DiabeVita

NEW PATIENT REGISTRATION *(page 1 of 2)*

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____Suffix_____

Name you go by _____ Date of Birth: _____ Email (personal) _____

Primary phone (home / work / cell) (_____) _____ Alternate (home / work / cell) (_____) _____

Address: _____ Apt/Unit # _____

City _____ State _____ Zip _____ Gender: Male Female

Social Security Number _____ Marital Status: ___ Single ___ Married ___ Divorced ___Widowed

Employer _____ Employer Phone # _____

Rank the methods below by your preference (numbering the options as 1 - 4) for us to reach you for appointment reminders, lab results and other health information:

____ Online via confidential web site (Patient Portal) available 24/7
____ Telephone (please list which phone number is best for confidential calls to you):_____
____ E-mail (do not list your workplace email address above - it is not confidential)
____ US Mail

What is your preferred language for communicating with us?

____ English
____ Spanish
____ Other (please state:) _____

Our office/clinic is participating in a national initiative to measure and improve the quality of care people receive. We are asking about your ethnicity and race for demographic purposes. However, providing this information is completely voluntary, and will not affect your health care.

Race =

____ American Indian or Alaska Native
____ Asian
____ Black or African American
____ Native Hawaiian or Other Pacific Islander
____ White
____ Other _____
____ I choose not to report"

Ethnicity =

____ Hispanic or Latino
____ Other _____
____ I choose not to report"

RESPONSIBLE PARTY (GUARANTOR) INFORMATION (if different from patient; otherwise, leave blank)

Last Name _____ First Name _____ Middle _____

Date of Birth: _____ Email _____

Primary phone (home / work / cell): (_____) _____ Alternate (home / work / cell): (_____) _____

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Social Security Number _____ Relationship to Patient: Spouse Parent Guardian Other _____

Employer _____ Employer Phone # _____

NEW PATIENT REGISTRATION *(page 2 of 2)*

INSURANCE COMPANY INFORMATION (please present card at check-in)

Primary Insurance Company: _____

Employer _____ Employer phone: _____

Policy #: _____ Group #: _____ Copay: $_____

Name of insured ("SAME" if patient): _____ Date of Birth_____

Insured's Address: _____ Apt/Unit # _____

City _____ State _____ Zip _____

Relationship to patient: ____ Self ____ Spouse ____ Child ____ Other

Secondary Insurance Company (if applicable): _____

Employer _____ Employer phone: _____

Policy #: _____ Group #: _____ Copay: $_____

Name of insured ("SAME" if patient): _____ Date of Birth_____

Insured's Address: _____ Apt/Unit # _____

City _____ State _____ Zip _____

Relationship to patient: ____ Self ____ Spouse ____ Child ____ Other

REFERRAL INFORMATION

How did you hear about us? ____Current Patient ____ Insurance Directory ____ Website: _____ Other: _____

Or if referred by a health care professional, who may we thank for referring you to us?_____

Is your visit due to a job related injury or automobile accident? _____ If yes, please notify us at check-in

YOUR PREFERRED PHARMACY FOR PRESCRIPTIONS

Pharmacy Name: _____ Phone _____ Fax _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Name: _____ Best Phone #: (_____) _____ Relationship to Patient: _____

ASSIGNMENT OF BENEFITS • GUARANTY OF PAYMENT

I hereby give authorization for payment of insurance benefits arising from services rendered by Diabevita Medical Center (DMC) to be made directly to DMC. I understand that I am financially responsible for all charges incurred by the above patient whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections including reasonable attorney's fees. I hereby authorize DMC to release all information necessary to secure the payment of benefits from my insurance company. I further agree that a photocopy or facsimile of this agreement shall be as valid as the original.

Signed _____ Date _____

DiabeVita MEDICAL CENTER

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below I give permission for DiabeVita Medical Center to access my pharmacy benefits data electronically through RxHub. This consent will enable DiabeVita Medical Center to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____ _____

Patient Name (PRINTED) Date of Birth

_____ _____

Patient/Guardian Signature Date

DiabeVita MEDICAL CENTER

NEW PATIENT PERSONAL HEALTH HISTORY

Full Name _____ Today's Date _____

Name you go by _____ Date of Birth _____

Your answers on this form will help our doctors and staff better understand your medical concerns and conditions. You do not have to answer all questions, but be aware that not answering completely could lead to misdiagnosis or inappropriate treatment recommendations. If you cannot remember specific details, please provide your best guess. All information is held confidential pursuant to our Privacy Policies.

