DGDClinic
Diabetes & Glandular Disease Clinic, P.A.
LEADING THE SEARCH FOR BETTER HEALTH

Dear New Patient,

The Providers and staff would like to welcome and thank you for choosing and trusting Diabetes & Glandular Disease Clinic, P.A. with your health care needs. Our goal is to make your visits as pleasant and informative as possible.

We understand the sensitive nature of your visit and respect your privacy. For these reasons, we are asking you to **complete** the enclosed new patient packet and mail or fax them to us prior to your first visit. Our direct confidential fax number is (210) 615-1083. If you are unable to complete the new patient packet prior to your visit, please bring it in completed at the time of your first visit. New patients are encouraged to register online at www.dgdclinic.com in order to have access to our patient portal where you can conveniently fill out the new patient packet at home instead of mailing, faxing or bringing it with you to your first appointment. As an established patient you will be able to access information in reference to future appointments, lab results, prescriptions and account billing summaries through our patient portal.

If you were previously treated at another clinic or facility for the same care you will be receiving from our clinic, it is important to provide us with your records before your initial appointment. Since this can take up to four weeks, realize that not every patient will have their medical records available by the first visit. However, the quality of one's visit is enhanced when we have the ability to review your health records prior to your visit, especially when a patient has a medical history of diabetes/glandular disease.

Please plan for your first appointment to be at least 45 minutes to an hour long. As a new patient, dependent on diagnosis and/or recommended treatment by your provider at the time of your first visit, you may be encouraged to attend a group class given by our Educators on staff. If applicable, the group class will be scheduled during your check out.

Insurance and required demographic information to verify insurance is taken by our staff before your appointment is scheduled, Insurance information is verified within 2 days of your appointment. If insurance and required demographic information is not obtained, the appointment will not be confirmed and may be rescheduled.

As a part of the patient information packet please know that payments all applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your visit. We accept cash, checks, Visa, MasterCard, and American Express. If patients are not able to pay their co-pay and/ or deductibles at the time of their appt., the patient's appointment will be rescheduled for a date when the patient is able to pay the co-pay and/ or deductible. Cancellations and Appointment Time is included in the packet.

We encourage you to visit our website at www.dgdclinic.com for information about our providers and the services we provide.

Thank you for choosing and trusting our providers and staff with your health care and we look forward to your first visit.

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__Please note: A driver's license from at least one parent will be required for the first visit__

Child's First _____ **Middle** _____ **Last** _____

Sex □ Male □ Female **Date of Birth:** _____ **Nickname** _____

Address of Child's Primary Residence: _____

City _____ ST _____ Zip _____

Referring physician or PCP _____

Telephones Numbers

- Primary phone (#1) is the one to be used first for messages and reminder calls. This does not have to be the home phone.
- Please list phone numbers in the order to be called.

1.( )_____ □Home □Cell □Work □Other/Ext:_____ □ Mother □ Father Other: Name:_____ Rel:_____

2.( )_____ □Home □Cell □Work □Other/Ext:_____ □ Mother □ Father Other: Name:_____ Rel:_____

3.( )_____ □Home □Cell □Work □Other/Ext:_____ □ Mother □ Father Other: Name:_____ Rel:_____

By providing us with your wireless or land line phone numbers, you are giving us your prior express consent to call those numbers for business purposes

Parent/Guardian Information

Mother's Full Name _____ **Date of Birth** _____/_____/_____

Social Security # _____-_____-_____ **Relationship:** □**Mother** □**Foster** □**Legal Guardian** □**Step** □**Other**

Marital Status □ Married □ Divorced □ Separated □ Single □ Remarried □ Widowed

Address: □ Same as child _____ City _____ ST _____ Zip _____

Employer _____ Phone ( )_____ ext:_____

Occupation: _____ Email: _____@_____

Father's Full Name _____ **Date of Birth** _____/_____/_____

Social Security # _____-_____-_____ **Relationship:** □**Mother** □**Foster** □**Legal Guardian** □**Step** □**Other**

