



## MOUNTAIN DIABETES & ENDOCRINE CENTER

Wendy S. Lane, MD Stephen L. Weinrib, MD Lynn K. Baru, MD Michael D. Skrzynski, ANP  
1998 Hendersonville Road Suite #31 Asheville, N.C. 28803  
[WWW.MOUNTAINDIABETES.COM](http://WWW.MOUNTAINDIABETES.COM) Phone: (828) 684-9588 Fax: (828) 684-9626

**Welcome to Mountain Diabetes and Endocrine Center!** We are honored that you have chosen us for your care. We strive to provide personalized, top-quality clinical care, and we pride ourselves on the amount of time and attention we devote to each of our patients. We are also proud to offer research studies in promising new medicines and medical devices to our patients, when available.

We currently have three doctors on staff, all of whom are board certified in endocrinology, internal medicine, or both, as well as a nurse practitioner. All new patients are guaranteed to see one of our doctors for their first visit, and may alternate visits with their doctor and the nurse practitioner for any follow-up appointments.

### **Please keep the following clinic policies and procedures in mind as you prepare for your visits:**

**Office Hours:** Monday – Friday 8:30 am to 5:00 pm. Doors open 8:00 am to 5:00 pm

**Phones answered:** 8:15 am to 4:55 pm. All non-urgent calls are returned within 2 business days, although the vast majority are returned within the same day. If you have not received a return call within 48 hours, please call back.

**Arrival:** Please arrive 15-20 minutes before your scheduled appointment to allow adequate administrative check-in, nursing intake, and to avoid lost time with the doctor. **We have a 24-hour cancellation policy or you may be charged a \$50.00 no-show fee.**

**Please bring a current insurance card to each visit.** We do participate with Medicaid. However, if you do not bring a current Medicaid card, we will have to reschedule your appointment. Patients who intentionally present insurance information that is outdated, cancelled or otherwise false will be discharged from the practice and may incur legal action. We also require a picture ID to be compliant with HIPAA regulations.

Please be prepared for your visit. Always have a current med list (with exact doses) or bring your medication containers to your visit. Patients with diabetes should bring in their blood glucose meter for download or a logbook of finger stick glucose readings. Patients without a meter or logbook may be rescheduled, as these items greatly impact care. Please bring all lab test and radiology reports/films dealing with your endocrine condition.

**Nurse Practitioner Visits:** Our nurse practitioner helps manage patients with stable endocrine conditions who require minor adjustments during regular rechecks. Nurse practitioners are advanced practice nurses who are licensed by the state of N.C to diagnose and treat patients and have the ability to prescribe medications, order lab tests, and order any other diagnostic study needed. To best serve our expanding patient population, we may alternate patient visits between the doctor and the nurse practitioner. Our nurse practitioner, **Michael Skrzynski, ANP**, is extremely knowledgeable, and he regularly discusses specific patient needs with each doctor. By expanding our practice with NP care, we can more readily meet your same day urgent care needs, should they arise. We are also able to schedule more frequent visits if necessary, which is something that has been difficult to do in the past.

5/2019



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**Appointment Changes by MDEC:** Rarely, the MD or NP with whom you are scheduled is unavailable at the time of your scheduled appointment due to unforeseen circumstances, typically related to acutely ill patients requiring urgent care. When possible, we will notify you in advance and offer to reschedule you. When this occurs the same day as your appointment, we will attempt to reschedule you with another provider (MD or NP) with our apologies.

**After Hours Doctor On-Call:** An on-call doctor is available after hours for any emergencies that arise. To reach them, call the main office number, **(828) 684-9588**, and select the option for the doctor on call. If you have not received a return call within 1 hour, please call back.

**Lab Results:** Depending upon the lab test, it may take anywhere from 1-5 business days for us to receive results. We will notify you of results by telephone call, letter, or patient portal. If you have not heard from us within 10-14 business days, please call us.

**Hospital Care:** The MDEC physicians stopped seeing patients at Mission Hospital in 2006 in order to focus on outpatient care. The admitting physician can reach us any time for information and suggestions. When endocrine-specific care is required in-hospital, the admitting physician may contact your primary physician, in-house physician, or hospital endocrinologist. We will make every attempt to ensure communication with the hospital physician when our input is needed.

**Clinical Research:** We perform clinical research for pharmaceutical companies and medical device makers, as well as perform studies we have independently designed. We have published numerous studies in peer-reviewed journals from 2002 to 2018. Most studies involve diabetes. All studies are approved by an independent ethical review board and registered with the FDA. Study participants usually receive free medication, testing supplies, medical care, and payment for time spent in the study. Please ask any of our care providers for more information if you would be interested in participating.

