Diabetes and Endocrinology Consultants of Pennsylvania (DECPA LLC)

EXISTING PATIENT DEMOGRAPHIC FORM

(Please Print Clearly and answer all)

Date: _____Name: _____ Date of Birth __/___/___

Last First Middle Initial

Address: _____

Sex: Male / Female Marital Status: □ Single □ Married □ Widowed □ Divorced

Social Security #:_____E-mail Address: _____@_____

Phone #: Home: _____ Cell: _____ Work: _____ Ext:_____

Which # can we call you (Circle all those you prefer): **HOME** **WORK** **CELL**

Patient Occupation:_____ Employer Name:_____

Insurance Information:

Primary Insurance: _____Phone #_____ Referral needed (Y / N)

Subscriber/Cardholder Name_____ DOB ___/___/ ____

Relationship to Patient _____Policy #_____ Group # _____

Secondary Insurance: _____Phone #_____

Subscriber/Cardholder Name_____ DOB ___/ __/____

Relationship to Patient _____Policy #_____Group # _____

Pharmacy Information:

Prescription Plan Name: _____ Policy #:_____ __

Pharmacy Name: _____ Phone #_____

Pharmacy Address: _____ Fax: _____

Please turn the page…

CONSENT TO TREAT - I (or my legal guardian or parent) request and consent to the performance of such service, procedures and medical treatment by *DECPA LLC* as the practice may believe to be necessary, advisable or beneficial to my health or the health of _____ of whom I am a legally authorized representative. This consent extends to the physician and other health care providers engaged by *DECPA LLC*, who may provide services connected to my care. I recognize and agree that practice of medicine is not an exact science and hence *DECPA LLC* can make no guarantee as to the results of its evaluation or treatments.

As per our Notice of Privacy Practices, we may disclose your protected health information to someone involved in your care or for payment of your care, such as a spouse, family member, or close friend. Please designate your Patient Representative(s):

_____ _____ _____

Print Name *Signature* *Date*

_____ _____ _____ _____

Print Name *Relationship to Patient Representative* *Home Phone #* *Cell Phone#*

HAS ANY OF THE FOLLOWING CHANGED? PLEASE CHECK ALL THAT APPLY!

_____ **HOME ADDRESS**	_____ **EMERGENCY CONTACT**
_____ **PHONE NUMBER(S)**	_____ **EMPLOYER**
_____ **INSURANCE (S)**	_____ **EMAIL**
_____ **PHYSICIAN(S)**	_____ **MARITAL STATUS**
_____ **PRESCRIPTION PLAN**	_____ **PHARMACY**
_____ **MEDICAL HISTORY**	_____ **MEDICATIONS**

If you checked off any of the Options above, please update your information at the front desk. Thank you!

Please turn the page…

E-MAIL CONSENT FORM

PATIENT NAME:_____ DATE OF BIRTH _____

E-MAIL ADDRESS _____

1. RISK OF USNG EMAIL

Our office offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks the patient should consider before using e-mail, these include, but are not limited to the following risks:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
c. E-mail senders can easily enter an incorrect e-mail.
d. E-mail is easier to falsify than handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems without authorization or detection,
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection. E-mail can be used as evidence in court.
h. E-mail can be used to introduce viruses into computer Systems.

2. CONDITIONS FOR USE OF E-MAIL

Practice will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Practice cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Practice intentional misconduct. Patients cannot request the staff to send unsecure or un-encrypted email. Thus, patients must consent to the use of email includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be saved to/made part of the electronic medical record, so that staff and billing personnel will have access to those e-mails
b. Practice may forward e-mails internally to Practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling, Practice will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. Although Practice will endeavor to read and respond promptly to e-mail from the patient, Practice cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time sensitive matters.
d. If the patient's e-mail requires or invites a response from Practice, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
f. The patient is responsible for informing Practice of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
g. The patient is responsible for protecting his/her password or other means of access to email. Practice is not liable for breaches of confidentiality caused by the patient or any third party.
h. Practice shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
i. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS *To communicate by e-mail, the patient shall:*

a. Limit or avoid use of his/her employer's computer
b. Inform Practice of changes in his/her e-mail address
c. Put the patient's name in the body of the email and accurate category in the subject line for routing purposes.
d. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to Practice.
e. Inform Practice that the patient received an email from Practice
f. Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding his/her computer password.
g. Withdraw consent only by written communication to Practice.
h. ***Comply with and use the encryption service used by the Practice to read and respond to emails****.*

4. PATENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Practice and me, and consent to the conditions outlined herein. In addition, agree to instructions outlined herein, as well as any other instructions that Practice may impose to communicate with patients by e-mail. Any questions I may have had were answered.

