NEW PATIENT QUESTIONNAIRE

Please fill out this form as thoroughly as possible, printing all responses clearly. All information is completely confidential and will not be released unless you authorize us to do so.

66 Gruene Park Drive Unit 210
New Braunfels, TX 78130
Phone: (830) 730-4375
Fax: (830) 730-4203

PERSONAL INFORMATION **Please provide a form of identification (Driver's License)				
Last Name	First	Sex M F Middle	Prefix	Birthdate
Mailing Address	City	State	Zip Social Security Number	
Home/Mobile Phone	Email Address			
Emergency Contact	Relationship	Home/Mobile Phone	Work Phone	
Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed		Number of Children:	Occupation:	

INSURANCE INFORMATION IF DIFFERENT FROM ABOVE **Please provide a copy of the Insurance Card(s)		
Name of Person Responsible for Insurance Account:		Relation to Patient:
Birthdate:	Soc. Sec. Number:	Insurance Company(ies)

MEDICAL HISTORY ***Check conditions you have or have had in the past***			
□ Adrenal insufficiency	□ Hyperthyroidism	□ Diabetes: Type _____ Duration _______	□ Osteoporosis
□ Adrenal tumor	□ Diabetes eye problems	□ Hypopituitarism	□ Pituitary tumor
□ Anemia or blood problems	□ Foot ulcer	□ Hypothyroidism	□ Polycystic ovaries
□ Arthritis	□ Heart disease/attack	□ Inherited disease: ___________________	□ Pre -Diabetes
□ Asthma	□ High blood pressure	□ Kidney disease/stones	□ Sleep apnea
□ Bone fracture(s)	□ High cholesterol	□ Mental illness	□ Stroke
□ Metabolic Syndrome	□ HIV/AIDS	□ Cancer/Tumor: _____________________	□ Thyroid nodule(s)
□ Morbid Obesity	□ Hypercalcemia	□ COPD, emphysema, lung disease	□ Thyroid cancer

REVIEW OF SYSTEMS ***Select condition(s) you are currently experiencing***							
Weight loss	Weight gain	Easy bruising	Fatigue	Acne	Tremor	Sleep disorder	Fevers or Chills

Patient Name____ Date of Birth____________ Today's Date____________

Excessive thirst	Headaches	Chest pain	Dizziness	Muscle pain	Hoarseness	Constipation	Diarrhea
Night sweats or Flushing	Palpitations (heart racing)	Blurred or double vision	Breast tenderness	Milk discharge from breasts	Muscle weakness	Nausea and vomiting	Shortness of breath or cough
Excessive hair growth	Hair loss	Irregular periods	Sexual issues (loss of interest or erections)	Numbness or tingling	Depression or Anxiety	Difficulty with urination	Difficulty swallowing

For Women: Age at first period:_____ Date of last period: _______________ Birth control method: __________________
Pregnancies: Live Births: ___ Miscarriages: ___ Abortions:___ Are you planning to have more pregnancies? □ Yes □ No

Primary Care Physician:	**Other Physicians:**

Reason for Visit:

ALLERGIES	
No Known Allergies	Yes, I have the following medication allergies and the following reaction.

HOSPITALIZATIONS & SURGERIES		
YEAR	LOCATION	REASON FOR HOSPITALIZATION / DESCRIBE SURGERIES

MEDICATIONS ***List all medications, vitamins, and supplements. Write dosage and frequency for each medication. *Please attach additional sheets if necessary.***

Are you testing your blood sugar? Y/N If so, how many times a day? _________________________________
What are your blood sugar results?
AM Fasting: ____ 2 HRS after breakfast: ____ Before lunch: ____ 2 hours after lunch: _____ Before dinner: _____ Before bed: _____
Are you using a continuous glucose monitor or insulin pump? Y/N If so, which one? _______________________

Preferred Pharmacy & Address:	Phone:
Secondary Pharmacy & Address:	Phone:

Patient Name____ Date of Birth____________ Today's Date____________

Health Maintenance History ***Record last date and result***	
Mammogram:	Eye exam:
Bone Density Testing:	Pneumovax23: Prevnar13:
Pap Smear or Prostate Exam:	Influenza Vaccine:
Foot Exam:	Dental Exam:
Last Diabetes Education:	

