NEW PATIENT CONSULTATION FORM

Confidentiality Notice: Please note this form is part of the confidential medical record and will be kept in your Diabetes Relief file. Information contained here will not be release to any person except under your authorization.

Name: _____Preferred Name: _____**DOB**: _____

In brief, what main concern(s) and/or interest(s) bring you to our office? _____

_____

SOCIAL HISTORY

Marital Status (*circle one*): Single Married Divorced Widowed

Number of children: _____ **Race or Ethnicity**: _____

Females (*circle*): Are you Pregnant? Nursing? Planning pregnancy?

Date of Last Menstrual Period: _____

Occupation (if retired, previous occupation): _____

Smoking Have you ever smoked? (*circle*): Yes No

If Yes, what age did you start? _____ How many cigarettes per day? _____

Have you tried to quit? _____ If successful, what age did you quit? _____

Alcohol Do you drink any alcohol? (*circle*): Yes No

If Yes, how much (# of drinks per day, month, or year)? _____

If so, what type of alcohol? (*circle all that apply*): Wine Beer Liquor

Recreational Drugs Have you ever used recreational drugs? (*circle*): Yes No

If Yes, which ones & when was the last date of use? _____

MEDICAL HISTORY

Allergies (list any allergy to drug, latex and/or food): _____

Medications (list all medications- with dosages- you regularly take including over the counter, herbal & natural remedies. If you are on **insulin**, please clarify administration method- vials, pens or pump):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Conditions:
Please ***circle*** diagnosed medical conditions, write date of each diagnosis, and if applicable include further details.

Diagnosis	Date of Diagnosis	Details
Diabetes *Circle one*: Type 1 Type 2 Gestational Unknown		
Pre-Diabetes		
High Blood Pressure		
High Cholesterol		
Heart Murmur		
Heart Attack(s)		
Stroke(s)		
Thyroid Disorder *Circle*: Hyperthyroidism Hypothyroidism Thyroid nodule(s) Other		
Liver Disease *Circle:* Hepatitis Fatty Liver Other		
Kidney Issues *Circle:* Kidney Stones Chronic Kidney Disease On Dialysis Other		
Gastrointestinal Problems *Circle:* Gastroparesis Acid Reflux Diverticulitis Other		
Eye Disease *Circle:* Cataracts Glaucoma Retinopathy Other		
Reproductive Issues *Circle:* Erectile Dysfunction Prostate Enlargement Infertility Other		
Vitamin Deficiencies *Circle:* Low Vitamin D Low Vitamin B12 Low Magnesium Other		

Psychological Diagnosis *Circle:* Depression Anxiety Bipolar Disorder Other		
Anemia *Specify type if known:*		
Cancer *Specify type if known:*		
Other Conditions: _____ _____ _____		

Surgical History:
Please list prior surgeries and an accompanying date or year, if known.

_____ _____

_____ _____

_____ _____

Family History:
Please list family health information if known, with emphasis on significant, chronic conditions.

Family Member	**If deceased, age at death**	**Significant Health Issues** (especially any diabetes, heart disease, stroke, cancer)
Father		
Mother		
Brother(s)		
Sister(s)		
Grandparent(s)		

Diabetes-specific Health Information:
Free text or circle your answers as designated. For some, note that **Y** indicates "Yes" & **N** indicates "No".