Marital Status □ Married □ Divorced □ Separated □ Single □ Remarried □ Widowed

Address: □ Same as child _____ City _____ ST _____ Zip _____

Employer _____ Phone ( )_____ ext:_____

Occupation: _____ Email: _____@_____

Step parents' name(s), if applicable:_____

Custodial Parent, if applicable: _____

Emergency/Alternate Contacts

Full Name _____ **Address/City/Zip** _____

Relationship _____ **Ph# (** **)** _____ or _____

Financial Responsibility

Invoices/Statements should be mailed to □ Mother □ Father □ Other_____(must be listed above)

(Both parents or legal guardians are responsible for any charges regardless of where the statements are mailed)

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Insurance Information

Child's Name: First _____ **Last** _____ **Date of Birth** _____

Primary Insurance _____

Cardholder's Full Name: First _____ **Last** _____
Social Security ___-___-___ **Date of Birth** _____ **Relationship To Child** _____
Address (if different than child's) _____
City _____ **State** _____ **Zip** _____
Phone ( ) _____ **Work** _____
Employer _____ **Business Phone** _____
Employers Address _____ **City/State** _____ **Zip** _____
Insurance Company _____ **ID#** _____ **Group#** _____
Effective Date of Insurance _____

Secondary Insurance _____

Cardholder's Full Name: First _____ **Last** _____
Social Security ___-___-___ **Date of Birth** _____ **Relationship To Child** _____
Address (if different than child's) _____
City _____ **State** _____ **Zip** _____
Phone ( ) _____ **Work** _____
Employer _____ **Business Phone** _____
Employers Address _____ **City/State** _____ **Zip** _____
Insurance Company _____ **ID#** _____ **Group#** _____
Effective Date of Insurance _____

PAYMENTS AND INSURANCE AUTHORIZATION / ASSIGNMENT OF BENEFITS

It is the policy of this office that all payments for medical services be made at the time *of your visit, or before in some cases.* This payment is required regardless of who brings the child in to be seen. In the case of separated or divorced parents, responsibility and payment shall belong to the guardian bringing the child in for treatment. For example, if parent #1 is financially responsible for medical expenses, and parent #2 is bringing that child in for treatment, payment will still be expected from parent #2 at the time of service.

Initial_____I understand and agree that regardless of what benefits are quoted, or misquoted, by my insurance company when you check my insurance status, I am ultimately responsible for any deductible, co-insurance/co-pays, or any other balance not paid by my insurance company. This includes services provided that the insurance company deems not medically necessary.

Initial_____I understand that I must pay my co-pay or my co-insurance at the time of service, regardless of who accompanies my child to his/her visit. Without my co-pay or co-insurance, I may be charged a late fee.

Initial_____I understand that I must pay my deductible responsibility, if I have one, at the time of service. If I cannot pay the entire deductible balance, a $50 deductible deposit will be required at each visit until my deductible has been met. If I request to be billed for a deductible balance, I must pay within 30 days, or I will lose the privilege of being billed. I will then be required to pay in full at each visit.

Initial_____I must have proof of insurance at every visitor I will have to pay in full to be seen.

Initial_____I understand that I am responsible for any costs incurred in the collection of my child's account in case of default, including reasonable attorney fees, court fees and agency fees.

Initial_____I understand that bad checks are sent to Check Services, USA for which there will be a $30 charge from our office. Failure to pay the check and all fees could result in arrest and criminal prosecution.

Initial_____I understand that cancellations are required 24 hours prior to the appointment. In the event that I fail to cancel a scheduled appointment, I will be billed $40.00. Excessive abuse of cancellations of scheduled appointments may result in discharge from the practice. Payment is due upon receipt of a statement from our office.

I hereby grant permission to Diabetes & Glandular Disease Clinic to release any pertinent information to my insurance company upon request, and I also authorize transfer of benefits to Diabetes & Glandular Disease Clinic. A photocopy of this authorizations shall be considered as valid as the original.

