Diabetes And Lipid Clinic of Alaska

Patient Information

Date: _____ Patient Name: _____
First MI Last

SS#:_____ ☐ Male ☐ Female Date of Birth: _____

Home Phone:_____ Cell Phone:_____ Work:_____

Address:_____ City:_____ St:_____ Zip:_____

Email:_____ Referred by: _____

Check appropriate box ☐Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient or Parent/Guardian's Employer:_____ Work Phone:_____

Business Address:_____ City:_____ St:_____ Zip:_____

Spouse or Parent/Guardian's Name:_____ Home/Cell Phone: _____

Spouse or Parent/Guardian's Employer:_____ Work/Phone:_____

Responsible Party

Person Responsible for account:_____ Relationship to patient:_____

Address:_____ City:_____ St: _____ Zip:_____

E-Mail:_____ Phone:_____ Cell Phone:_____

SS#:_____ Date of Birth:_____ Work Phone:_____

Employer:_____ Is this person a patient? ☐ Yes ☐ No

Primary Insurance Information

Insurance Company:_____ ID #:_____ Group #:_____

Insurance Address:_____ City:_____ St:_____ Zip:_____

Co-Pay Amount:_____ Deductible Amount:_____ Max. Annual Benefit:_____

Name of Insured: _____ Relationship to patient:_____

Date of Birth:_____ SS:_____ Date Employed:_____

Employer:_____ Work phone:_____

Employer Address: _____ City:_____ St._____ Zip:_____

Do you have any additional insurance? ☐ Yes ☐ No Diabetes and Lipid Clinic of Alaska invoices primary insurance *only* but will provide you with necessary information to assist you in billing your secondary insurance.

Insurance Information (secondary)

Insurance Company:_____ Group #:_____ Union/Local #:_____

Insurance Address:_____ City:_____ St:_____ Zip:_____

Co-Pay Amount:_____ Deductible Amount:_____ Max. Annual Benefit:_____

Name of Insured: _____ Relationship to patient:_____

Date of Birth:_____ SS:_____ Date Employed:_____

Employer:_____ Work phone:_____

Employer Address: _____ City:_____ St._____ Zip:_____

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____

Signature of patient (or parent/guardian if minor) Date

Diabetes And Lipid Clinic
of Alaska

Payment Policy

Thank you for choosing us as your Diabetic Care Specialists. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this policy. Please read it, ask us any questions that you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance: We bill most insurance plans, except Medicare and Medicaid. If you are not insured by a plan we business with, payment in full is expected at each visit. If you are insured by a plan that we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments and Deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered Services: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay in full for these services at the time of the visit.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims Submission: We will submit your claims and assist you in anyway we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 30 days, the balance will automatically be billed to you.

Non-Payment: If your account is over 90 days past due you will be contacted about paying your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware

that if a balance remains unpaid, we may refer your account to collection agency and you and your immediate family may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternate medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Cancellation Policy: Your appointment time is reserved for you; you will be expected to pay for it unless you provide 24 hours advanced notice of your cancellation, with the exception of circumstances which we would both define as an unavoidable emergency. You will be charged in full for non-cancelled missed appointments, and as follows for late cancellation's
(not within 24 hours):
1st Missed Appointment**…**……..$50.00
2nd Missed Appointment…….$75.00
3rd Missed Appointment…….Cost of schedule appointment & referral out of the office.

These charges will be your responsibility and billed to you. Please help us to serve you better by keeping your regularly scheduled appointment. _____ (Please initial)

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines

Signature of patient or responsible party **Date**

Diabetes And Lipid Clinic
of Alaska

Authorization for Disclosure of Health Information

Patient Name: _____
Date of Birth: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

- The following physician(s) or clinic(s) are authorized to release my medical records;
  (Very important that you complete this portion so we know where to secure your medical records)

_____
_____
_____

- The type and amount of information to be used or disclosed is as follows:

_____ Complete health record
_____ Physical exam
_____ Immunization record
_____ Other (please specify) _____
_____ Lab results / X-ray reports
_____ Consultation reports

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
- This information may be disclosed to and used by the following:

Diabetes and Lipid Clinic of Alaska
2841 DeBarr Rd Ste 43
Anchorage, AK 99503

For the purpose of: _____

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on _____.

- If I fail to specify an expiration date, this authorization will expire in ninety days. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and that the information may not be protected by the federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact: Tamara Tanner, HIPAA Privacy Officer for Diabetic Consultants of Alaska.

_____
Signature of patient or legal representative

Date: _____

_____
Signature of witness

Date: _____

NOTICE OF PRIVACY 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.

Diabetes and Lipid Clinic of Alaska respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services, including:
    - medical quality review by your health plan;
    - accounting, legal, risk management, and insurance services;
    - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:
Tamara Tanner, HIPAA Compliance Officer, , 2841 DeBarr Rd Suite 43,
Anchorage, AK 99508, (907) 274-7847.

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Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice.

You may receive the most recent copy of this Notice by calling and asking for it or by visiting our [office/medical records department] to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may *contact*: Tamara Tanner, HIPAA Compliance Officer, 2841 DeBarr Rd Suite 43, Anchorage, AK 99508, (907) 274-7847.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Tamara Tanner at our practice/health care facility. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
- [Hospitals] Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory:
  - your name,
  - location,
  - general condition, and
  - religion (only to clergy).

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws**—if you make a workers' compensation claim.

- **For Public Health and Safety Purposes as Allowed or Required by Law:**
    - to prevent or reduce a serious, immediate threat to the health or safety of a person
    - or the public.
    - to public health or legal authorities
        - to protect public health and safety
        - to prevent or control disease, injury, or disability
        - to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Web Site

- We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at this address: www.diabetesalaska.com

Effective Date:

July 1, 2005

NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Tamara Tanner, HIPAA Compliance Officer, , 2841 DeBarr Rd Suite 43, Anchorage, AK 99508, (907) 274-7847.

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Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge I have been informed of the Notice of Privacy Practices and that I may request a written copy of these Privacy Practices if I desire.

Written Copy of Notice of Privacy Practices (please check one):

□ Requested

□ Denied

_____	_____
Patient or legally authorized individual signature	Date Time
_____	_____
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

Last Update: July 27, 2005 Copy of Notice of Privacy Practices given by:_____