1) What was your most recent HgbA1c? _____%
2) Have you been hospitalized in the last 12 months related to diabetes (*circle*)? **Y** **N**
3) Do you have any of the following diabetes-related complications? (*circle*- a, b, c)
    a. Neuropathy (nerve damage). If yes, do you clarify symptoms/diagnosis:
        i. When were you diagnosed? _____
        ii. Numbness/tingling in hands? **Y** **N**
        iii. Numbness/tingling in feet? **Y** **N**
        iv. Pain in hands? **Y** **N**
        v. Pain in feet? **Y** **N**
    b. Retinopathy (bleeding behind your eyes)
        i. When was your last eye exam? _____
        ii. Do you wear (*circle*) glasses? contacts?
        iii. Have you received any eye injections? **Y** **N** When? _____
    c. Kidney dysfunction
        i. Have you ever been referred to a kidney doctor? **Y** **N**
        ii. Are you on (*circle*) hemodialysis? peritoneal dialysis?
4) How often do you check your blood sugar? _____
    a. How often do you have blood sugars below 80 mg/dL? _____
    b. If known, what do your blood sugars range at the following times?
        i. on fasting (8 hours without eating)? _____
        ii. two hours after your largest carbohydrate meal? _____
        iii. at bedtime? _____
5) How many meals do you eat per day? _____ Do you snack at bedtime? **Y** **N**
6) Have you seen a dietician? **Y** **N**
7) Do you count carbohydrates? **Y** **N**
    a. If so, how many carbohydrates do you currently eat per day? _____grams
8) Do you exercise? **Y** **N**
    a. If so, how many minutes per week on average? _____
    b. What type (e.g. yoga, weights, running, walking)? _____

SYSTEM REVIEW

Please check current issues and symptoms, if a chronic concern or a recent significant change.

Constitutional:

- ☐ Fever
- ☐ Fatigue
- ☐ Chills
- ☐ Night sweats
- ☐ Sleep disruption
- ☐ Recent, significant weight change

Eyes and Ears:

- ☐ Wear glasses
- ☐ Wear contacts
- ☐ Blurred vision
- ☐ Double vision
- ☐ Photophobia
- ☐ Eye drainage
- ☐ Eye pain
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Ear pain
- ☐ Hearing loss

Nose:

- ☐ Allergy or sinus problems
- ☐ Nosebleeds
- ☐ Nasal congestion
- ☐ Nasal discharge

Mouth and throat:

- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Bad breath or taste
- ☐ Sore throat
- ☐ Voice change
- ☐ Current, untreated dental problems
- ☐ Trouble swallowing

Cardiovascular:

- ☐ Chest pain
- ☐ Chest pressure
- ☐ Chest tightness
- ☐ Palpitations
- ☐ Dizziness

Respiratory:

- ☐ Chronic or frequent cough
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal:

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Hemorrhoids
- ☐ Heartburn
- ☐ Change in usual bowel pattern
- ☐ Blood in stool or vomit

Genitourinary:

- ☐ Blood in urine
- ☐ Painful urination
- ☐ Straining to urinate
- ☐ Increased frequency of urination
- ☐ Nighttime urination
- ☐ Leaking urine
- ☐ Sexual dysfunction

Musculoskeletal:

- ☐ Joint pain
- ☐ Neck pain
- ☐ Back pain
- ☐ Stiff joints
- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Difficulty walking

Skin:

- ☐ Rashes
- ☐ Changes in skin color
- ☐ Change in hair or nails
- ☐ Leg swelling
- ☐ New lesion(s)

Neurological:

- ☐ Numbness
- ☐ Tingling sensation
- ☐ Complete loss of sensation
- ☐ Loss of balance
- ☐ Paralysis
- ☐ Frequent or severe headaches
- ☐ Convulsions or seizures
- ☐ Tremor

Psychosocial:

- ☐ Depression
- ☐ Memory loss
- ☐ Confusion
- ☐ Anxiety
- ☐ Suicidal thoughts

Hematologic / Lymphatic:

- ☐ Trouble healing after cuts
- ☐ Excessive bleeding
- ☐ Excessive bruising
- ☐ Swollen lymph nodes

Endocrine:

- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst

Other Comments: _____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

BHRT Checklist For Women

Name: _____ **Date:** _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue Memory				
Loss Mental				
confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

BHRT Checklist For Men

Name: _____ **Date:** _____

E-Mail: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

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PATIENT AND INSURANCE INFORMATION

Patient's Full Name: ____

SSN #:_______________________DOB:______________Age:__________Gender: ☐ M ☐ F

Status: Single Married Widow Divorced Spouse Name ______________________

Address: ____

City:_______________________State:_______________Zip: _______________

Home #:______________Work #:___________________Cell #: ______________

E-mail____

Employer:________________________Occupation: _________________________

How did you hear about us?

