Print

Patient Information
Record

AUTHORIZATION TO PAY
BENEFITS TO PHYSICIAN

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I, the undersigned, authorize payment of medical benefits to Diabetes Control Center for any services furnished to me. I understand I may be financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company information concerning health care, treatment or supplies provided to me. I permit a copy of this authorization to be used in place of the original.

DATE_____SIGNATURE_____

MEDICARE LIFETIME SIGNATURE ON FILE:

I request payment of authorized Medicare benefits be made on my behalf to Diabetes Control Center for any services furnished to me by a health care provider. I authorize any holder of medical information about me to release to Diabetes Control Center any information needed to determine these benefits or benefits payable for related services.

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DATE_____SIGNATURE_____

MEDICAL SERVICES AUTHORIZATION:

I authorize you to give me reasonable and proper medical care by today's standards.

DATE_____SIGNATURE_____

PHONE MESSAGE AUTHORIZATION

I authorize the staff of the Diabetes Control Center to leave a message on my voice mail,
e-mail or with another party at the number(s) or address provided.

DATE_____SIGNATURE_____

FAX OR OTHER ELECTRONIC MEANS AUTHORIZATION

I authorize Diabetes Control Center to fax or electronically transmit medical records to other providers participating in my care.

DATE_____SIGNATURE_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

This form instructs The Diabetes Control Center to discuss, or not to discuss your health information with specific individuals.

[] Do not discuss my information with anyone. *

[] My health information may be discussed with the following person(s).

	NAME	RELATIONSHIP	PHONE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

NAME PRINTED _____

Signature:_____

Date_____

*Pertinent information must be provided to insurance companies and government agencies for payment purposes.

MEDICAID SECONDARY WAIVER
MEDICARE/MEDICAID OR PRIVATE INSURANCE/MEDICAID

DATE: _____

PATIENT'S NAME: _____

AS OF 10-26-01, MEDICAID WILL NO LONGER COVER YOUR 20% CO-PAY OF YOUR OFFICE VISIT. YOU WILL BE RESPONSIBLE FOR PAYING THIS AMOUNT AT THE TIME OF SERVICE. BY SIGNING THIS WAIVER, YOU UNDERSTAND AND AGREE THAT YOU WILL BE RESPONSIBLE FOR PAYING THIS AMOUNT AT THE TIME OF MY VISIT.

PATIENT'S SIGNATURE: _____

WITNESS: _____

DATE: _____

Effective Date: April 14. 2003

ACKNOWLEDGEMENT

Diabetes Control Center

I hereby acknowledge receipt of the Diabetes Control Center notice of privacy practices

_____ _____

Signature Date

_____

Print Name

EXAMPLES OF DISCLOSURES OF INFORMATION: TREATMENT:

a. We will use your health information for treatment purposes. As an example, Information given to a nurse or physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare team will document your treatment goals. actions taken and clinical observations.

b. We will provide your other healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.

c. Payment 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, your diagnoses. treatments and supplies used.

d. Healthcare Operations: The physicians and members of your healthcare team may use the information to evaluate the quality of care you received by others like you. This information will be used to improve the effectiveness of healthcare operations and services we provide.

PAYMENT AGREEMENT

It is the policy of Diabetes Control Center that charges for services rendered by our physicians and staff be paid for at the time of services unless other formal arrangements have been made with our business office.

Electronic insurance claims will be filed by Diabetes Control Center for your convenience; however, it will be your responsibility to provide our office with the necessary information and signed authorization for filing insurance. This information and authorization must be provided at your first visit, accompanied with a copy of your insurance card(s).

Arrangements for monthly payments may be made with our business staff for any patient account balance in excess of $200. A minimum payment is required each month to keep the account active. You are responsible for making the monthly payments by the 5th working day of each month whether or not a statement has been sent to you. Any patient account which becomes delinquent (monthly payment not made within 30 days of the last payment), will begin to be processed in the office COLLECTION department and the complete balance will become due immediately.

I agree to the above financial for any services provided to me by Diabetes Control Center.

DATE

RESPONSIBLE PARTY SIGNATURE

Diabetes Control Center: NOTICE OF PRIVACY PRACTICES

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

UNDERSTANDING YOUR MEDICAL RECORD HEALTH INFORMATION:

As your healthcare provider. We will maintain a record of your visit that contain your symptoms, reports of examinations and test results, diagnosis, treatments, correspondence with other providers and plans for future care or treatment.

YOUR HEALTH INFORMATION RIGHTS:

Your health record is the physical property of this practice; however, the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the practice of your request for any of these actions:

- Request Restrictions: you have a right to request restrictions on the use of your information.
- You have a right to obtain a paper copy of this notice.
- Inspect and copy: you have a right to inspect and receive a copy of your health information. If you request a copy of your information, you will be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
- Amendment: you have the right to request that we amend your health information.
- Accounting Disclosures: You have the right to request an accounting of disclosures of information made about you. These include disclosures of information beyond those of treatment, or payment. Within 6 years, the First Listing of Disclosure is provided as a complementary service. You will be charged a reasonable fee for additional requests within 12 months.
- Request Communications of Your Health Information: You have the right to request a record of communications regarding your Information.
- Revoke Your Authorization for Disclosure: you have the right to revoke an authorization for disclosure of information that was previously given.

OUR RESPONSIBILITIES

- Confidentiality: maintain the privacy of your health information.
- Provide a copy of this notice: we will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
- Abide by the terms of this notice.
- Unable to Restrict: we will notify you if we are unable to agree to a requested restriction of your information.
- Provide alternative means or alternative locations: we will accommodate reasonable request by you to communicate health information by alternative means or locations.
- We reserve the right to change and to make new provisions effective for all protected health information.
- Should information practices change, we will notify you of these.
- We will not use or disclose health information without your authorization, except as described in this notice.

FOR MORE INFORMATION.

If you have a question or would like additional information you may contact our Privacy Officer.
If you have a concern about the privacy of your information, you may contact our Privacy Officer. Your concerns will be responded to by our practice. You may also file a complaint with the Secretary of Health and Human Services in the US Office of Civil Rights. The Privacy Officer will supply information about this procedure.