Great Plains Diabetes
Medical and Family History

Name (Last, First, Middle Initial)	Date of Birth	Today's Date:

Your Occupation	Education (Circle highest level received) Grade School Junior High High School (1 2 3 4) College (1 2 3 4) Graduate School

List other people living at your residence and their ages:

Personal and Family Medical History (parents, children, grandparents, brothers and sisters)

Disease(s)	List year YOU were diagnosed:	Current Problem?		Physician Treating Your Condition?	Do you have a Family Member with this condition? List Relationship
		Yes	No		
EX (Arthritis)	***2011***	***X***		***Dr. Hand***	***Dad, sister***
Arthritis					
Asthma					
COPD					
Diabetes					
Heart Disease					
Stroke/TIA					
High Blood Pressure					
Cholesterol/Triglycerides					
Congestive Heart Failure					
Sleep Apnea					
Anemia					
Cancer (list location)					
Emotional/Depression or other Psychiatric diagnosis					
Thyroid Disease					
Retinopathy/Cataracts/ macular changes					
Kidney Disease					
Neuropathy-nerve pain					
Foot ulcers					
Gastroparesis					
Gastric Reflux					
Celiac Disease					
Alcohol/Drug Abuse					
Other (list)					

Allergies (explain)

If applicable, please list your children and their birth weights: _____

_____

_____

Surgeries/Hospitalizations: _____

_____

_____

MEDICATION LIST

Name: _____Date:_____

Please list *all* medications with complete dose information including all herbs, supplements, and vitamins.

Name of Medication	Dose	Taken When	Purpose
EXAMPLE: DIOVAN	160mg	Am	High BP

ALLERGIES:_____

_____

_____

Great Plains Diabetes

834 N Socora, Suite 4 - Wichita KS 67212

PATIENT INFORMATION

Name (Last, First, Middle Initial)	Gender ⑤ Male ⑤ Female	Date of Birth	Todays Date:
Address	City	State	Zip Code
Email	Home Phone	Work Phone	Cell Phone
Marital Status: ⑤ Child ⑤ Single ⑤ Married ⑤Divorced ⑤Widowed ⑤Separated	Spouse Name	Parents' Name (if minor)	
Ethnicity: ⑤Hispanic or Latino ⑤Not Hispanic or Latino	Spouse Daytime phone	Parent Daytime Phone	

Race: ⑤White ⑤Black or African American ⑤Asian ⑤American Indian or Alaska Native
⑤ Native Hawaiian or Pacific Islander ⑤Other(list)

Social Security Number	Place of Employment	Occupation
Emergency Contact	Emergency Contact Phone Number	Relationship to patient

Other Family Members Seen here

Preferred Pharmacy (location – cross streets)

Primary Care Physician/Provider (list city/state where located)	Referring Physician/Provider

INSURED'S BILLING INFORMATION

Subscriber's Name (Last, First, Middle Initial)		Relationship to Patient	
Address	City	State	Zip Code
Subscriber's Date of Birth	Subscriber's Social Security No	Patient's Social Security No	
Subscriber's Employer	Home Phone	Work Phone	

MEDICAL INSURANCE INFORMATION (Please present insurance card to receptionist)

Primary Insurance	Insurance Company Name	
Insurance Company Address	Policy Number	Group Number
Secondary Insurance	Insurance Company Name	
Insurance Company Address	Policy Number	Group Number

Patient's or Authorized Person's Signature: I hereby state the above is true. I authorize the release of any medical or other information necessary to process my medical claims. I also request payment of government benefits either to myself or Great Plains Diabetes who accepts assignment. I authorize payment of medical benefits to Great Plains Diabetes for services received.

I consent for the provider to import my medication history as provided by SureScripts.

X

Great Plains Diabetes
Financial Policy

Patient Name_____

We are pleased that you have chosen our practice for your medical care. We are committed to providing you with the highest quality of care and achieving desired outcomes through a collaborative effort with you, the patient.

We will file your services with your primary and secondary insurance plans should you provide us with complete and accurate information about your insurance. As required by law, Great Plains Diabetes automatically files all Medicare and Medicaid claims. You are responsible for deductibles, co-payments, non-covered services, co-insurance and items considered "not medically necessary".

Co-payments are due at the time of service. We accept cash, checks and credit cards, (Mastercard or Visa). **Copayments are a contractual obligation with your insurance company.** You are required to pay your co-payment, and we are required to collect your co-payment, at the time of each visit.