____

Emergency Contact:_____________________________Phone #:_________________

Primary Care Physician:__________________________Phone #: ________________

PRIMARY INSURANCE:

Insurance Company:______________Policy #:________________Group #:___________

Subscriber's Name:_______________Subscriber's SS #:________________DOB:________

Patient's Relationship to Subscriber: Self Spouse Child Other: _________________

SECONDARY INSURANCE:

Insurance Company:______________Policy #:________________Group #:___________

Subscriber's Name:_______________Subscriber's SS #:________________DOB:________

Patient's Relationship to Subscriber: Self Spouse Child Other: _________________

* *

Assignment of Benefits: It is customary to pay for all services on the date rendered unless other arrangements were made before your appointment. The patient/guarantor is responsible for deductibles, co-pays, non-covered services, other services that are not considered medically necessary, as well as any other fees in accordance with insurance contracts. I hereby assign all medical benefits to which I am entitled. I hereby authorize my insurance carrier(s), including Medicare to issue payment directly to Diabetes Relief.

I hereby acknowledge that I am fully responsible for payment as listed above.

______________________________________ ______________________

Patient or Patient's Representative Signature Date

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PATIENT INFORMATION

HIPAA – ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

Diabetes Relief is required by law to maintain privacy and provide individuals with the attached notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this notice, please ask to speak with our HIPAA Compliance Officer. If you would like a copy of the notice, one will be provided for you.

I hereby acknowledge that I have received and reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Patient or Patient's Representative Signature Date

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Relationship to Patient

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Diabetes Relief to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Health Care Operations (TPO).

I have the right and have had the opportunity to review the Notice of Privacy Practices prior to signing this consent, should I choose to revoke my authorization. Diabetes Relief has reserved the right to revise its Notice of Privacy Practices at any time. I understand that I may obtain a revised Notice of Privacy Practices by written request to Diabetes Relief. I consent to allow participation/observation of my treatment to persons who may be present for purposes of education/training concerning the treatment or who are present to advise concerning improvements to treatment or research about the treatment. I understand that Diabetes Relief will maintain a record of those present and that a copy will be made available to me upon request.

With this consent, Diabetes Relief may call or text me at my home or other alternative location and leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, or other items pertaining to my clinical care, such as laboratory test results; and that Diabetes Relief may send to my home or other alternative location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked "Personal and Confidential."

I have the right to request that Diabetes Relief restrict how it uses or discloses my PHI to carry out TPO. Diabetes Relief is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that I am signing this authorization voluntarily and that TPO for my benefits will not be affected if I do not sign it. I further understand that I have the right to receive a copy of this authorization.

By signing this form, I have read the HIPAA Disclosure and I am consenting to allow Diabetes Relief to use and disclose my PHI to carry out TPO.

_____ _____

Patient or Patient's Representative Signature Date

_____

Print Name of Patient

_____

Print Name of Patient's Representative

_____

Relationship to Patient

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CONSENT TO TREAT INCLUDING GROUP PROVISIONS

This document sets forth a brief description of the Infusion therapy that you will be receiving, and your consent to the procedures, which include being treated in a group setting unless you make other written arrangements. You may refuse treatment now, or at any time.

Metabolism Restoration:

Treatment:
The patient must follow the pre-treatment therapy guidelines. The patient's blood glucose levels are maintained slightly high during the treatment so that the liver gets the two signals needed to generate proper metabolism.

1. Patient vital signs are recorded: weight, blood pressure, heart rate, respiratory rate, temperature and capillary blood glucose. Oral glucose is given at the start of treatment. Normal saline and insulin are placed in the syringe attached to the pump.
2. An intravenous catheter is inserted in the right/left arm or hand.
3. The patient's O2/CO2 level is measured and documented on a breathing machine, which measures the amount of cellular energy and type of metabolism (fat, protein or carbohydrates). We do this two (2) times during the treatment.
4. Patient's capillary blood glucose is monitored frequently throughout the entire treatment. This measurement may be made monitored more frequently if the blood sugars are lower or higher than what is optimal for the treatment.