Signature _____ **Print Name** _____ **Date** _____

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HIPAA Acknowledgment Form
PATIENT ACKNOWLEDGEMENT

Health Insurance Portability and Accountability Act (HIPPA)

Our clinic's Notice of Privacy Practice provides information about how we may use and disclose protected health information about you, the patient. The Notice contains a Patient Rights sections describing your rights under the law. You have the right to review our Notice before signing this acknowledgment. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office.

The Summary of our Notice of Practices is posted in our main lobby. The complete Notice of Privacy Practices is also available in our main lobby for your review. If you would like to receive a copy of the Summary and complete Notice, we have one available for you at the front desk.

If you wish for persons other than those released under normal operations, as indicated in the Notice, to receive confidential information that is now protected under this law, you must release them in writing. Please indicate on your patient registration form a spouse, or any family or friends whom you wish to be able to receive information about you. You may, of course, choose not to release anyone. You may also be more specific in your restrictions for the persons you have released, provided that the request is made in writing. Parents or Guardians of minors do not need to be released.

Please be aware that our staff must follow federal law on information that we release by phone. We may at any time choose not to release information of any kind by phone if we deem the person requesting information is not authorized or that the information is too sensitive.

By signing this form, you are acknowledging that the Diabetes & Glandular Disease Clinic has made our Notice of Privacy Practices available to you for review and that we have offered you a personal copy.

Patient Name: _____ Date of Birth: _____

Signature: _____ Acct.# _____

This acknowledgment was signed by:

_____ Date: _____
Printed Name (Patient or Representative)

Relationship to Patient
(if other than patient):_____

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AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Name of Patient/ Minor(s) MRN	DOB	Allergies/Special Conditions

I hereby authorize the treatment of the above minor(s).

I give the following people permission to bring my child to his/her appointment if I cannot make it:

Name	Address	Phone #
Name	Address	Phone #
Name	Address	Phone #

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence. i understand the listed person(s) above are the only authorized person(s) on file.

Patients under the age of 18 unaccompanied by parent(s) or legal guardian(s) or written authorization will not be seen.

This document shall be presented to a physician, dentist or appropriate hospital representative at such as unexpected medical, dental surgical care or hospitalization may be required.

Signature of Parent/Guardian	**Date**
Signature of Parent/Guardian	**Date**
Signature of Parent/Guardian	**Date**

Medical/Hospitalization Coverage for above Named Minor(s)

Insurance Company or Government Program ID or Contact #:

Primary Physician Name:	Phone:

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Patient Information

Welcome to the Diabetes & Glandular Disease Clinic. We appreciate the opportunity to work with you. The following information is provided for your benefit so that we may serve you better. Please read carefully and sign at the bottom. You will be given a copy for your records.

1. **PAYMENTS**: All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your visit. We accept cash, checks, Visa, MasterCard, and American Express.
2. **CANCELLATIONS**: If you need to cancel your appointment, be sure to call us at least 24 hours before your scheduled appointment. There will be a $40.00 administrative charge to all patients who miss their appointment and do not call to cancel or reschedule their appointment at least 24hours in advanced. This charge is not payable by any insurance company and I understand that this will be my responsibility.
3. **APPOINTMENT TIME**: We ask that our patients arrive on-time for their appointments; this will facilitate our ability to see you as scheduled. In an effort to serve all our patients well, patients arriving past their appointment time may be rescheduled.
4. **HMO & PPO REFERRALS**: If your policy requires written authorization from your Primary Care Physician, we will request authorization in advance **for established patient only.** This is done as a courtesy for our patients; however, we cannot guarantee authorization will be granted. Please keep in contact with your physician to ensure your visit is pre-approved, to avoid having to make payment in full.
5. **CHANGE OF INFORMATION**: Please provide us with any change regarding your address, phone number or insurance information as soon as possible. Chance of insurance will require the completion of a New Patient Information Form and may not be changed over the telephone.
6. **MEDICATION REFILL REQUESTS**: Please contact your pharmacy first. They will call our office for authorization of the refill.
7. **AFTER HOURS CARE** ***In a life threatening emergency, please call 911.*** For urgent non- emergency matters, please dial the main office number (210) 614-8612 and leave a message with the answering service. The physician-on-call will return your phone call as soon as possible.
8. **MEDICAL RECORD/ LAB RESULTS COPY REQUEST** Requests for copies of your medical records must be made in writing on a form provided by our office. Our office will respond within 15 business days to properly completed written request.
   FEES: As per the rules adopted by the Texas State Board of Medical Examiners, our office will charge the following for copying your medical records:
   8.1. $25.00 for the first 20 pages, $.50 cents for each page thereafter, and the actual cost of mailing, shipping or delivery, if applicable.
   8.2. Lab Results are available at no cost on DGD Clinic Patient's Portal. All Lab Result paper request will incur a $6.00 processing fee per visit.
   8.3. Copies of medical records/ lab results will be retained until payment is received, unless requested by a licensed Texas health care provider or any American or Canadian licensed physician for acute or emergency medical care, or to support an application for disability or other benefits or assistance under Aide to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, Federal Old- Age and Survivor Insurance, or the Veterans Administration.
9. **COLLECTION AGENCY:** In the event of a delinquent account balance, I will be responsible for all collection fees assessed by the collection agency onto the account.