**MDEC website:** Visit [www.mountaindiabetes.com](http://www.mountaindiabetes.com) to learn more about our practice, providers, and research, as well as to find links to useful endocrine and medical informational sites. You can also provide us feedback regarding your visit.



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## Patient Information

\_\_\_\_\_  
Date

\_\_\_\_\_  
First Name Middle Last Name Date of Birth

\_\_\_\_\_  
Preferred Name Preferred Pronoun

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip code

\_\_\_\_\_  
Social Security # Marital Status (please circle) S M D W Sep

\_\_\_\_\_  
Home Phone Cell Phone Work Phone

\_\_\_\_\_  
If patient is a student, name of school

\_\_\_\_\_  
Emergency Contact Phone Number Relationship

\_\_\_\_\_  
Employer Name Phone

**Insurance Information:** In order to accurately file your insurance, we will need a copy of your current insurance card(s).

\_\_\_\_\_  
Insurance Company Policy#

\_\_\_\_\_  
Name of Insured Relationship to patient

\_\_\_\_\_  
Insured person's date of birth Social Security #

### Secondary Insurance Information:

\_\_\_\_\_  
Insurance Company Policy#

\_\_\_\_\_  
Name of Insured Relationship to patient

\_\_\_\_\_  
Insured person's date of birth Social Security #



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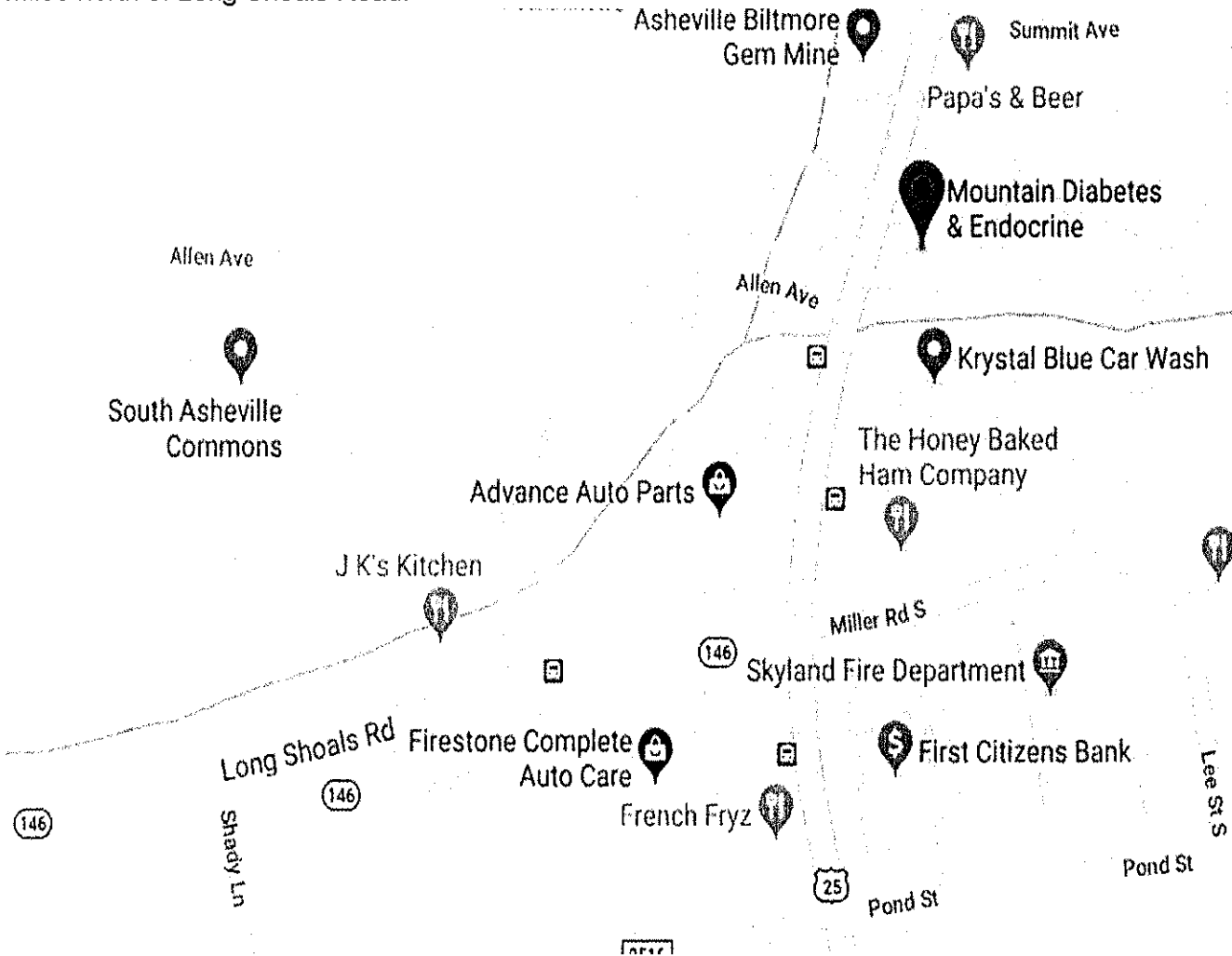
## **Directions to our office:**