For the initial treatment, the patient is scheduled for 2 days, back to back or with one day between treatment days, for two consecutive weeks. Thereafter, the treatment is usually once a week for 90 days or 3 months until further treatment decisions are made, based on the patient's individualized care plan.

After Treatment:

1. After the infusion is complete, the IV site is disconnected.
2. Patient must continue to monitor his or her blood sugar carefully, particularly if they engage in any exercise or physical activity.
3. It is normal to have somewhat elevated blood glucose after the treatment. Patients are advised to engage in some form of light physical activity during the post-activation period to decrease the amount of glucose stored in the muscles. This will help in keeping blood glucose levels in a more normal range. **Patient should review any physical plans with the practitioner.**

The Patient must report any changes in his or her health or and medically related complications since the last treatment.

Exclusions:

1. Medical disorders (HTN, Dialysis, ESRD), unstable psychiatric disorders
2. Pregnant
3. Patients who do not comply with the treatment recommendations will be counseled and/or dropped from the treatment program. This includes missed appointments.

Risks, Discomforts, and Complications: Local complications of intravenous (IV) therapy rarely occur, but may present as adverse reactions or mild trauma to the surrounding venipuncture site. These complications can be recognized early by objective assessment. Proper venipuncture technique is the main factor related to the prevention of most local complications associated with IV therapy. Local complications can include bleeding, hematoma, thrombosis, phlebitis, post-infusion phlebitis, thrombophlebitis, infiltration, extravasation, local infection, venous spasm, and hypersensitivity reactions. Systemic complications may include hypoglycemia, hyperglycemia, nausea/vomiting, mild diarrhea, bloating, and muscle cramping, sometimes due to the ingestion of glucose. There is no known unusual or additional risk from the IV access other than any other IV therapy.

Benefits: The overall effect of metabolic reconditioning and recovery therapy is to treat the root cause of the metabolic disease or disorder and restore the patient's ability to lead a normal, or near normal, lifestyle by mitigating or eliminating the chronic effects of the disease. The benefits demonstrated in the ongoing research program include:

1. More controlled and stable blood glucose levels.
2. Increased energy levels and a feeling of wellbeing.
3. The reduction of complications related to diabetes and other metabolic failures.

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4. There is no absolute certainty you will react as other patients, or that you will receive the benefits suggested by clinic studies or prior patient outcomes. However, these outcomes are anticipated and normal with the great majority of other patients.

Right to refuse or withdraw: Your treatment is voluntary and you may refuse any or all treatment, and you may discontinue treatment at any time.

Anonymous and Confidential Data Collection: Any information that specifically identifies you will be kept in a secure location and only the healthcare professionals and their authorized staff will have access to the data, or as otherwise agreed by you.

Group Setting and Group Interface, including Visitors: The treatment is usually provided in the presence of other patients, and perhaps their families, friends, and visitors. This implies that you will learn about other people in this setting, and they may hear or see something about you. The fact that you are being treated suggests that you have diabetes or a related disease, and other facts of your medical, mental, and emotional condition may be disclosed, and those are confidential facts disclosed in a group setting. By group treatment, there are many other things that occur that normally would be private, such as psychological help, prayer, or other non-physical aspects of life. You hereby agree that privacy of treatment cannot be maintained in this setting. You may ask to talk in a private room at any time about these issues. However, Diabetes Relief personnel are not able to control what is said or seen by others, and it is not unusual for information of the most personal type to come out. Information about religious, political, sexual, or socioeconomic views will routinely be discussed in an open forum and if you are not able to be treated in this open forum manner, then private treatment arrangements must be made at a cost that is usually not paid for by insurance. Diabetes Relief personnel will attempt to keep loud, obtrusive and offensive conduct to a minimum. If you want special private treatment settings, you must inform the Diabetes Relief representative at the first possible time.

