subscriber's Name:_____

Subscriber's Date of Birth:_____ Patient Relationship to Subscriber: Self Spouse Child Other

Group Name:_____ Group Number:_____

Co-Payment Amount: $_____ or Deductible $_____ Has Deductible Been Met This Year?_____
As a courtesy, we will bill your secondary insurance. If payment not received 30 days after filing, the balance owed will be your responsibility

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Reconcile my medications prescribed by Piedmont Endocrinology and other healthcare providers.

Piedmont Endocrinology has informed me of their "Notice of Privacy Practices". I have been given the right to review their "Notice of Privacy Practices and understand Piedmont Endocrinology has the right to change their "Notice of Privacy Practices" from time to time and that I may contact Piedmont Endocrinology to obtain a current copy.

Signed:_____ Date: _____
Patient, Parent or Guardian

Understanding of Commitment to Care

We are dedicated to providing you with the best possible care and service, treatment. Nationally there is a shortage of Endocrinologists, therefore limiting the availability of appointment time and resources to meet patient needs. This practice has established the following criteria in an effort to provide the highest level of care for our patients.

- You must give 48 hours notice if a scheduled appointment is not going to be kept.

- If you cancel or do not show for appointments, you may be discharged from the practice. In the event you are discharged from Piedmont Endocrinology, it will be your responsibility to access care at another facility with the assistance of their primary care physician.