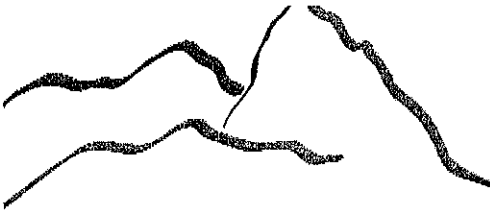
We are located in Skyland Office Park, just north of Long Shoals Road on the east side of Hendersonville Road. Skyland Office Park is across from Asheville Eye, and the entrance is between Krystal Blue Car Wash and Papa's and Beer Mexican restaurant. We are in the last building at the end of the office park.

From I-40: Take Exit 50A to Hendersonville Road. Drive 6.1 miles until you see Papa's and Beer on the left, then take the very next left into Skyland Office Park.

From I-26: Take Exit 37 to Long Shoals Road and turn east off the ramp. Drive 1.8 miles to reach the intersection with Hendersonville Road and get in the right-most left turning lane. Turn left, and the entrance to Skyland Office Park is 0.1 miles on the right after Krystal Blue Car Wash.

From Hendersonville Road: We are 5.3 miles south of I-40, 2.5 miles south of the Blue Ridge Parkway, and 0.1 miles north of Long Shoals Road.





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**Information and Assignment of Benefits**

**Please read the information below and initial:**

\*I am aware that if I am more than 10 minutes late for an appointment, my visit may be rescheduled.

**Initials:** \_\_\_\_\_

\*I understand that if I am being seen for diabetes and do not bring my blood glucose readings, my appointment may be rescheduled to a later date when readings are readily available.

**Initials:** \_\_\_\_\_

\*I understand that if I do not bring my current insurance card, my appointment may be rescheduled.

**Initials:** \_\_\_\_\_

\*I understand that if I will be responsible for all charges not paid by insurance or insurance is not applicable.

**Initials:** \_\_\_\_\_

\*I understand that payment is expected at the time of visit, including Medicare insured patients.

**Initials:** \_\_\_\_\_

\*I understand that I may request copies of my medical records for my benefit or to be released to another party with signed release and payment (**\$25 flat fee**) according to policies of Mountain Diabetes & Endocrine Center. I also understand that any request for medical records will be completed within one (1) week after receipt of written release and payment.

**Initials:** \_\_\_\_\_

\*I am aware that the doctor may alternate my visits with the nurse practitioner to optimize my care.

**Initials:** \_\_\_\_\_

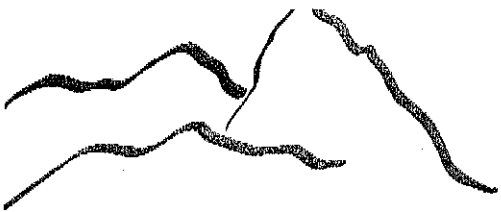
\*I understand that the provider (MD or NP) with whom I am scheduled to see may change without prior notice due to unforeseen circumstances, and I may be placed with another provider for that one visit. (This occurs very uncommonly.) Refusal to keep this appointment may result in a cancellation charge.

**Initials:** \_\_\_\_\_

I hereby authorize the patient-care providers of Mountain Diabetes & Endocrine Center to apply for benefits on my behalf for covered services rendered by her/him or by her/his order. I request that payments from my insurance company or companies be made directly to Mountain Diabetes & Endocrine Center or to the party who accepts assignment.

I permit a copy of this authorization to be used in the place of the original. This authorization may be revoked by either me or my insurance company or companies at any time in writing. I certify that the information I have reported with regard to my insurance(s) is/are correct.

