PATIENT INFORMATION

HIPAA – ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________ **Date of Birth:** ______________

Diabetic Health and Wellness are 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 Office Manager. 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.

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Patient or Patient's Representative's Signature

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Date

____
Print Name of Patient

____
Print Name of Patient's Representative

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Relationship to Patient

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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 about 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 can 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, Diabetic Health and Wellness 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. Diabetic Health and Wellness personnel will attempt to keep loud, obtrusive, and offensive conduct to a minimum. If you want special private treatment settings, you must inform the Diabetic Health and Wellness 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 and signature: I have read the information provided above, have been asked if I have any questions, and all of 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 or Patient's Representative's Signature **Date**

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Print Name of Patient and Representative

PATIENT INFORMATION

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

1. The Practice's Privacy Notice is available to me prior to my signing this Consent. The Privacy notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with applicable law.

3. I consent to the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my voicemail or with the individual answering the phone; and/or c) text.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that any insurance I may have is an agreement between the carrier and I and that I am responsible for the payment of any covered or non-covered services I receive. Assignment of Benefits. I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the supplier of services performed at Diabetic Health and Wellness.

6. It is the practice of this office to provide medical care in an "enclosed infusion environment." "Enclosed infusion" involves several patients being seen and monitored in the same room at the same time. Patients are within sight of one another, and ongoing routine details of care and treatment are discussed within earshot of other patients and staff.

We are requesting this authorization of you due to various interpretations under Federal Law with respect to what is known as an "Incidental Disclosure" of health information. It is our view that the kinds of matter related to an enclosed infusion environment are incidental matters. In the event you or someone else would not agree, we are providing this disclosure. The use of this format is intended to make your experience with our office more efficient and productive, as well as enhance your access to quality health care and health information.

7. It is the practice of this office to take photograph(s) to use for patient files, posture programs, and other assessment devices. These photographs may be used for display purposes in the office and may be sent to insurance companies as part of your medical records. It is your choice as the patient to inform Diabetic Health and Wellness if they do not want these photos included as part of your medical record.

8. It is the practice of this office to take video recordings. These video recordings may be used for display purposes in the office or be released to the public, or may be sent to a practice management company (business associate) for training purposes. It is up to the patient to inform Diabetic Health and Wellness if they do not want to participate in these video recordings.

9. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

10. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is legally binding on the Practice.

11. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

12. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

13. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

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