Family Medical History ***Check appropriate medical conditions***	
Father Alive: Y/N	□ Diabetes □ Low thyroid □ High thyroid □ High blood pressure □ High cholesterol □ Adrenal gland □ Calcium issue □ Pituitary □ Heart disease (age<45 for males and <55 for females) □ Thyroid cancer □ Kidney stones □ Osteoporosis
Mother Alive: Y/N	□ Diabetes □ Low thyroid □ High thyroid □ High blood pressure □ High cholesterol □ Adrenal gland □ Calcium issue □ Pituitary □ Heart disease (age<45 for males and <55 for females) □ Thyroid cancer □ Kidney stones □ Osteoporosis
Brother Alive: Y/N	□ Diabetes □ Low thyroid □ High thyroid □ High blood pressure □ High cholesterol □ Adrenal gland □ Calcium issue □ Pituitary □ Heart disease (age<45 for males and <55 for females) □ Thyroid cancer □ Kidney stones □ Osteoporosis
Sister Alive: Y/N	□ Diabetes □ Low thyroid □ High thyroid □ High blood pressure □ High cholesterol □ Adrenal gland □ Calcium issue □ Pituitary □ Heart disease (age<45 for males and <55 for females) □ Thyroid cancer □ Kidney stones □ Osteoporosis
Other	□ Diabetes □ Low thyroid □ High thyroid □ High blood pressure □ High cholesterol □ Adrenal gland □ Calcium issue □ Pituitary □ Heart disease (age<45 for males and <55 for females) □ Thyroid cancer □ Kidney stones □ Osteoporosis

Health Habits ***Mark (X) conditions you use and how much/how many hours***		
Tobacco use:	Alcohol use:	Diet:
Illegal drug use:	Exercise:	Sleep:
Caffeine intake:	Level of Stress:	Hobbies:

**** Please review our Clinical Policies and Agreements****

Your signature below signifies that you have read and acknowledge the policies regarding:

1) Consent for Treatment
2) Financial Responsibility
3) Release of Information
4) Benefit Assignment
5) About Physician Assistants
6) Acknowledgement
7) Notice of Privacy Practices

Patient Name____ Date of Birth____________ Today's Date____________

I attest that the above information is correct to the best of my knowledge.

I also certify that I, and/or my dependent(s), have insurance coverage with the insurance(s) provided and assign all insurance benefits, if any, directly to the Diabetes Metabolic Wellness Center. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The clinicians assigned to the Diabetes Metabolic Wellness Center may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below:

____ ___________________________

Signature of Patient, Parent, Guardian, or Personal Representative Date

____

Printed name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Consent for Release of Protected Health Information (PHI)

This form is used to authorize consent for this clinician and its affiliates to communicate PHI to the person(s) or organization listed below as directed by the patient.

Patient Name: ________________________ Date of Birth: _________

Patient Address: ____

Patient Email address: _______________________________________

Home Phone: _______________________ Cell Phone: __________________

1) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name:____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

2) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name:____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

3) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name:____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

I understand that this consent will allow this healthcare clinician and its affiliates to use or disclose the protected health information described below. (Please check only one box).

□ Full Disclosure: Any protected health information this provider and its affiliates collect and maintain, including mental health, HIV, sexually transmitted diseases, health status, alcohol and substance abuse treatment records, and genetic testing. This also includes information on health treatment programs, plan information and caregiver resources with the person being authorized.

□ Limited Disclosure: **Identify what protected health Information is to be <u>excluded</u> from any disclosure**. Such as a medical condition or treatment information or a specific date range of services:

____

I understand:

- **This consent will expire in 24 months from the date of signature, unless I cancel it before that time. I can cancel this consent at any time by sending a written request to my provider.**
- **If I cancel the consent, it will not apply to information previously released with this consent. Once information is shared, this provider cannot prevent the person or organization that has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.**
- **I understand I am not required to sign this consent and that this provider and its affiliates cannot base treatment or payment decisions based on my decision to sign this consent form.**
- **Protected Health Information includes Medical, Dental, Pharmacy, Behavioral Health, Vision, and Long-Term Care.**

Individual or Legal Representative Signature ________________________ Date: ____________

□ Individual □ Legal Representative (attach copy of authorization, ie MPOA, guardianship)

Nutrition Consultation Questionnaire

Welcome! We are so excited you've made the decision to improve your wellbeing and quality of life through nutrition therapy. We find it very helpful to learn a little bit about you prior to our first session. This helps us to better understand your needs, preferences, and goals in order to offer realistic and personalized care for your health concerns.

