



Diabetes and Thyroid Center of Fort Worth, PLLC
Darren Lackan, MD, PA, FACE, ECNU  **Anjanette Tan, MD, FACE, ECNU** 
Sara Matani, MD

Welcome to the Diabetes and Thyroid Center of Fort Worth!

Thank you for choosing our clinic. We are dedicated to providing you with compassionate and comprehensive care for endocrinology disorders, including diabetes, osteoporosis, and conditions related to the thyroid, parathyroid, pituitary, and adrenal hormones.

Managing these chronic conditions requires a team approach, and the leader of that team is *you*. Our mission is to empower you to take control of your health by teaching you about your condition and guiding you through meaningful lifestyle changes. If you are ready to take charge of your health, you've come to the right place.

To ensure efficient and high-quality care, we ask that you review our clinic policies below:

Clinic Policies

1. First Visit Preparation:

- Bring all relevant medical records with you or have your primary care physician (PCP) fax them to us in advance.
- Bring all your current medications and supplements or a detailed list of them.
- Arrive **30 minutes early** to complete any necessary forms.

2. Diabetic Patients:

- Bring your glucometer or glucose logbook, and carbohydrate counting sheets (if applicable) to every visit.

3. Timeliness:

- Arriving late will result in your appointment being rescheduled to the next available time.
- We value your time, but due to the personalized care we provide, we sometimes run behind schedule. Rest assured, we will dedicate the time needed to provide you with exceptional care.

4. Appointment Cancellations:

- Please notify us at least **24 hours in advance** if you need to cancel or reschedule an appointment.
- A **\$25 fee** may apply for cancellations made without 24 hours' notice. Missing more than two appointments without proper notice may result in discharge from the clinic.

5. Primary Care Physician (PCP):

- Every patient must have a PCP for general health concerns. If you need a recommendation, our staff will be happy to assist.

6. Lab Work:

- Returning patients must complete lab work at least **10 days prior to appointments**. Lab results will be discussed during your appointment only.
- For labs done between visits, we recommend signing up for our **Next MD Patient Portal** to securely access and review results with your physician or provider.

7. Prescription Refills:

- Contact your pharmacy at least **48 hours in advance** for refills. Your pharmacist will fax a request to our office, and we will respond within 48 hours of receiving the request.

We are here to support you every step of the way toward better health. If you have any questions or concerns, please do not hesitate to call us. We look forward to partnering with you on your journey to wellness!


Sincerely,

The Diabetes and Thyroid Center of Fort Worth Team

Diabetes and Thyroid Center of Fort Worth, PLLC

Darren Lackan, MD, PA, FACE, ECNU ✎ **Anjanette Tan, MD, FACE, ECNU** ✎ **Sara Matani, MD**

New Patient Registration Form (Please Print)

Today's Date:					
Patient Information					
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (circle one) Single / Mar. / Div. / Sep. / Wid.
Nickname:	Former Name:	Birth Date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address:			City:	State:	Zip Code:
Social Security #:		Home Phone #: ()		Cell Phone #: ()	
Occupation:		Employer:		Employer Phone #: ()	
Referred to clinic by:			<input type="checkbox"/> Dr.		
Guarantor Information					
<input type="checkbox"/> Check if same as patient information					
Person Responsible for bill:		Birth Date: / /	Address (if different):		Home Phone #: ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Social Security #:		Employer:	Employer Address:	Employer #: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Patient Portal					
<p>The Patient Portal is internet based and used at a personal computer. The Patient Portal is a secure way to:</p> <ul style="list-style-type: none"> • Send secure messages to your doctor • View test results • Request appointments • Renew Medication 					
					
Please provide your email address below to obtain access to the Patient Portal.					
Email Address:			Signature:		
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to Patient:	Home Phone #: ()	Work Phone #: ()	

Diabetes and Thyroid Center of Fort Worth, PLLC

HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Today's Date: _____

Reason for visit: _____

S O C I A L	Marital Status:	[Single] _____	[Married] _____	[Widowed] ___/___/_____	[Divorced] ___/___/_____	
	Occupation:	[Retired] _____	[Active] _____			
	Do you: (Please circle No or Yes and explain if Yes)					
	Get Exercise	[No] _____	[Yes] _____	⇒	_____ Hours per week	Type of exercise: _____
	Use Illegal drugs	[No] _____	[Yes] _____	⇒	_____	
Use Alcohol	[No] _____	[Yes] _____	⇒	Ounces per day: _____		
Use Tobacco	[No] _____	[Yes] _____	⇒	_____ Packs per day for _____ years	_____ current	

P A S T M E D I C A L	What medications are you currently taking (including supplements and vitamins)? Please list dose and frequency.					

