Diabetes Control Center

Dedicated to the prevention of diabetes complications

THIS FORM AUTHORIZES DIABETES CONTROL CENTER TO REQUEST MEDICAL RECORDS FROM DOCTORS, HOSPITALS ETC

Name of Patient_____

Social Security Number_____

Date of Birth _____

By signing this authorization, I authorize _____
(Name of Doctor or institution)
Address_____
to disclose protected health information (PHI) about me to The Diabetes Control Center. This authorization permits the use and/or disclosure the following individually identifiable health information about me Hx and PE, Operative notes, Lab and radiology results, _____
(Strike any that do not apply).
The information will be used or disclosed for the following purpose: Medical Care. If requested by the patient, purpose may be listed as "at the request of the individual". The purpose is/are provided so that I can make an informed decision about whether to allow release of the information. This authorization will expire on_____
The Diabetes Control Center will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights). I understand that I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Diabetes Control Center, 1760 Villagepark Drive, Orangeburg, SC 29118.

Signed _____ Date_____

Relationship to
patient_____

Printed name of
signer_____
Health Care Provider: PLEASE FAX RECORDS TO 803-536-6734

Charles H. Raine, III, M.D.
Diabetology

1760 Villagepark Dr.
Orangeburg, SC 29118
803-536-6339
www.DiabetesControlSC.com

Diabetes Control Center

Charles H. Raine, III, M.D.
Director

NEW PATIENT MEDICAL INFORMATION FORM

Please complete this form and bring it with you at your first Center visit.

Name_____

Date of birth_____

Past Medical Problems (place a check mark if you have had any of the following):
[] Diabetes| year started_____ [] High Blood Pressure| year started_____

[] Heart disease | year started_____ [] Kidney disease | year started_____

PAST SURGERY

[] Tonsils removed [] Hysterectomy [] Appendix removed

[] Gallbladder removed [] Other_____

Do you smoke? [] No [] Yes Age started_____

PAST HOSPITALIZATIONS

Year	Diagnosis	Year	Diagnosis
1_____	_____	2____	_____
3_____	_____	4____	_____

ARE YOU ALLERGIC TO ANY MEDICINES?
[] No (none known)
[] Yes (please list)

FAMILY HISTORY
Has a parent, brother or sister had any of the following? (Check if yes)
[] Diabetes
[] Mother [] Father [] Brothers or Sisters
[] High blood pressure
[] Mother [] Father [] Brothers or Sisters
[] Heart attack
[] Mother [] Father [] Brothers or Sisters
[] Kidney failure
[] Mother [] Father [] Brothers or Sisters

1707 VillagePark Dr. - Orangeburg, SC - 29118 - (803) 536-6339

Charles H. Raine, III, M.D.
Director

MEDICINES YOU NOW TAKE

NAME OF MEDICNE	DOSE	NAME OF MEDICNE	DOSE

PROBLEMS YOU NOW HAVE

Yes	No	
[]	[]	Headaches, more than one per week.
[]	[]	Lightheadedness.
[]	[]	Failing vision.
[]	[]	Sinus trouble.
[]	[]	Ringing in the ears.
[]	[]	Chest pain.
[]	[]	Pounding heart.
[]	[]	Shortness of breath when lying flat.
[]	[]	Shortness of breath when walking less than one block.
[]	[]	Heartburn.
[]	[]	Need to take a laxative more than one time weekly.
[]	[]	Diarrhea more than one time weekly.
[]	[]	Blood in the stools.
[]	[]	Stools as black as tar.
[]	[]	Stomach pain from eating greasy food.
[]	[]	Stomach pain from eating spicy food.
[]	[]	Painful urination.
[]	[]	Overnight urination more than two times.
[]	[]	Frequent urination, more than five times while awake.
[]	[]	Blood and urine.
[]	[]	Burning or stinging of the feet and legs.
[]	[]	Loss of feeling in the feet and toes.
[]	[]	Very thirsty lately.

Thank you very much for taking the time to complete this form. This information will be helpful to the Diabetes Control Center as we attempt to provide you with the best possible medical care.

Diabetes Control Center: 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.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION:

As your HealthCare Provider, we will maintain a record of your visit that contains your symptoms, reports of examinations and test results, diagnoses, treatments, correspondence with other providers and plans for future care or treatment.