If you become overwhelmed, find any of the questions challenging, or don't feel comfortable answering, please leave them blank. Only complete the sections which feel appropriate to you to complete.

Name: ________________________________ Date of Birth: _________ Age: ________

Purpose of our Consult- Tell me about why we are meeting. What do you feel is the primary purpose?

Have you ever worked with a dietitian/nutritionist? Yes or No

Digestive Health

Have you ever received a gastrointestinal (GI) diagnoses? If yes, please describe

Do you have any food allergies or intolerances? Yes or No

Relevant Family History- Share with me any family dynamics you feel are important for me to know/understand.

Food & Nutrition

Tell me about your dieting and/or your eating disorder history

Eating Patterns

How many meals a day do you eat?

Do you skip meals?

If yes, which ones do you skip and why?

Who does the grocery shopping and food preparation?

Please list the usual time and typical daily intake for each meal:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Do you have any cultural or religious food preferences or practices? If yes, please describe:

Exercise and Activity

Have you ever had a consistent exercise routine?

If yes, tell me about your past exercise habits/relationship to exercise:

Tell me about your current exercise habits/relationship to exercise:

Working together

What do you hope to accomplish through our visits together?

Please feel free to share any additional information here.

Authorization to Disclose (Release) Health Care Information

1. Patient Information:
PRINT Patient Name: ____
Birth Date ____
Address: ____
City, State, Zip Code: ____
Telephone Number: ____

2. INFORMATION TO BE RELEASED TO: [ ] Check if the same as 1 above
Organization: **Diabetes & Metabolic Wellness Center**
Address: **66 Gruene Park Drive Unit 210**
City, State, Zip: **New Braunfels, TX 78130**_
Phone: **(830) 730-4375** Fax: **(830) 730-4203**

3. INFORMATION TO BE RELEASED FROM:
Organization, physician, or provider: _______________________________
Address: ____
City, State, Zip: ____
Phone: ________________________ Fax: __________________________

4. PURPOSE OF RELEASE
[ ]Transfer of Care [ ]Legal [ ]Insurance [ ]Specialist [ ]Personal copy [ ]Other ___________

5. WHAT KIND OF INFORMATION DO YOU WANT RELEASED:
[ ] Copies of Records
[ ] Medical Records from ___/ ___ /___ to date: ___/___ /___
[ ] Specific Information (please specify): ____________________________
[ ] Billing Records (please specify): _______________________________
[ ] Diagnostic Reports (please specify): ____________________________

PATIENT AUTHORIZATION: I understand that:
a. Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness and for patients age 13-17, information regarding reproductive care. I give my specific authorization for this information to be released.
b. Generally, the Diabetes & Metabolic Wellness Center and any other entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this authorization is for purposes of determining enrollment, eligibility, underwriting or risk rating prior to enrollment, not signing or revoking this authorization may impact enrollment or benefit determinations by Pak Medical Group.
c. I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization. Once disclosed, health care information may be subject to redisclosure by the recipient and may no longer be protected under health information privacy laws.
d. This authorization expires 90 days from the date signed OR on this date: _________

SIGNATURE: ________________________________ DATE: ____/___/___
(Patient or Member, Guardian, or Authorized Representative).

MINOR SIGNATURE: __________________________ DATE: ____/___/___
(Signature of minor ages 13-17 is required to release information listed above)

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. CONTACT PERSON. If you have any questions about this Notice of Privacy Practices (Notice), please contact us.

II. EFFECTIVE DATE OF THIS NOTICE. The original effective date of this Notice was April 26, 2003.

III. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). We are required by law to maintain the privacy of your personal information. This medical information is called protected health information or "PHI" for short. PHI includes information that can be used to identify you that we have created or received about your past, present, or future health or medical condition, the provision of health care to you, or the payment of this health care. We need access to your medical records to provide you with health care and to comply with certain legal requirements. This Notice applies to all of the records of the care and services you receive from us, whether made by our employees or your physician. This Notice will tell you about the ways in which we may use and disclose PHI about you and describes your rights and certain obligations we have regarding the use and disclosure of your PHI. However, we reserve the right to change the terms of this Notice and our Privacy Policies and Procedures at any time. Any changes will apply to the PHI we already have. Before we make an important change to our Privacy Policies and Procedures, we will promptly change this Notice and post a new Notice in the main patient waiting area. When we make a significant change in our privacy practices, we will change this notice and post when applicable and provide you a copy of the revised notice. You can also request a copy of this Notice from us anytime.