	Have you had previous surgeries? Please list any below:					

	Problems for which you have seen a physician or have been treated for: (use back of page if necessary)					
	Diabetes	[No] _____	[Yes] _____	⇒	Type _____	Year _____
Cancer	[No] _____	[Yes] _____	⇒	Type _____	Year _____	Treatment _____
Nodule/Tumor	[No] _____	[Yes] _____	⇒	Location _____	Year _____	Treatment _____
Cholesterol	[No] _____	[Yes] _____	⇒	Meds _____	Side Effects? _____	
Stroke	[No] _____	[Yes] _____	⇒	Year _____	Treatment _____	
Blood Pressure	[No] _____	[Yes] _____	⇒	Year _____	Medications _____	
Heart Problem	[No] _____	[Yes] _____	⇒	Year _____	Treatment _____	
Eye Disease	[No] _____	[Yes] _____	⇒	Diabetic? _____	Year _____	Treatment _____
Kidney Disease	[No] _____	[Yes] _____	⇒	Diabetic? _____	Year _____	Treatment _____
Foot Infections	[No] _____	[Yes] _____	⇒	Diabetic? _____	Year _____	Treatment _____
Thyroid Disease	[No] _____	[Yes] _____	⇒	Type _____	Year _____	Treatment _____
Others	[No] _____	[Yes] _____	⇒	_____		
Do you have any allergies/reactions? {please list reaction}						

F A M I L Y	Do any of your blood relatives have or have had any of these diseases or do any other problems run in the family:					
	Diabetes	[No] _____	[Yes] _____	⇒	Type: _____	
	Cancer	[No] _____	[Yes] _____	⇒	Location: _____	
	Tumor/lesion	[No] _____	[Yes] _____	⇒	Location: _____	
	Heart Problem	[No] _____	[Yes] _____	⇒	_____	
	TB	[No] _____	[Yes] _____	⇒	_____	
	Thyroid Disease	[No] _____	[Yes] _____	⇒	Type: _____	
	High Blood Pressure	[No] _____	[Yes] _____	⇒	_____	
Stroke	[No] _____	[Yes] _____	⇒	_____		

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REVIEW OF SYSTEMS

Completed by: [Patient] [Family Member _____] on: ____/____/____

Name: _____ [Male] [Female] Age: _____ DOB: _____

Please check any of the following that apply:

<p style="text-align: center;">Constitutional Symptoms <i>Have you noticed recently?</i></p> <p><input type="checkbox"/> Weight Gain <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Weight Loss <input type="checkbox"/> Malaise</p>	<p style="text-align: center;">Skin <i>Do you have?</i></p> <p><input type="checkbox"/> Hives <input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Itching <input type="checkbox"/> Skin Lesions</p>
<p style="text-align: center;">Ears-Nose-Mouth-Throat <i>Have you recently had?</i></p> <p><input type="checkbox"/> Sinus Pressure <input type="checkbox"/> Eye Pain</p> <p><input type="checkbox"/> Sore Throat</p>	<p style="text-align: center;">Eyes <i>Have you recently had?</i></p> <p><input type="checkbox"/> Visual Changes <input type="checkbox"/> Peripheral Vision Loss</p>
<p style="text-align: center;">Respiratory <i>Do you have?</i></p> <p><input type="checkbox"/> Cough <input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Shortness of Breath</p>	<p style="text-align: center;">Cardiovascular <i>Do you have?</i></p> <p><input type="checkbox"/> Chest Pain <input type="checkbox"/> Leg Pain with Walking</p> <p><input type="checkbox"/> Palpitations <input type="checkbox"/> Swollen Ankles</p>
<p style="text-align: center;">Gastrointestinal <i>Do you have?</i></p> <p><input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Change in Stools <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation <input type="checkbox"/> Loss of Appetite</p>	<p style="text-align: center;">Endocrine <i>Do you have?</i></p> <p><input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Excessive Hair Growth</p> <p><input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Excessive Thirst</p> <p><input type="checkbox"/> Brittle Hair/Nails <input type="checkbox"/> Excessive Hunger</p>
<p style="text-align: center;">Musculoskeletal <i>Do you have?</i></p> <p><input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pains</p> <p><input type="checkbox"/> Muscle Weakness</p>	<p style="text-align: center;">Allergies/Immune <i>Do you have?</i></p> <p><input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Food Allergies</p>
<p style="text-align: center;">Psychology <i>Do you feel?</i></p> <p><input type="checkbox"/> Anxious <input type="checkbox"/> Depressed</p>	<p style="text-align: center;">Hematology/Lymphatic <i>Do you?</i></p> <p><input type="checkbox"/> Bruise Easily <input type="checkbox"/> Swollen Glands</p>