PATIENTS SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____WITNESS NAME_____

RELATIONSHIP TO PATIENT _____DATE: _____

Please turn the page…

DEC-PA, LLC FINANCIAL POLICY

The DEC-PA, LLC practice is dedicated to providing you with the best possible care as we attempt to keep our professional charges reasonable. For questions about our office policies, please ask any member of our staff

We participate with Medicare & IBC (Independence Blue Cross) Insurance Plans

Traditional Medicare - Expected at the visit: Any unmet portion of your annual Medicare Deductible and your 20% Medicare Coinsurance amount, if not covered by a secondary or supplemental insurance.

Other Medicare Advantage Plans: We will submit your claim to your insurance as a Courtesy Only. At time of service, you will be responsible for any amounts your plan does not cover (i.e. copays, deductibles and any out of network costs).

IBC: Expected at visit: Your Copay/Coinsurance/Deductible.

All other Insurances: Payment in full is due at time of service. Receipt may be requested for submission to your insurance for direct reimbursement to you.

Acceptable method of payment for Initial visit: cash, money order or valid credit card (Visa, MasterCard, American Express: add 4%, Discover).
Acceptable method of payment for continued care: cash, checks, money order or valid credit card. Office Visit fees/outstanding balance are due & payable in full at the time of your visit. Check(s) returned by the bank for any reason will be assessed a **$35.00** processing fee per check. Postdated checks are not accepted, please do not ask the staff to hold checks for future dates.
Please bring to every appointment a valid Photo ID, Insurance and Prescription Cards.

Referral: If your visit requires a referral/prior authorization, it is your responsibility to request your Primary Care physician to send a referral to DEC-PA LLC. Your visit will be rescheduled if it is invalid or there is no referral. You will be responsible for full payment for the service, if referral is invalid or claim is denied.
Medical Records: Pre-payment of fees and a signed records release authorization form are required for processing and release of any medical records, copies of lab results, or any form which requires the Doctor's signature (disability, long-term insurance, etc). Please allow 30 days for preparation. Fees based on calculations as allowed by PA medical society.
Appointments are confirmed as a courtesy only. We require 48 business hours (two business days) in advance for any changes or cancellations. A charge of **$110 ($250 for new patients)** will be assessed for any missed or broken appointment without at least a 2 business days' notice. Kindly be aware that three visits missed without a valid reason may result in dismissal from our practice.

I have read and fully understand the Financial Policy of DEC-PA LLC. I hereby authorize DEC-PA LLC to release any medical information to my insurance carrier necessary to process my claims. I authorize direct payment of medical benefits to this provider for charges not paid in full by myself. I understand that I am financially responsible for all charges for medical services rendered to me, or my legal dependent regardless of insurance coverage and/or payment. I understand that should my account be placed in Bad Debt/Collections, I will be responsible for all collection costs, including court costs and reasonable attorney fees.

_____

Print Patient Name, Legal Guardian or Personal Representative **D.O.B**

_____

Signature of Patient, Legal Guardian or Personal Representative **Date**

Additional Policy for Medicare Patients Only

We accept Traditional Medicare & Independence Blue Cross (IBC) Medicare Advantage Plans only!

Traditional Medicare: If you carry Traditional MCR as your primary insurance, at the time of your visit you will be expected to pay any unmet portion of your annual Medicare Deductible and your 20% Medicare Coinsurance amount if not covered, directly to our office by a secondary or supplemental insurance.

Other Medicare Advantage Plans: We will submit your claim to your insurance as a Courtesy Only. At time of service, you will be responsible for any amounts your plan does not cover (i.e. copays, deductibles and any out of network costs).

Per Federal law, in order to determine if Medicare is your Primary or Secondary coverage, **please check all applicable items and sign below:**

- I am: ____employed ____unemployed ____retired ____disabled
- ___ I am 65 years of age or older and am covered by an Employer Group Health Plan (EGHP) through my own employer or that of my spouse.
- ___I am under 65 years of age and covered by Medicare due to disability.
- ___I am entitled to Medicare coverage due to End Stage Renal Disease.
- ___I am currently receiving Worker's Compensation Benefits
- ___I am covered through the Federal Black Lung Program
- ___I am covered by the Veterans' Administration Program
- ___I am currently receiving benefits due to No fault or Liability Case (i.e. Automobile Accident)

Medicare Identification # (Health Insurance Claim Number) _____
Name/Address of Secondary Insurance: _____
Subscriber Name_____ Relationship to patient: _____
Subscriber Social Security #_____Date of Birth: _____
Policy#_____ Group#_____

PLEASE READ AND SIGN: I certify this information is true and complete to the best of my knowledge. I request that payment of authorized Medicare/Medigap Benefits be made either to me or on my behalf to DECPA LLC for any services furnished to me by this provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare &Medicaid Services/ Medigap Insurer, and their agents any information needed to determine these benefits or the benefits payable for related services.

_____

Print Name of Patient/Beneficiary Signature Date

_____

Print Name of Legal Guardian/Personal Representative Relationship Signature Date