IV. OUR DUTIES. We are required by law to:

- make sure that PHI that identifies you is kept private;
- give you this Notice of our privacy practices with respect to your PHI;
- disclose information on HIV, mental health, and/or communicable diseases only as permitted under federal and state law; and
- follow the terms of this Notice as long as it is currently in effect. If we revise this Notice, we will follow the terms of the revised Notice.

V. HOW WE MAY USE AND DISCLOSE YOUR PHI. The following categories (listed in bold-face print) describe different ways that we use and disclose your PHI. Disclosures of PHI may be provided in various media, including electronically. For each category of uses or disclosures we will explain what we mean and give you some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information about you will fall within one of the bold-face print categories. Also, not all of the categories may apply to the health care service you are seeking.

A. For Treatment. We may disclose your PHI to physicians, nurses, case managers, and other health care personnel who provide you with health care services or are involved in your care. We may use and disclose your PHI to provide and coordinate the treatment, medications and services you receive including dispensing of prescription medications when applicable. For example, if you're being treated for a knee injury, we may disclose your PHI regarding this injury to a physical therapist or radiologist, or to medical equipment suppliers or case managers.

B. To Obtain Payment for Treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our Business Associates, such as billing companies and others that process our health care claims.

C. For Health Care Operations. We may disclose your PHI in order to operate our facilities. For example, we may use your PHI to evaluate the quality of health care services that you received, for utilization management activities, or to evaluate the performance of the health care professionals who provided the health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us.

D. To Business Associates for Treatment, Payment, and Health Care Operations. We may disclose PHI about you to one of our Business Associates in order to carry out treatment, payment, or health care

operations. For example, we may disclose PHI about you to a company who bills insurance companies on our behalf so that company can help us obtain payment for the health care services we provide.

E. Individuals Involved in Your Care or Payment for Your Care. We may release PHI about you to a family member, other relative, or close personal friend who is directly involved in your medical care if the PHI released is relevant to such person's involvement with your care. We also may release information to someone who helps pay for your care. In addition, we may disclose PHI about you to an entity assisting in a disaster relief effort so that your family can be notified about your location and general condition.

F. Appointment Reminders. We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or health care if you have not opted out of such reminders.

G. Treatment Alternatives. We may use and disclose PHI to give you information about treatment options or alternatives if you have not opted out of such reminders. H. Health-Related Benefits and Services. We may use and disclose PHI to tell you about health related benefits or services that may be of interest to you if you have not opted out of such reminders.

I. Workers' Compensation. We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

J. Special Situations.

1. **As Required By Law.** We will disclose PHI about you when required to do so by federal, state, or local law, such as the Occupational Safety and Health Act (OSHA), Federal Drug Administration (FDA), or Department of Transportation (DOT).
2. **Public Health Activities.** We may disclose PHI about you for public health activities. Public health activities generally include:
a. preventing or controlling disease, injury or disability;
b. reporting births and deaths;
c. reporting child abuse or neglect;
d. reporting reactions to medications or problems with products;
e. notifying people of recalls of products;
f. notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
g. notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
3. **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
4. **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI about you under a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else in the dispute.
5. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:
a. in response to a court order, subpoena, warrant, summons or similar process;
b. to identify or locate a suspect, fugitive, material witness, or missing person, but only if limited information (e.g., name and address, date and place of birth, social security number, blood type, RH factor, injury, date and time of treatment, and details of death) is disclosed; Notice of Privacy Practices
c. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
d. about a death we believe may be the result of criminal conduct;
e. about criminal conduct we believed occurred at our facility; and
f. in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
6. **Coroners, Medical Examiners and Funeral Directors.** We may release PHI about patients to a coroner or medical examiner to identify a deceased person or to determine the cause of death or to funeral directors to carry out their duties.
7. **Organ and Tissue Donation.** We may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation.
8. **Research.** Under certain circumstances, we may use and disclose PHI about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects are subject to a special approval process which requires an evaluation of the proposed research project and its use of PHI, and balances these research needs with our patients' need for privacy. Before we use or disclose PHI for research, the project generally will have been approved through this

special approval process. However, this approval process is not required when we allow PHI about you to be reviewed by people who are preparing a research project and who want to look at information about patients with specific medical needs, so long as the PHI does not leave our facility.

