



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

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Board Certified: Endocrinology

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Board Certified

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.



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 Viewmont Car Wash, 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 Viewmont Car Wash, 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 CONSULTATION (2)

NAME _____ Date of Birth: _____
Last First Initial

Please list your health problems

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

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

SURGERIES (LIST ANY SURGERIES YOU HAVE HAD):

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 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
Michelle Woods, PA-C
Ben Bullard, PA-C

PIEDMONT ENDOCRINOLOGY CONSULTATION

NAME _____ Date of Birth: _____
Last First Initial



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: _____



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.