Main reason for today's visit: _____

Other concerns you would like to discuss: _____

ATTACH A SEPARATE PIECE OF PAPER LISTING ALL MEDICATIONS YOU ARE CURRENTLY TAKING. Include prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc. List the name of the medication or supplement, the normal dosage, and how many times a day you take the dosage. In addition, please answer the following two questions:

What medications have you ever had a negative (allergic) reaction to?

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Are you allergic to any other substances or chemicals? _____

SCREENING TESTS: Please check any you've had done in past 5 years.

Blood sugar	_____	When? _____	Results _____
Cholesterol	_____	When? _____	Results _____
PSA (prostate)	_____	When? _____	Results _____
Triglycerides	_____	When? _____	Results _____
Diabetes Hba1C	_____	When? _____	Results _____
Urine protein	_____	When? _____	Results _____
Colonoscopy	_____	When? _____	Results _____
Mammogram	_____	When? _____	Results _____
Pap smear	_____	When? _____	Results _____
Osteoporosis	_____	When? _____	Results _____

SURGICAL HISTORY: Please list all prior surgeries you have had (with year):

_____

_____

_____

HOSPITALIZATION HISTORY: Please list all in-patient hospital stays (for other than listed surgeries), the dates and the reason

_____

_____

_____

PERSONAL MEDICAL HISTORY: Please **circle** any listed medical condition you have now or have had in the past. Please explain with comments.

- Allergies _____
- Heart problems (what kind) _____
- Asthma/COPD _____
- Prostate problems _____
- Stroke _____
- Gallstones _____
- Cancer (specify type) _____
- Diabetes _____
- Broken bones _____
- Heartburn/ulcers _____
- Headaches/migraines/tension _____
- High cholesterol/triglycerides _____
- High blood pressure _____
- Thyroid Problems (type) _____
- Anemia _____
- Arthritis/Osteoporosis _____
- Urinary Tract Infections _____
- Kidney stones _____

FAMILY MEDICAL HISTORY: Please write in on each line which family member - mother / father / brother / sister / maternal grandfather / maternal grandmother /paternal grandfather / paternal grandmother / aunt / uncle - have had the listed medical condition.

Who?

- Heart attack _____
- Bleeding / clotting disorder _____
- High cholesterol _____
- High blood pressure _____
- Sudden death _____
- Cancer, specify type _____
- Asthma / COPD / TB _____
- Stomach/Intestinal problems _____
- Kidney Stones / kidney disease _____
- Dementia _____
- Migraines _____
- Seizures _____
- Stroke _____
- Diabetes _____
- Thyroid Problems (type) _____
- Anemia / blood disorder _____
- Arthritis _____
- Gout _____
- Allergies _____
- Depression / suicide _____
- Mental Illness _____
- Alcoholism or drug abuse _____

DIABETES HISTORY. If you have been diagnosed with diabetes or told you have pre-diabetes, please answer these questions.

When were you diagnosed? _____

When and how often do you check your blood sugar? _____

How many diabetes education classes have you attended? _____

Have you had diabetes nutritional counseling? _____

When was your last test, and the results for these tests:

Hemoglobin A1C _____
Urine Protein _____
Cholesterol _____
Triglycerides _____
EKG _____
Eye Exam by an Ophthalmologist _____
Foot Exam _____

LIFESTYLE QUESTIONS:

Occupation: _____
Employer: _____
Years of education/highest degree: _____

Marital Status: Single / Partner / Married / Divorced / Widowed
Spouse / partner's name: _____
Number of children/ages: _____
Who lives at home with you? _____

What kind of exercise do you do?_____
How long (minutes) / how many days a week?_____

Do you wear a helmet when you ride a bike, motorcycle or skate board? No ___Yes ___ N/A ___

What are your hobbies /recreation _____

Cigarettes:
Never Smoked _____ Quit Date _____
Current Smoker: packs/day _____ # of years _____
Other Tobacco: Pipe _____ Cigar _____ Snuff _____ Chew ____
Are you interested in quitting? No _____ Yes _____

Do you drink alcohol? No _____Yes _____ # drinks/week _____

Birth control method: _____None needed _____
Do you have sex with: Men _____ Women _____ Both _____

How many cups of Coffee or tea per day do you drink _____

How many glasses of soda _____
Do you drink regular or diet soda? _____

Are you satisfied with your weight? No ____ Yes ____
How do you rate your diet? Good ___ Fair ___ Poor ____