9. To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone who is able to help prevent the threat.

10. Armed Forces and Foreign Military Personnel. If you are a member of the Armed Forces, we may release PHI as required by military command authorities or about foreign military personnel to the appropriate foreign military authority.

11. National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

12. Protective Services for the President and Others. We may disclose PHI about you to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

13. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary, for example, for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

14. Food and Drug Administration (FDA). We may use and disclose to the Food and Drug Administration (FDA), or person under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

K. Incidental Uses and Disclosures. Uses and disclosures that occur incidentally with a use or disclosure described in this Notice are acceptable provided there are reasonable safeguards in place to limit such incidental uses and disclosures.

VI. WHAT DO WE DO WITH YOUR INFORMATION WHEN YOU ARE NO LONGER A PATIENT OR YOU DO NOT OBTAIN SERVICES THROUGH US. Your information may continue to be used for purposes described in this notice when you no longer obtain services through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

VII. YOUR RIGHTS REGARDING YOUR PHI.

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to approve it. If we approve your request, we will put any limits in writing and follow them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make. You have the right to request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations. We must comply as long as it is not for purposes of carrying out treatment; and the PHI pertains only to a health care service for which we have been paid out of pocket in full without the application of insurance benefits or discounts. If the payment is not honored, then we do not need to comply with the request if we need to seek payment.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you to an alternate address or via an alternate method. We must agree to your request so long as we can easily provide it in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI, but we know who does, we will tell you how to get it. In certain situations, we may deny your request. If we do, we will tell you in writing our reasons for the denial and explain your right to have the denial reviewed. If you request copies of your PHI, there may be a per page charge. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to any additional costs in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI in the past six (6) years. The list will include the date of the disclosure(s), to whom PHI was disclosed, a description of the information disclosed, and the reason for the disclosure. The list will not include uses or disclosures that were made for the purposes of treatment, payment or health care operations, uses or disclosures that you

authorized, or disclosures made directly to you or to your family. The list also will not include uses and disclosures made for national security purposes, or to corrections or law enforcement personnel. Your request must state a time period that may not be longer than six (6) years prior, but may certainly be less than six (6) years.

E. The Right to Correct or Update Your PHI. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment of the existing information or to add the missing information. You must provide the request and your reason for the request in writing. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI. We may deny your request if the PHI is: (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a statement of disagreement, you have the right to request that your request and our denial be attached to all future disclosures of your PHI.

F. The Right to Get This Notice. You have the right to get a copy of this Notice in paper and by e-mail.

G. The Right to File a Complaint. If you believe your privacy rights have been violated or if you disagree with a decision we make about your rights, such as accessing or amending your records, you may file a complaint with us by contacting us any time. You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR) or the option to e-mail your complaint to OCRmail@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services. We will respond to all privacy requests and complaints. It has always been our goal to ensure the protection and integrity of your personal and health information. Therefore, we will notify you of any potential situation where your information would be used for reasons other than what is listed above.

H. What type of communications can I opt out of receiving from you? You can opt out regarding the following communications by letting us know:

a. Appointment reminders.
b. Treatment alternatives or other health-related benefits and services.
c. Fundraising activities.

VIII. HOW TO REQUEST YOUR PRIVACY RIGHTS. If you believe your privacy has been violated in any way, you may file a complaint by contacting us. We are committed to responding to your request in a timely manner. To request any of your privacy rights, please call your primary clinic.

IX. WHAT WILL HAPPEN IF MY PRIVATE INFORMATION IS USED OR DISCLOSED INAPPROPRIATELY. You have the right to receive a notice that a breach has resulted in your private information being inappropriately used or disclosed. We will notify you in a timely manner if such a breach occurs.

X. HOW WILL MY INFORMATION BE USED FOR PURPOSES NOT DESCRIBED IN THIS NOTICE. In all situations other than described in this notice, we will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not disclose your information for any reason not described in this notice without your permission. The following uses and disclosures will require authorization:

1. Most uses and disclosures of psychotherapy notes
2. Marketing purposes

XI. HOW TO CONTACT US

Please contact your primary clinic phone number or mail a letter to the clinic address. You can also call our centralized office number at 830-730-4375 for any concerns, questions, or requests.

