Heartland
Endocrine Group

M. Kathleen Figaro, MD, MS, FACE
4620 E 53rd Ave., Suite 200
Davenport, IA 52807
563 424-6306
Fax: 563 424-6602
www.heartlandendocrinegroup.com

Patient Information Sheet

Patient name: _____ Birth Date: _____

Sex: _____Race: _____ Marital status: Single Divorces Married Widowed Separated

Past Medical History:

Asthma or lung disease: _____
Cancer: _____
Depression: _____
Anxiety: _____
Diabetes: _____
Eye disease: _____
Heart disease: _____
High blood pressure: _____
High cholesterol: _____
Kidney problems: _____
Neurological disease: _____
Stomach or intestinal problems:
Hypothyroidism: _____
Hyperthyroidism: _____
Pituitary disease: _____
Other: _____

Allergies: (please list allergies and the type of reaction: _____
Surgeries: _____

Medications:

Name: _____ Dose: _____How often: _____
Name: _____ Dose: _____How often: _____
Name: _____ Dose: _____How often: _____
Name: _____ Dose: _____How often: _____
Name: _____ Dose: _____How often: _____
Name: _____ Dose: _____How often: _____
Name: _____ Dose: _____How often: _____
Name: _____ Dose: _____How often: _____
Name: _____ Dose: _____How often: _____

More meds, please add to opposite side of this sheet

Family History: (Please note medical conditions that they have , such as diabetes, hypothyroidism and heart disease

Dietary history:

Low carb: _____ Low calorie: _____How Low fat: _____
Keto: _____ High protein: _____Other: _____

Social History:

Smoke? Type: _____ Daily amount: _____How long: _____
Alcohol? type: _____ Weekly amount: _____How long: _____

Recreational Drugs? Type: _____ amount: _____How long: _____

Patient name: _____ Birth Date: _____

NO	Yes	Symptoms:	Comments: duration, severity, frequency, location
		Fever and or chills	
		Night sweats	
		Heat or cold intolerance	
		Weight increase or decrease >10 lbs	
		Headaches	
		Blurred or double vision	
		Throat pain or swelling	
		Shortness of breath	
		Palpitations	
		Chest pain with exertion	
		Nausea and or vomiting	
		diarrhea	
		constipation	
		Abdominal pain or bloating	
		Pain or burning w/ urination	
		Blood in the urine	
		Frequency with urination	
		Low libido	
		Erectile dysfunction (men)	
		Menstrual problems (women)	
		Joint pain or swelling	
		Numbness in hands or feet	
		Muscle weakness	
		Tremor	
		Excessive bruising	
		Thinning hair	
		Dry or oily skin	
		Swelling in lower legs	
		Depression	
		Anxiety	
		insomnia	
		Fatigue	

Comments: _____

_____

Reviewed by: _____ Date: _____

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Heartland Endocrine Group Clinic Policies Agreement

Welcome to the Heartland Endocrine Group!

These office policies reflect what you can expect from us and what we expect from you. They are designed to optimize your personal experience with our practice. We sincerely appreciate you reading them carefully. Then print, sign, and bring with you during your initial visit. In order to get the best care, please complete the enclosed registration forms. Please arrive and check in **at least 15 minutes** prior to your appointment time so we can complete an initial registration process or update your chart with new information. **If you have diabetes,** please bring the following with you: your blood glucose meter/CGM OR your blood sugar readings for the past 30 days, your medication list OR your medication bottles and insulins (if you use insulin)

If you have further questions or need to change your appointment, please feel free to call our office at **563 424-6306**.

1. HOURS OF OPERATION Our office is open Mondays, Tuesdays, Wednesdays and Thursdays from 9AM to 4PM. Office visits are by appointment only and by mutual agreement.

2. OFFICE CONTACT Phone and email are the best ways to communicate with us. Dr. Figaro is available for questions or problems concerning your care 24/7. Please call 563 424-6306 and leave a message. You can also contact us through our patient portal or email directly to encrypted info@heartlandendocrinegroup.com. Urgent messages will be returned on the same day. Non-urgent calls and emails will be returned within 72 hours. We understand that a text message may be necessary for short easy requests and check-ins, however, with significant medical information exchange, we discourage text messaging to safeguard your medical information.

3. APPOINTMENTS We will do our best to confirm your appointment one week and 48 hours prior to your scheduled visit using our electronic health record reminder system. Please call or email us if you have to cancel or reschedule an appointment at **563 424-6306. You are responsible for paying the full price of the appointment at the time of service. Other payment**

arrangements can be made at the time of service at the discretion of the physician and patient.

4. MEDICAL RECORDS Requests for full medical records are charged as stipulated by the Iowa Medical Society ($1 per page) to help cover the cost of labor and supplies. Our office will return all requests for medical records. However, it may take between one and four weeks to fulfill non-urgent requests.

5. Diabetes related prescription: If there are insurance changes that require a change in your medications or supplies these will be taken care of by the office. Any other requests for glucose test scripts or other diabetes supplies outside of an office visit will be charged at **$25** per instance.

6. PRESCRIPTION REFILLS During your visit, we will make plans for future follow-ups and provide you with enough medication until at least the next follow-up.

7. TEST RESULTS We will always call to review your blood test results, unless we have made arrangements for a follow-up visit to discuss them in person. If you do not hear from us within seven days after your test is complete, please call our office with your name, return phone number and the lab or imaging study you are enquiring about.

8. MEDICAL QUESTIONS A request for medical information or new or revised treatment protocol shall be considered an appointment and you might be asked to make a follow-up visit either by phone or in person.

9. GROUNDS FOR DISMISSAL Failure to reschedule or keep an appointment on three occasions creates an unfortunate burden on our practice and our ability to serve our community. We therefore consider such to be grounds from dismissal from the practice. Repeated unwillingness to pay will also lead to dismissal from the practice. This practice is within a building owned by Regus, and as such, requirements such as masking, opening times and other public rules must be adhered to by patients at all times.

I have read, agree and understand the Heartland Endocrine Clinic Policies and by signing below I accept these responsibilities.

_____ Date _____

(Signature of Patient or Patient's Legal Representative)

Patient Name_____

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Medical Release of Information

Patient Name _____ Date _____

Date of Birth _____ Phone_____

I authorize: _____ to release my health information to Dr. M. Kathleen Figaro, Heartland Endocrine Group.

Purpose of disclosure:_____

I specifically authorize the use or disclosure of the following health information:

___ ALL MEDICAL RECORDS

___ Radiology Reports _____ from _____

___ Chart Notes ALL or from _____to _____

___ Labs ALL or from _____to _____

___ Other (please list)_____

___ Verbal exchange of information between providers

I understand that I may revoke this authorization at any given time by giving written notice. I understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

_____ Date _____

(Signature of Patient or Patient's Legal Representative)

Printed Name: _____

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I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____

Relationship: _____

Contact information: _____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

____A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

____B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):

___Mental health records

___Communicable diseases (including HIV and AIDS)

___Alcohol/drug abuse treatment

___Other (please specify): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

____An electronic record or access through an online portal

____Hard copy

This authorization shall be effective until (Check one):

____All past, present, and future periods, OR

____Date or event:_____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Name of the Individual Giving this Authorization: Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R.