"I, the Guarantor of Payment and Responsible Party, have read and agree to the above policies and terms regarding payment and payment responsibilities.

Printed Name Signature Date

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Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/ medical plan, to issue payment check (s) directly to Diabetes and Glandular Diseases Clinic, P.A., 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 the insurance.

Authorization to Release Information

I hereby authorize Diabetes and Glandular Disease Clinic, P.A. to: (1) release any information necessary to insurance carrier(s) regarding my or my child's 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 and Glandular Disease Clinic, P.A. 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 have read and understand the Diabetes and Glandular Disease Clinic, P.A. Financial Policy. 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 presentations of the appropriate statement. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the charge by the collection agency for costs of collections. A photocopy of this assignment is to be considered as valid as the original. I also understand and agree that the practice may amend such terms from time to time.

_____

Print Name of the Patient

_____

Signature of Insured or Authorized Representative Date

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Patient's Name: _____ **Age** _____
Account No. _____ **DOB:** _____
Emergency Contact Name & Telephone: _____

Child's Health History

(PLEASE PRINT)

Chief Complaint/ Reason for visit: _____

_____

_____

_____

Past Medical History:

(Please list all medical problems and approximate dates of onset)

_____

_____

_____

_____

Previous Hospitalizations, date and reason:

_____ _____

_____ _____

_____ _____

Birthing History

Pregnancy: _____ **Delivery mode:** **Vaginal** _____ **Cesarean** _____
Birth Weight: _____ **Birth Length:** _____
Breast or Bottle Fed: _____ **Vaccinations:** _____

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Patient 's Name: _____

Medications

Name	**Dosage**	**Date Started**

Allergies:

Drug: _____

Food: _____

Social History

Pre-school, kindergarten or school _____ **Grade** _____

Other activities and sports: _____

Smokers in household (please circle one) **Yes** **No**

Family History

Father: **Age:** _____ **Height:** _____ **Health Condition:** _____

Pubertal development: **(Early, average, or late)** _____

Mother: **Age:** _____ **Height:** _____ **Health Condition:** _____

Age at first menstrual period _____

Health condition of siblings and other family members: _____

_____

_____

_____

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Patient's Name: _____

Review of Body Systems

(Please Print)

Please list any problems relating to the following:

Growth and weight gain, appetite: _____

Energy level, heat/cold tolerance: _____

Skin: _____

Ears, nose and throat: _____

Growth and weight gain, appetite: _____

Vision: _____

Neck: _____

Chest, lung, and heart: _____

Abdomen: _____

Nervous system (headache, balance, gait): _____

Urinary and bowel: _____

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Patient's Name: _____

Menstrual Periods:

Age at onset: _____ **Frequency** _____ **Length** _____
Date of last period: _____
Sexually active: **(please circle one)** **Yes** **No**

Behavioral: _____