Group Instruction: Some of the instructions to you will include information that is usually confidential, and you agree to be instructed in public, with the further agreement that your personal interviews, as well as any of your requests, will be conducted in a private room.

Photographs, images of injured tissue, and graphic depictions: In order to follow the treatment outcomes, photographs, images, and other recorded means may be used to exhibit progress. This information is used for both your treatment and to substantiate the results and outcomes, and can be shared with others not using your name.

Whom to contact with questions: If you have any questions about your treatment, please contact the Clinic Manager.

Acceptance & signature: I have read the information provided above, have been asked for any questions, and all my questions have been answered to my satisfaction. I can continue to ask questions at any time I request treatment and will reserve a copy of this consent form for my information.

_____ _____

Patient's or Patient's Representative's Signature Date

_____

Print Name of Patient and Representative

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ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Diabetes Relief for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Diabetes Relief to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Diabetes Relief on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient / Responsible Party Signature Date

_____ _____

Witness Date

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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.

This serves as our Health Information Portability and Accountability Act (HIPAA) notice. It took effect on January 20, 2015, and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY
Law Requires Us to:
1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:
1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:
1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION
The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. *We will not disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.*

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.
FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.
FOR DATA BREACH NOTIFICATION PURPOSES: We may use your medical information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information due to a breach.
FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to service you.
ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information to you.
Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in a disaster relief efforts.
Research in Limited Circumstances: We may use your medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information or where we are improving our services.
Funeral Director Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.
Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.
Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.
Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.
Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment emails, phone calls, texts, postcards, or otherwise reminding you of your appointments.
Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you $5 plus postage if you want the copies mailed to you. Additionally, if we maintain an electronic health record contacting your health information, you have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency)
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.
7. You have the right to restrict information given to your third party payer (e.g. health insurance plan) if you full paid for your health care services out of your own pocket. If you paid in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third party payer since no claim is being made against the first party payer.
8. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health in formation. Notice of any such breach will be made in accordance with federal regulations.

QUESTIONS AND COMPLAINTS:

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Sections 4 of this notice by writing to the following address:

Diabetes Relief℠
Get your life back℠

DIABETES RELIEF *OFFICE* POLICIES

We would like to thank you for choosing Diabetes Relief. We have written this policy to keep you informed of our current office and financial policies.

Appointments: We see patients by appointment only. For same day appointments, please call our main office number and we will do our best to accommodate you.

After Hours and Emergencies: If you have an emergency call 911 immediately.

Cancellations: Please call within 24 hours if you are unable to keep your scheduled appointment. This allows us to provide that time slot to another patient. ***If a patient fails to keep an appointment and does not call within 24 hours to cancel, a $50 fee will be charged. If a patient fails to keep a consultation appointment and does not call within 24 hours to cancel, a $25 fee will be charged.***

Late Arrival: Late arrival of 30-minutes or more could necessitate rescheduling your appointment.

Leaving the Facility: Under no circumstance is a patient permitted to leave the building during their treatment session. IV insulin cannot be administered except in the presence of trained personnel. There is a significant risk that anyone leaving the building during treatment could become hypoglycemic or hyperglycemic which would require immediate medical attention. If you leave the building, that medical attention is now unavailable, which is a very real danger, including the risk of death. We will not be held liable for any medical emergency or occurrence of any kind or nature resulting from your leaving the building.

Treatment of Minors: Patients under the age of 18 must be accompanied by a responsible adult or have written permission, for treatment, from a parent or guardian.

Blood Work: Patients are required to have routine labs drawn **every 3 months**, which must include but not limited to CBC, CMP, C-peptide, and Hemoglobin A1c. We will not treat you if we do not have updated labs on file. As a patient, it is your responsibility to ensure that we receive your test results. If your physician will not fax test results, you will need to pick-up a ***copy of your test results from the physician's office and hand deliver them to our clinic.***

History & Physical: Patients are required to have a current History & Physical (H&P), within 1-year. If you do not have a current H&P, one will be done at your consult. If you do not have a primary care physician, please inform our Nurse Practitioner and we will advise you accordingly.