Welcome to the Diabetes & Metabolic Wellness Center

Clinical Policies and Agreements

Consent for Medical Treatment

I, undersigned, as the patient (or the patient's authorized representative), do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments and transfer to other facilities considered necessary or advisable in the judgment of the attending physician, his/her assistants or designee. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations performed in this facility. I authorize the Diabetes & Metabolic Wellness Center ("DMWC") or members of its attending staff to retain, preserve and use for scientific or teaching purposes, or dispose of, at their convenience, any specimens of mine.

Financial Responsibility Statement

It is the policy of the Diabetes & Metabolic Wellness Center to bill your insurance carrier as a courtesy to you, even though you may be considered responsible for the entire bill when the services are rendered. If your insurance carrier does not remit payment within 60 days, the applicable balance will then be due in full from you. Unless your insurance carrier has a contract with the Diabetes & Metabolic Wellness Center to pay based on a specific negotiated fee schedule, you may be held responsible for any difference remaining between the insurance payment and the total charges.

We also require that arrangements for payments of your estimated share be made on the date services are rendered. If payment is made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit to the appropriate party. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to the Diabetes & Metabolic Wellness Center.

However, if you are an HMO enrollee, the above statements only apply to your applicable co-pay and/or any other non-covered charges that you have agreed to be responsible for in advance of treatment. If you are a Worker's Compensation patient, you will be held responsible for charges in the event your claim is not approved by either your employer or your insurance company. You understand and agree that if you fail to a make the payments for which you are responsible in a timely manner, after such default and upon referral to a collection agency or attorney by the Diabetes & Metabolic Wellness Center, you will be responsible for all costs of collecting monies owed including court costs, collection agency fees and attorney fees. You also understand that you are responsible for keeping Allied advised of any address changes. If any correspondence is retuned via mail, you understand that the account will be considered in default and will be turned over for collection immediately.

Release of Information

I, hereby, authorize the Diabetes & Metabolic Wellness Center to release information to my insurer(s), their agent(s) (including employer, if worked related injury), about my injury or disability, medical condition, evaluation, treatment, work history and/or any medical information as may be necessary for payment by my hospital and medical claims, except as otherwise provided by applicable State or Federal Laws. This release also allows information to be released for utilization review and financial audits or for the purpose of evaluation, treatment and/or rehabilitation. This may include all reports and others contained in the medical record pertaining to the medical condition or injury for which I have sought treatment. In addition, this release authorizes the Diabetes & Metabolic Wellness Center to release my records

to any referred physician for purposes of continued medical care. This will include all pertinent clinical note, diagnostic tests and personal information. Also, any medical information returned from referral physician used for Case Management purposes can be released to the above listed entities. I understand that this authorization may be revoked by me at any time and that it is valid for a period which is consistent with the medical records policy of the Diabetes & Metabolic Wellness Center. Its personnel are hereby released from all legal responsibilities for such release of information as described above.

A photocopy or scanned copy of this document shall be considered to be valid as the original.

Benefit Assignment

I, hereby, assign all medical benefits and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurances, and any other health plans to the Diabetes & Metabolic Wellness Center.

A photocopy or electronic/scanned copy of this assignment is to be considered as valid as the original.

About Physician Assistants

This facility may have on staff a physician assistant to assist in the delivery of medical care. A physician assistant is not a doctor. A physician assistant is a graduate of an accredited, two-year training program and is licensed by the state board. They are required to pass the Physician Assistant National Certifying Examination to become a certified Physician Assistant (PA-C). Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of the supervising physician, but rather refers to overseeing the activities of and accepting responsibility for the medical services that the physician assistant provides. These services may include obtaining histories, performing physical exams, diagnosing and treating illness, ordering and interpreting tests, counseling on preventive health care, assisting in surgery, writing prescriptions, and making appropriate referrals.

Acknowledgement

I understand that as part of my healthcare, the Diabetes & Metabolic Wellness Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

1) a basis for planning my care and treatment;
2) a means of communication among the many health professionals who contribute to my care;
3) a source of information for applying my diagnosis and surgical information to my bill;
4) a means by which a third party payer can verify that services billed were actually provided;
5) and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. I understand that the Diabetes & Metabolic Wellness Center reserves the right to change its practices and to make the new provisions effective for all protected health information maintained by the Diabetes & Metabolic Wellness Center.