**Signature (patient or guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**Consent for Disclosure of Medical Information**

**Patient:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

In connection with the medical services that I am receiving from MDEC and its medical staff, I hereby authorize the above named physician, and their respective agents to disclose any and/or all information concerning my medical condition and treatment, (including, but not limited to, super confidential information concerning sexually transmitted diseases, mental health, chemical dependence, or other such information) including redisclosure of applicable hospital and medical records to:

- A. Any third party payer covering the medical services of the patient;
- B. Other healthcare professionals and institutions involved in the delivery of health care to the patient;
- C. The proponent of any legally sufficient subpoena, or in response to a court order;
- D. Employees and agents of the practice, to the degree necessary to facilitate the provision of healthcare services and payment for such services;
- E. Pharmacies; and as otherwise required by law.

I consent to allow Mountain Diabetes & Endocrine Center to use my health information for purposes of billing, utilization review, practice quality assurance and retrospective research endeavors, as long as my identifying information is removed.

A photograph of my face may be taken if used solely for purpose of identification in medical records.

In providing information to me, information may be transmitted by any or all of the following means (initial all that apply):

Telephone Messages on house answering machine or cell phone voicemail. \_\_\_\_\_

Messages to the following family/friends listed below. \_\_\_\_\_

- 1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_
- 2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_
- 3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_
- 4. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Email to the following address: \_\_\_\_\_

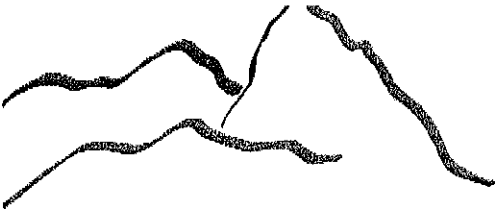
In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to my physician's privacy notice and that I have the opportunity to place special restrictions upon the consent hereby given:

Special Restrictions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This consent is valid from the date executed until revoked in writing by the patient:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness: \_\_\_\_\_ Date: \_\_\_\_\_



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**HIPAA Privacy Notice**

In accordance with the Health Insurance Portability and Accountability Act, patients of Mountain Diabetes & Endocrine Center are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law, and a patient's Protected Health Information (PHI) may only be released as authorized by this law. Upon request we can provide you with a copy of our Privacy Policies. Mountain Diabetes & Endocrine Center will strive to ensure that patient information is used only for purposes authorized by the patient. These may include, but are not limited to:

- A. Patient treatment and payment operations;
- B. Lawful subpoenas;
- C. Sharing of information with other health care providers;
- D. As otherwise required by law.

The Confidentiality of Alcohol and Drug Abuse Patient Records regulations prohibit disclosure or redisclosure of this information unless expressly permitted by the written consent of the person to who it pertains. The only exceptions are release to medical personnel in a genuine medical emergency, or as authorized by a court order.

Additionally, Patients have a right to review their medical records and furnish comments to their records during normal business hours, upon providing reasonable advance notice. In addition patients have the right to obtain information regarding entities to which Protected Health Information has been provided.

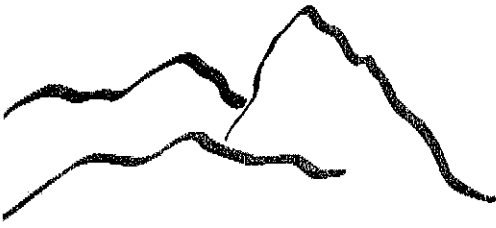
Moreover, patients have the right to:

- 1. Be informed of each breach of their PHI.
- 2. Decline to have PHI delivered to Health Insurers if the patient pays for services in full without submitting an insurance claim.

Should you ever have a concern or complaint, you should contact your MDEC doctor, or the MDEC Manager (Kathryn Mayo), or our HIPAA Compliance Officer (Dr. Stephen Weinrib). **This consent is valid from the date signed until revoked in writing by the patient:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



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**Diabetes Questionnaire:**

Please describe the diabetic issues that concern you most. (What can we do to help? Please give background on your condition or symptoms.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Diabetes Background:**

What year were you first diagnosed with diabetes or first told of abnormal sugars?	
How was your diabetes discovered?	
What was your weight when you were first diagnosed?	
Have you ever been hospitalized for diabetes or had diabetic ketoacidosis? If yes, when?	
Have you ever had any formal diabetes instruction from a diabetic nurse educator or nutritionist? If yes, when?	
Are you a member of the American Diabetes Association?	

**Diabetes Lifestyles:**

Do you exercise? What kind, how often, and how long?	
Who shops for and prepares your food?	
How many times per week do you eat out?	