YOUR HEALTH INFORMATION RIGHTS:

Your health record is the physical property of this Practice; however, the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the Practice of your requests for any of these actions:

a. Request Restrictions: You have a right to request restrictions on the use of your information.
b. Obtain a Paper Copy of this Notice.
c. Inspect and Copy: You have a right to inspect and receive a copy of your health information. If you request a copy of your information, you will be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
d. Amend: You have the right to request that we amend your health information.
e. Obtain and Accounting of Disclosures: You have the right to request an accounting of certain disclosures of information that have been made about you. This listing includes disclosures of your information for other than treatment, payment or healthcare purposes and is within a specified period of up to six years. The first listing of disclosures is provided as a complimentary service to you, but you will be charged a reasonable fee for additional requests made with a twelve-month period.
f. Request Communications of Your Health Information: You have the right to request that you receive communications regarding your information in a certain manner or at a certain location.
g. Revoke Your Authorization for Disclosure: You have the right to revoke an authorization for disclosure of information that was previously given.

OUR RESPONSIB ILITIES:

Our Practice is required to:

a. Confidentiality: Maintain the privacy of your health information.
b. Provide a copy of this notice: We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information w collect and maintain about you.
c. Abide by the terms of this notice.
d. Unable to restrict: We will notify you if we are unable to agree to a requested restriction of your information.
e. Provide alternative means or alternative locations: We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our Privacy Practices and to make new provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION

a. Il you have a question or would like additional information, you may contact our Privacy Officer.
b. B. If you have a concern about the privacy of your information, you may contact our Privacy Officer. Your concerns will be responded to by our Practice, but you may also file a complaint with the secretary of Health and Human Services in the U. S. Office of Civil Rights. The Privacy Officer will supply information about this procedure.

EXAMPLES OF DISCLOSURES OF INFORMATION: TREATMENT:

a. We will use your health information for treatment purposes. As an example, Information given to a nurse or physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare team will document your treatment goals, actions taken and clinical observations.

b. We will provide your other healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.

c. Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnoses, treatments and supplies used.

d. Healthcare Operations: The physicians and members of your healthcare team may use the information to evaluate the quality of care you received by others similar to you. This information will be used to improve the effectiveness of healthcare operations and services we provide.

Effective Date: April 14, 2003

ACKNOWLEDGEMENT

Diabetes Control Center

I hereby acknowledge receipt of the Diabetes Control Center Notice of Privacy Practices.

_____ _____

Signature **Date**

_____

Print Name

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

This form instructs The Diabetes Control Center to discuss, or not to discuss your health information with specific individuals.

[] Do not discuss my information with anyone.*

[] My health information may be discussed with the following person(s).

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Name Printed: _____

Signature: _____

Date _____

*Pertinent information must be provided to insurance companies and government agencies for payment purposes.

Patient Information Record

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I, the undersigned, authorize payment of medical benefits to Diabetes Control Center for any services furnished to me. I understand I may be financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company information concerning health care, treatment or supplies provided to me. I permit a copy of this authorization to be used in place of the original.

DATE_____ SIGNATURE_____

MEDICARE LIFETIME SIGNATURE ON FILE:

I request the payment of authorized Medicare benefits be made to me or on my behalf to Diabetes Control Center for any services furnished to me by a health care provider. I authorize any holder of medical information about me to release to Diabetes Control Center any information needed to determine these benefits or benefits payable for related services.

DATE_____ SIGNATURE_____

MEDICAL SERVICES AUTHORIZATION:

I authorize you to give me reasonable and proper medical care by today's standards.

DATE_____ SIGNATURE_____

PHONE MESSAGE AUTHORIZATION

I authorize the staff of the Diabetes Control Center to leave a message on my voice mail, e-mail or with another party at the number(s) or address provided.

DATE_____ SIGNATURE_____

FAX OR OTHER ELECTRONIC MEANS AUTHORIZATION

I authorize Diabetes Control Center to fax or electronically transmit medical records to other providers participating in my care.

DATE_____ SIGNATURE_____

PAYMENT AGREEMENT

It is the policy of Diabetes Control Center that charges for services rendered by our physicians and staff be paid for at the time of services unless other formal arrangements have been made with our business office.

Electronic insurance claims will be filed by Diabetes Control Center for your convenience; however, it will be your responsibility to provide our office with the necessary information and signed authorization for filing insurance. This information and authorization must be provided at your first visit, accompanied with a copy of your insurance card(s).

Arrangements for monthly payments may be made with our business staff for any patient account balance in excess of $200. A minimum payment is required each month to keep an active account. You are responsible for making the monthly payment by the 5th working day of each month whether or not a statement has been sent to you. Any patient account, which becomes delinquent (monthly payment not made in 30 days of the last payment), will begin to be processed in the office collection department, and the complete balance will become due immediately.

I agree to the above financial agreement for any services provided to me by Diabetes Control Center.

DATE _____ RESPONSIBLE PARTY SIGNATURE _____