Is violence at home a concern for you? No ____ Yes ____
Have you ever been abused? No ____ Yes ____

Have you completed a living will or durable power of attorney for health care? No ____ Yes ____

YOUR IMMUNIZATIONS: Please list the year you last had each of these immunization shots:

Influenza (flu shot) - when? _____

Pneumonia shot - when? _____

Tetanus (Td) - when? _____

Tdap (tetanus & pertussis) - when? _____

Varicella (chicken pox or shingles) shot - when? _____

Hepatitis A - when? _____

Hepatitis - when? _____

Meningitis - when? _____

WOMEN'S HEALTH HISTORY:

First day of your most recent period _____

pregnancies _____ # deliveries _____ # abortions _____ # miscarriages _____

Age at start of periods: _____ Age at end of periods:_____

MEDICAL SPECIALISTS YOU CURRENTLY SEE:

Name _____

Specialty _____

Phone / Fax _____ / _____

City / State _____ / _____

Name _____

Specialty _____

Phone / Fax _____ / _____

City / State _____ / _____

Name _____

Specialty _____

Phone / Fax _____ / _____

City / State _____ / _____

Name _____

Specialty _____

Phone / Fax _____ / _____

City / State _____ / _____

ANY OTHER COMMENTS / CONCERNS TO ADDRESS WITH DR. HILTS:

_____

_____

_____

_____

_____

_____

PRIVACY POLICIES ABOUT YOUR PERSONAL HEALTH INFORMATION

We are required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)to describe how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. the most current copy of our Privacy Notice is available at www.diabevita.com.

If you have questions about this Notice

Please contact us at the address at the end of this document:

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to authorized others who may assist in your care, such as your spouse, children or parents. If you are incapacitated, or under emergency circumstances, we may exercise our professional judgement and disclose relevant information to other authorized recipients if we believe it is in your best interest. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

Use and disclosure of your PHI in certain special circumstances

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

Your rights regarding your PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to us at the address at the end of this document specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to us at the address at the end of this document. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to us at the address at the end of this document in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to us at the address at the end of this document. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to us at the address at the end of this document. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact us at the address at the end of this document or see www.diabevita.com.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact us at the address at the end of this document. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact us at DiabeVita Medical Center, Inc, 7400 McDonald Drive, Suite 105, Scottsdale AZ 85250 (480) 315-9757.

PATIENT PORTAL AUTHORIZATION AGREEMENT

Patient Name: _____Date of Birth _____

Patient Email: _____

(PRINT CLEARLY AND DOUBLECHECK. This should be a personal email to which you have consistent, frequent access; DO NOT use your workplace email)

Our "Patient Portal" is a free webpage that uses encryption to keep messages and content secure from unauthorized persons. Secure messages and information can only be viewed by someone entering the correct username and password to log in to the Portal site. We will assign you this login info. From this portal you can:

- Schedule, confirm, cancel or reschedule an appointment
- Request a medication refill
- See lab results
- Receive confidential messages from us
- View your medical history information for your own information or to give to another provider
- Other convenient functions as may be added from time to time

The portal is intended to save you time and perhaps save an administrative-related office visit. It does not allow for any type of diagnosis or medical advice, and should never be used in an emergency situation. You can still contact our office via telephone or in person at any time.

Once you have reviewed, approved, and given us this signed form, we will assign you a username and password. You can access the Patient Portal through any page on our website at www.diabevita.com to log in with the assigned name and password.

For your ease of use and to maintain security of your medical information, you should:

- Read the Patient Portal user manual on our web site www.diabevita.com
- Change the originally assigned password as soon as you first login
- Advise us of any changes in your primary contact email address
- Use caution when communicating highly sensitive or personal information via Portal messages
- Follow up your inquiry with our office if a portal inquiry is not responded to within a reasonable time
- Not allow anyone else to have access to your username and password
- Not store messages on your employer-provided computer
- Never use the portal for emergency needs
- Renew this Authorization once a year

I acknowledge that I have read and fully understand the above terms and understand there are confidentiality risks associated with any type of online communication, including this patient portal.

.

_____

Patient Signature / Date

Please mail, drop off or fax this form to 480-315-9758

DiabeVita MEDICAL CENTER

FINANCIAL POLICIES

Thank you for considering the DiabeVita Medical Center as your healthcare provider. We provide our services with care, pride and professionalism, and as with any business, we want the financial implications of our providing this service to you to be as clear as possible. Due to many changes in health care financial matters in recent years, you may find that some policies have changed from what you have been used to in the past. This form explains our very simple policies and expectations on billing, payments, and terms of service. Please review carefully to avoid possible misunderstandings between us later. We will gladly answer any questions you may have.