Referrals - It is your responsibility to contact your primary care physician and obtain the referral prior to your appointment. Failure to obtain a referral may result in reduction of benefits or non-payment by your insurance provider. If you wish to be seen without the referral, you will be required to sign a waiver and you will be responsible for all charges.

We understand that not everyone is provided with health insurance. We do ask that payment is received at the time your services are rendered. If you are unable to meet this obligation, we ask that you meet with one of our staff to set up financial arrangements prior to your services. Should you meet certain requirements, we will ask you to complete a financial assistance application.

No Show Policy - We understand busy schedules and time constraints, however, should you fail to show for scheduled appointments without advance **24 hours notice to the practice, a $25.00 charge will be assessed** to your account. A continuation of "no show" appointments could require us to dismiss you from the practice. Please cancel by calling 316.440.2802 during office hours or by emailing nurse@greatplainsdiabetes.com.

Payment Plans - Should a payment plan be necessary we ask that you meet with our staff. Payments are required every month to stay current with our office. A missed payment will force the account to be flagged as delinquent and could be considered for collection action.

Collection Process - Should we not receive your payment in full within 90 days of your first mailed statement, and you have not made arrangements with our staff, your account will be delinquent and considered for collection action. You will be responsible for collection fees including but not limited to, agency fees, attorney fees and court cost. Once an account has been placed for collection, payment arrangements cannot be made thru our office but must be set up with the collection agency.

Returned Check Charge - A $30.00 fee will be charged for any checks returned for insufficient funds or closed accounts.

Minor Children - When a parent presents with a minor child, that parent is considered the responsible party. We are unable to bill the other parent if divorced/separated without a copy of the divorce papers/legal paperwork that has been signed by the Courts. The legal paperwork must state the other party is 100% responsible as we are unable bill multiple responsible parties.

Forms - Forms such as FMLA, Drivers License, DOT paperwork, School Plans, etc., will be assessed a **$25.00 fee if not completed at the patients visit.**

I have read and understand the financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____ _____

Responsible party member's name Relationship

_____ _____

Responsible party member's signature Date

834 N Socora Wichita KS 67212-3279

ONE TIME AUTHORIZATION

Please Read and Sign the Following to Help Us with Your Insurance Filing

I hereby authorized Great Plains Diabetes to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to same all payments for medical services rendered to me. I understand that my insurance will be filed as a courtesy and I agree to be financially responsible for any balance due to Great Plains Diabetes. I also authorize Great Plains Diabetes to perform any treatment which is considered necessary by the provider. A photocopy of the authorization and assignment shall be considered as valid as the original.

_____ _____

Patient or Guardian Signature **Date Signed**

MEDICARE PATIENT'S ONLY:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Great Plains Diabetes for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Great Plains Diabetes and it agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient or Guardian Signature **Date Signed**

PATIENT "OPT-OUT" OF FUNDRAISING EFFORTS

A communication to an individual that is made by a covered entity, an institutionally related foundation, or a business associate on behalf of the covered entity for the purpose of raising funds for the covered entity is a fundraising communication. The Department has stated that permissible fundraising activities include appeals for money, sponsorship of events, etc. They do not include royalties or remittances for the sale of products of third parties (except auctions rummage sales, etc.).

Patient Name:_____ Date:_____

Protected Health Information disclosed for the purpose of Fundraising Efforts by Great Plains Diabetes Research would only include information involving your **demographics**.

I understand that I have the right to opt-in or opt-out of any or all fundraising communications. Should I choose to opt out of fundraising activities, I understand I will not receive communications from this practice; including, appeals for money, sponsorships of events, etc.

☐ I would like to receive Fundraising Communications

☐ I would like to **OPT-OUT** of **ALL** current and future Fundraising Communications

If you choose to receive fundraising communications, you may opt out at any time by calling, emailing, faxing or in writing.

Date Opt-Out Occurred: _____

Patient Signature: _____

834 N Socora Wichita KS 67212-3279

PATIENT PORTAL ACCESS AUTHORIZATION

Patient Identification Information

Patient Name:_____ Date of Birth:_____

If Patient is under 18, name of Parent/Legal Guardian:_____

Patient Email Address (REQUIRED):_____

An Invitation to register for the Great Plains Diabetes (GPD) Portal will be sent to your email, please accept this request. You will then be able to set up your own User ID and Password for access to information through the GPD portal.

