M. Kathleen Figaro, MD, MS, FACE
1820 E 54th Street, Suite A
Davenport, IA 52807

563 224-2212
Fax: 563 202-2911
www.heartlandendocrinegroup.com

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 them with you during your initial visit if you are viewing this on the website. In order to get the best care, please complete the enclosed registration forms prior to your visit. Please arrive and check in at least 15 minutes prior to your appointment time so we can complete the initial registration process or update your chart with new clinical information.

If you have diabetes, please bring the following with you: your blood sugar meter or CGM or your blood sugar readings for the past 30 days, your medication list, or your medication bottles and insulin (if you use insulin).

If you have further questions or need to change your appointment, please feel free to call our office at 563-224-2212.

1. **Hours of operation.** Our office is open Mondays, Tuesdays, Wednesdays, and Thursdays from 9 AM to 4 PM. Office visits are by appointment only, and by mutual agreement.

2. **Office contact.** Phone and email are the best way to communicate with us. For questions and problems concerning your care 24/7, please call 563-224-2212 and leave a message or text. You can contact us through our patient email directly to our encrypted info@heartlandendocrinegroup.com.

*Urgent messages will be returned within 24 hours and non-urgent messages will be returned within 72 hours or the next business day. We understand that a text message may be necessary for short and easy requests and check-ins, however, with significant medical information exchange, we encourage the use of the encrypted office email to safeguard your HIPAA protected 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 reminder system. Please call or email us

if you must cancel or reschedule an appointment at 563-224-2212. You're 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 the patient.

4. **Medical records.** Requests for full medical records are charged as stipulated by the Iowa medical society, one dollar 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 fill non-urgent requests.

5. **Diabetes related prescription.** If there are insurance changes that require a change in your medication supplies, these will be taken care of by the office. Any other request for glucose test strips 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 visit.

7. **Test results.** We will always call or email 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 at 563 224-2212 with your name, return phone number, and the lab or imaging study you're inquiring about.

8. **Medical questions.** Requests for medical information or new or revised treatment protocol will 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, create an unfortunate burden on our practice, and our ability to serve you. We therefore consider such to be the grounds for dismissal from the practice. Repeated and 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 always adhered to by our patients.

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

____Date_____________________

(Signature of patient or patient's legal representative)

Printed Name: ___________________________________

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Patient Information Sheet

Patient name: ___________________________________
Date of birth: _________________
Sex: _____Race:______
Marital Status: single, divorced, married, widowed, separated (circle 1)

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: _______________
hypothyroid: _______________
hyperthyroidism: __________________
pituitary disease: __________________
Other: _______________

Allergies: please list allergies, and type of reaction:
Surgeries: __________________ (please use other side of page for multiple procedures)
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
*If you have more meds, please add to the opposite side of this sheet.
Family history: please note medical conditions that family members have such as diabetes, hypothyroidism, and heart disease____
Dietary history: low-carb, low calorie, low-fat, fasting, keto, high protein, (circle one)
Social history: smoke? Type: _________daily amount: ________ how long: _________
Alcohol: type: _________daily amount: ____________how long: ____________
Recreational drugs: ________ daily 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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Name____ Date____________________________

Date of birth____________________________ Phone number: ____________________________

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

Purpose of disclosure: ________________________________
I specifically authorize the disclosure of the following protected health information:

____All medical records
____Radiology reports: All _____OR from__________ to ________
____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 receiving this information is not a healthcare provider or health plan, covered by federal privacy regulations, the information described above may be redisclosed, and no longer protected by these regulations.

____Date______________________
(Signature of patient or patient’s legal representative)

Printed Name: _____________________________________

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I, __________________________, direct Heartland Endocrine Group to disclose and release my protected health information under the specific circumstances below.
Health information may be disclosed on my request OR in case of emergencies when I am not cognitively able to direct my medical care.

The person closest to me and who should communicate for me in case of emergencies is:
Name: ________________________________

Relationship: ________________

Contact information: ____
Check either A or B:
____ A: Disclose my complete health record, including, but not limited to, diagnoses, lab tests, prognoses, treatment, and billing for all conditions.
____B: Disclose my health records as above, but do not disclose the following (check as appropriate):

____mental health records:

____alcohol, drug treatment (buprenorphine)

___ Other (please specify): ____________________

Form of disclosure, unless another per format is mutually agreed upon between Dr. Figaro and Designee:
____An electronic record OR _____access through an online portal OR ___ hardcopy.

This authorization will be effective until: (circle one) all, past, present, future. OR date: _______ OR event: _______ unless I revoke it.

Note you may revoke this authorization in writing anytime by notifying Dr. Figaro.
____Date of birth: _____________________
Name of the individual giving this authorization

HIPAA authority for right of access: 45C. F. R. Updated 8-5-24