Payments for services

All financial arrangements must be made prior to rendering services. Co-pays and any outstanding balances for insured patients must be paid at check-in. Self-pay patients and insured patients with an open deductible at time of service must pay for the service in full before provided, or if the scope of service is unknown in advance, pay a deposit of at least $125 to reasonably cover the expected service. Payments for any service or products may be made by cash, most major credit cards, debit cards and checks. Please note all checks are run through TeleCheck Services and may clear your account the same day as written.

Insured Patients

We will ask for your insurance card prior to or at each visit and collect your co-pay at check-in. We verify current coverage with your insurance company prior to rendering service at every visit. This basic verification does not guarantee that the insurance company will pay for any specific rendered service. If current information is unavailable, or there is any uncertainty over coverage, we will collect payment from you and then provide you with the necessary forms to remit to your insurance company for reimbursement directly to you at your convenience. When applicable, we will file your claim and bill your insurance company as a courtesy, but you remain responsible for payment until we receive payment from your insurance company. It is not unusual for an insurance company to refuse to cover the service rendered as you expected. Your insurance policy is a contract between you and your insurance company, and we cannot get involved in disputes on such matters as deductibles, co-payments, or non-covered charges and rates. If your insurance company does not pay us within 60 days of filing your claim, you will be held responsible for payment.

Self-pay Accounts

Self-pay accounts are patients without verified coverage by insurance companies with which we are registered participants. We do not accept attorney letters or contingency payments on liability cases. We may collect a deposit of $125 for all self pay accounts at check-in, and will reconcile with you at checkout for any additional charges or refunds due. We can provide a receipt for you to submit to any insurance company with which we do not participate

Minors and Wards

The parent(s) or guardian(s) for a child or ward must sign all financial obligation forms and is responsible for full payment. A signed release to treat may be required for unaccompanied minors.

Payment Plans

Under very limited circumstances, we may extend payment plan terms to you for certain procedures and treatments. An application is required, and decisions are made on a case-by-case basis by the Business Office. Any such arrangement must be made prior to us rendering services.

Unpaid Bills are Reported

In many respects, DiabeVita is a small, locally owned business just like your neighborhood pet store, dry cleaner, restaurant or auto mechanic. And like any type of business, we rely on payment from our customers to be able to provide the highest level of service. We will reasonably work with cooperative past due accounts until they are cleared, but we are required to turn over unpaid accounts to agencies and attorneys for collection when all other efforts fail. Delinquent accounts with us may be reported to credit-reporting agencies. Should you find yourself behind on a bill, please maintain close communication with us.

DiabeVita

PATIENT AUTHORIZATIONS AND ACKNOWLEDGEMENTS

PATIENT FULL NAME _____DATE OF BIRTH _____

We are required to maintain records indicating that we have given you privacy and other information to review if you so desire, and must keep record of certain authorizations. Please read each of the following statements and initial each one. If there are any questions, please let us know. Thank you, and we look forward to working with you to achieve optimal health!

I have been given a business card, brochure, or other printed material with the DiabeVita Medical Center contact information, including phone and email address. _____

I have been given a copy or access to DiabeVita privacy policies pursuant to the Health Insurance Portability and Accountability Act of 1996 which state how DMC may use my personal health information. I authorize DiabeVita to contact me to remind me of an appointment, including by phone and/or by email, and to leave a message regarding my appointment on my voice mail if I am not available at the time of the reminder call. If I do not want a voice mail message left, I will advise DiabeVita in writing of this request. I have been given an opportunity to register for and utilize the patient portal, which allows my confidential online access to my medical records, set appointments and have other communications with the Diabevita office staff. _____

I have reviewed DiabeVita's Financial Policies, including our requirement that all charges incurred not payable by insurance must be paid prior to or at time of service. I also understand that if for any reason my insurance company does not pay for a rendered service, I remain responsible for such billing. I understand past due bills may be turned over to outside parties for collection and are subject to reporting to credit -reporting agencies. _____

I have been given an opportunity to list my current and past medical condition and history on forms provided by DiabeVita, and that to the extent I chose to not answer fully or truthfully, DiabeVita is not liable for any errors or omissions in treatment that might arise from lack of accurate information as requested. _____

I understand that if I do not cancel a previously scheduled appointment within 24 hours of the appointment time, I will incur a $25 Missed Appointment Fee. _____