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**Please Describe Meals (Meals examples of typical foods):**

Breakfast	
Lunch	
Supper	
Snacks	

**Diabetes Medications:**

Please list your current diabetes medication:	
How were you first treated after diagnosis?	
What diabetes medications have you taken in the past? Why were they stopped?	
Does anyone prepare your diabetes medications for you? Does anyone inject your insulin for you?	
Do you ever forget to take your diabetes medications? If so, how often?	
Do you self-adjust your medications?	

**Monitoring:**

Do you check your blood sugar? If yes, how often?	
What glucometer do you use? How old is it?	



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**Blood sugar Ranges:**

What are the approximate ranges of your blood sugar readings at meals and at bedtime?

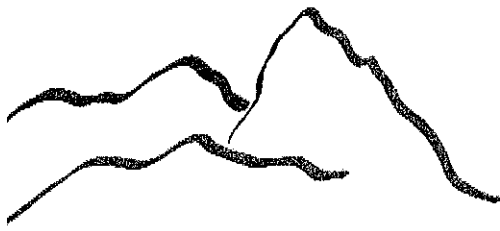
Pre breakfast	Post breakfast	Pre lunch	Post lunch	Pre supper	Post supper	Bedtime	2:00 am

**Hypoglycemia (low blood sugars):**

What symptoms do you experience?	
How often do they occur?	
What causes these symptoms? Can you explain them?	
How do you treat low blood sugars?	
Have you ever passed out from a low blood sugar or had a reaction so severe you required the help of someone else?	

**Prevention:**

Do you get the flu vaccination each fall?	
Have you ever had a pneumococcal vaccine in the last 15 years?	
Do you wear a medic alert medallion?	
Do you examine your feet daily?	
When was your last dilated eye exam?	
Who is your eye doctor?	
Do you take a daily aspirin?	
Do you use contraception? If so, what kind?	



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**Diabetic Complications:**

Have you ever been told that you have retinopathy (diabetic eye damage)?	
Have you ever needed laser therapy for retinopathy? If yes, when?	
Have you ever had a diabetic foot infection? If so, when?	
Do you have numbness, tingling, or a burning sensation in your feet or hands?	
(Female) Do you have trouble with recurrent yeast infections?	
(Male) Do you have trouble with recurrent rashes on the head of your penis?	
(Male) Do you have problem with erections? If yes, describe.	

**Please describe your past medical history with dates (e.g. hospitalizations, surgeries, medical/psychiatric diagnoses):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list drug allergies and symptoms:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**List medications, prescription, and over the counter. If more space is needed, please bring a list:**

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**Social History:**

Please list your marital status.	
Do you have children? If so, how old?	
Does anyone live with you? If so, who?	
What is your highest education level?	
Do you consume alcohol? How many drinks per day?	
Do you use tobacco? If so, what kind and how often?	
Are you employed? If so what is your occupation?	

**Gynecological History:**

Age of first period?	
Are your periods regular or irregular?	
Please list dates and outcomes of all pregnancies.	
Date of last menstrual period?	
If applicable, date of Menopause.	



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### Family History:

	Mother	Father	Grand Parent(s)	Sibling(s)	Description
Diabetes					
Thyroid					
Osteoporosis					
Hypertension					
Heart Disease					
Lipid Disorders					
Lung Disease					
Kidney Disease					
Ulcers/GI					
Arthritis					
Stroke/Neurolog ic					
Cancer					
Blood Disorder					
Other(specify)					



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**Review of systems (Please circle all that apply):**

- |                |                  |  |              |
|----------------|------------------|--|--------------|
| Fatigue        | Hoarseness       | Sexual problems (describe below)       | Weight gain  |
| Weight loss    | Osteoporosis     | Trouble swallowing                     | Palpitations |
| Leg cramps     | Poor sleep       | Shortness of breath                    | Back pain    |
| Snoring        | Nausea           | Arthritis (describe below)             | Poor Vision  |
| Diarrhea       | Constipation     | High cholesterol or high triglycerides | Poor hearing |
| Liver problems | Weakness         | Excessive hair                         | Indigestion  |
| Numbness       | Edema            | Urinary problems (describe below)      | Hair loss    |
| Infertility    | Acne             | Problems periods (describe below)      | Gout         |
| Dizziness      | Excessive thirst |  |              |

**Descriptions and/or other health issues related to your endocrine concerns:**

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**Please remember that the patient-care providers at Mountain Diabetes and Endocrine Center are focusing on your endocrine conditions. Therefore, it is important that you maintain regular follow-up with your primary care provider for general medical issues.**