SIGNATURE AND ACKNOWLEDGEMENT

By signing as/for the Patient below and submitting this Enrollment Form, I acknowledge I will be sent an Invitation to register my User ID and Password for access to selected health information through Great Plains Diabetes (GPD) Portal. I ACKNOWLEDGE THAT LOGGING ONTO THE PATIENT PORTAL THROUGH A GPD PORTAL ACCOUNT WILL CONSTITUTE MY AGREEMENT TO THE TERMS AND CONDITIONS OF THE CONSENT AND USER AGREEMENT.

_____ _____

Patient or Legal Guardian Signature **Date Signed**

Great Plains Diabetes
834 N Socora, Suite 4 - Wichita KS 67212 - 316-440-2802

ACKNOWLDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Great Plains Diabetes's Notice of Privacy Practices.

Patient Name (print) _____

_____ _____
Signature of Patient/Patient Representative Date

_____ _____
Patient Representative Name (PRINT) Relationship to Patient

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Great Plains Diabetes (GPD) to share health information with **my care givers/family members** listed below.

_____ _____
(Name of Person or Organization) (Name of Person or Organization)

_____ _____
(Name of Person or Organization) (Name of Person or Organization)

This authorization shall remain in effect from the date listed below unless revoked or terminated by the patient or the patient's representative.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name of Representative Relationship

ORIGINAL TO BE MAINTAINED IN PATIENT'S PERMANENT MEDICAL RECORD

NOTICE OF PRIVACY PRACTICES

Patient Summary

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION. Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for your future care or treatment, and billing-related information. Such records are necessary for the healthcare provider to provide you with quality care and to comply with certain legal requirements.

We are committed to protecting the confidentiality of our records containing information about you. This notice applies to all records of your care created or received by Great Plains Diabetes (GPD).
We are required by law to provide this notice to you and obtain your acknowledgement of its receipt prior to providing any services to you. **Please note that we understand that medical information about you is personal. We are committed to protecting your medical information.**
This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.
The following is a brief summary of the contents of the Notice. We encourage you to read the entire Notice and ask any questions you may have concerning its contents.
Your Rights Regarding Your Health Information. This section describes the following rights you have with respect to your health information and tells you how you may exercise these rights.

- Right to inspect and copy - You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

- Right to request amendment - If you believe that our records contain information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for GPD.

- Right to an accounting of disclosures - You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law.

- Right to request restrictions on certain uses and disclosures - You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations.

- Right to request alternative means of communication - You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

- Right to receive a paper copy of our Notice of Privacy Practices - You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the person identified on the last page of this Notice.

How We May Use and Disclose Health Information About You Without Your Specific Authorization. This section describes the different ways we may use or disclose your health information without first obtaining from you a specific authorization. These types of uses and disclosures are specifically permitted by federal law because it is assumed you would want us to use or disclose your information for these purposes, or because such use or disclosure is recognized as critical to the proper functioning of our health care system.

- We may use information about you to provide you with **medical treatment or services, to receive payment for services, to support our health care operations, to send you appointment reminders, to assess your satisfaction with our services, to tell you about health related benefits or services.**

  - There are some services provided in our organization through contracts or arrangements, we may disclose your health information to our business associates so they can perform the job we've asked them to do.

  - We may release health information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give information about you for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, organ donation, workers' compensation, research, law enforcement, and emergencies.

  - We may disclose information when required by law, such as in response to valid judicial or administrative orders.

Other Uses of Health Information. Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. Of course, we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

How To File Complaints Concerning Our Privacy Practices. If you wish to file a complaint because you feel that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our office. **You will not be penalized for filing any complaint.**

Changes to this Notice. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our facility and on our website. The notice will contain on the first page the effective date.

Acknowledgement. You will be asked to provide a written acknowledgement of your receipt of this Notice. We are required by law to make a good faith effort to provide you with our Notice and obtain such acknowledgement from you. However, your receipt of care and treatment from GPD is not conditioned upon your providing the written acknowledgement.

Effective Date: September 2, 2014

If you have any questions about this notice, please contact

Great Plains Diabetes
834 N Socora, Suite 4
Wichita, KS 67212
Telephone Number (316) 440-2802
Facsimile Number (316) 440-2809
E-mail Address: nurse@greatplainsdiabetes.com