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NEXTGEN[®]

Patient Portal

The Patient Portal is internet based and used at a personal computer.

The Patient Portal is a secure way to:

- Send secure messages to your doctor
- View test results
- Request appointments
- Renew Medication

If you would like to sign up for the Patient Portal, please provide your email address below.

Email Address: _____

Diabetes and Thyroid Center of Fort Worth, PLLC

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Patient Name: _____ DOB: _____

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

WHO TO CONTACT

I hereby give permission to Diabetes and Thyroid Center of Fort Worth, PLLC to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name	Relationship

- I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition(s).

HOW TO CONTACT

Communication by Phone / Text Message

Home Phone: ()	Work/Cell Phone: ()
<input type="checkbox"/> Ok to leave message with detailed information	<input type="checkbox"/> Approve to leave message with detailed information <input type="checkbox"/> Approve to send text messages with detailed information

Written Communication

<input type="checkbox"/>	Approve to send mail to my home address:
<input type="checkbox"/>	Approve to send to my Email address:

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient or Parent/Guardian Signature: _____ Date: _____

DIABETES AND THYROID CENTER OF FORT WORTH

Darren Lackan, MD, PA, FACE, ECNU ✎ Anjanette Tan, MD, FACE, ECNU ✎ Sara Matani, MD

NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

This notice describes the practices of Diabetes and Thyroid Center of Fort Worth (DTC) and that of its physicians with respect to your protected health information created while you are a patient at DTC. DTC physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, DTC physicians may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at DTC. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at DTC.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of DTC, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction;
- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to Diabetes and Thyroid Center of Fort Worth, 7801 Oakmont Blvd., Suite 101, Fort Worth, TX, 76132.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at DTC.
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations, and As Otherwise Allowed By Law

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories

We will use your health information for treatment.

For example: We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at DTC. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at DTC.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.

Business associates: There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research

proposal and established protocols to protect the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Communications for treatment and health care operations:

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising: We may contact you as part of a fundraising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative, and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative, and law enforcement purposes.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state, or local law.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact Enterprise Medical Management at 866 4597818. If you believe your privacy rights have been violated, you can file a complaint with Enterprise Medical Management or the Secretary of Health and Human Services. There will be no retaliation for filing a complaint

Diabetes and Thyroid Center of Fort Worth, PLLC

Darren Lackan, MD, PA, FACE, ECNU ✎ **Anjanette Tan, MD, FACE, ECNU** ✎ **Sara Matani, MD**

ACKNOWLEDGEMENT OF THE RECEIPT OF DIABETES AND THYROID CENTER OF FORT WORTH (DTC)
NOTICE OF HEALTH INFORMATION PRACTICES

ACKNOWLEDGEMENT

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. DTC is furnishing you with the attached notice, which provides information about how DTC and its physicians may use and/or disclose protected information about you for treatment, payment, healthcare operations and as otherwise allowed by the law. By signing this form, you acknowledge that you have received a copy of Notice of Health Information Practices.

Initial: _____

CONSENT TO TREAT

I hereby authorize employees and agents, including physicians of this medical office, to render routine medical care to the patient indicated on this form, and to fulfill the orders of the physicians including consultants, associates and assistants of the physician's choice. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Initial: _____

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to DTC and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to DTC. I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of DTC, if any. I also understand that interest may be charged at a rate of 11% per annum for accounts over 60 days old. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Initial: _____

FOR MINORS

If the patient is a minor:

I consent for _____ to authorize evaluation and treatment for my child named herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

Initial: _____

GOVERNING LAW AGREEMENT

I (we), the patient or patient's representative and DTC, including employees and agents of DTC, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choices of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Initial: _____

Patient Name: _____

Date: _____

Patient/Guardian Signature: _____