Speaking with a "Nurse": To speak with a nurse please call the main number and you will be transferred to the appropriate medical professional. Often at the time you call, the nurse may be in session and assisting other patients, in this instance please leave a detailed message with the receptionist-including your full name and a call back number. The nurse will call you back – usually within the same day.

Prescriptions and Refills: We are not your primary care physician and under no circumstances will we fill any requests for prescriptions or refills. If you are participating in the BioTe program, those medications may be refilled at the discretion of the provider.

Diabetes Relief℠
Get your life back℠

DIABETES RELIEF *FINANCIAL* POLICIES

No Insurance: Payment will be due at the time of service.

Insurance: With some insurance companies, we are considered an Out-of-Network provider. This treatment is covered by Medicare Insurance. In addition, most private insurance carriers are providing coverage. Our goal is to help as many patients as possible to improve their health, and we have developed several programs to do so. Patients who are not covered by insurance are either using medical credit cards or making cash payments until they obtain insurance. We are willing to work on a patient-by-patient basis. As a courtesy to our patients, we will verify your insurance benefits for you. In order to do this, we will require information from you. We will need all your demographic and insurance information prior to your appointment. We ask that at the time of your appointment you bring your insurance card and a photo ID as well as any other forms that will assist in making sure that your claim is filed correctly. ***If there are any changes in your insurance, please notify our receptionist before your next treatment.***

At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our clinic, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact.

You may receive a statement from our office for any balance due. For your convenience we accept cash, checks, credit cards (Visa, MasterCard, American Express and Discover), and money orders. Payments are also accepted by phone.

Returned Checks: There will be a $25 charge assessed for any check returned by your bank for any reason.

Medical Records: We will provide you a copy of your medical records upon request for a fee of $5. You will need to sign a letter of release prior to having them copied. Please allow up to 3 days for this request to be processed. Should you need to request medical records from your physician, ***we will provide you with a letter of release to complete and send to the physician's office for no fee.***

Billing: If you receive a bill from Diabetes Relief, it is because we believe the balance on your account is your responsibility. Please contact your insurance company first, if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.

Acknowledgement

I acknowledge that I have received and read a copy of the **Diabetes Relief Office and Financial Policies.**

Patient or Patient's Representative Signature _____ Date _____

Diabetes Relief℠
Get your life back℠

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO DIABETES RELIEF

By signing this form, I authorize the physician/person/facility/entity listed below to release my confidential health information to Diabetes Relief.

Patient's Name: _____ **DOB:** _____

Maiden Name: _____ **SSN:** _____ **Gender: M ❑ F❑**

Release my protected health information from the following physician/person/facility/entity:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

The information you may release subject to this signed release form is as follows:

❑ History & Physical (within 1 year) Year Date_____
❑ Lab Reports (minimum to include CBC, CMP, C-peptide, U/A, Micro Albumin and Hgb A1c)
❑ Medication Record
❑ Medical Release from Physician/Doctor
❑ Other: _____

Information pertaining to the following will not be released unless specifically authorized by marking the relevant box(es):

❑ Drug and alcohol abuse, diagnosis or treatment ❑ HIV/AIDS test results, diagnosis or treatment
❑ Mental health diagnosis or treatment ❑ Genetic testing

Expiration of Authorization: Unless otherwise revoked, this authorization expires on _____. If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

_____ _____
Patient or Patient's Representative Signature Date

_____
Print Name of Patient and Representative

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Get your life back℠

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM DIABETES RELIEF

By signing this form, I authorize Diabetes Relief to release my confidential health information to the physician/person/facility/entity I direct.

Patient's Name: _____ **DOB:** _____

Maiden Name: _____ **SSN:** _____ **Gender: M ❑ F❑**

Please specify the health information you authorize to be released:

Type(s) of health information: _____

Date(s) of treatment: _____

Expiration of Authorization: Unless otherwise revoked, this authorization expires on _____. If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

_____ _____
Patient or Patient's Representative Signature Date

_____
Print Name of Patient