

**HUMPHREYS DIABETES CENTER
1226 RIVER ST
BOISE, ID 83702
PH# 208-331-1155
FAX# 208-383-0190**

Name: _____

Appointment Date: _____

Appointment Time: _____

PLEASE READ THE INFORMATION CAREFULLY

- If you are seeing a Registered Nurse, your first visit may include:
 - ~ A diabetes assessment
 - ~ Education/Action plan
 - ~ Blood sugar monitoring instruction
 - ~ Insulin review
- If you are seeing a Registered Dietitian, your first visit may included:
 - ~ A diabetes assessment
 - ~Meal plan instructions
 - ~Education/Action plan

Bring the following items to every appointment:

- ~ Blood sugar meter and log book (if you have one)
- ~ List of current medication (or bring bottles with you)
- ~ Current lab work (obtain this from your doctor)
- ~ Food record for 3 days
- ~ Picture ID
- ~ Insurance card

Blood sugar meter: If you do not have a meter, do not purchase one before your appointment. You will be shown a variety of meters and may choose the meter that works best for you.

Call your insurance company to ask:

- What is my diabetes education coverage? For example, is there a co-pay at each visit, do I have a deductible to meet, at what percentage rate will be reimbursed, how many visits or hours of education is covered?
- Is there a preferred blood glucose meter?
- Are there preferred oral medications/insulin

IF YOU NEED TO RESCHEDULE/CANCEL THIS APPOINTMENT CALL (208) 331-1155



PATIENT REGISTRATION

Last Name _____ First Name _____ Middle Initial _____ Nickname _____
 Have you ever been a patient at HDC before? _____ If yes, under what name? _____
 SSN _____ Date of Birth _____ Gender Male Female
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ ext. _____
 Message Phone Cell Phone _____ Email _____

Optional

Marital Status:	Race:	Education:	Language:	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> White <input type="checkbox"/> Black/Afric.Amer. <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian <input type="checkbox"/> Indian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/> Elementary <input type="checkbox"/> Junior High <input type="checkbox"/> High School <input type="checkbox"/> College	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other List _____

Special Needs

- Hearing impairment Vision impairment Physical barrier/disability
 Low literacy Language barrier Emotional/Behavioral Health Issues

Employment Status:

- Occupation: Employer:
 Unemployed Disabled Retired Homemaker
 Work Hours: Day Evening Night Rotate/swing

Primary Care Physician: _____ City _____
 Other Doctor to receive progress notes: _____ City _____

Emergency Contact: _____
 Home Phone _____ Work Phone _____
 Relationship _____

Research:

Are you interested in participating in diabetes research: Yes No Type 1 diabetes Type 2 diabetes

Insurance:

(1st) Insurance company name: _____
 Subscriber ID # _____ Group # _____ Card holder Name _____
 Date of Birth ___/___/___ Social security # _____

(2nd) Insurance company name:

Subscriber ID # _____ Group # _____ Card holder Name _____
 Date of Birth ___/___/___ Social security # _____

CONSENT FOR TREATMENT

I am presenting myself for outpatient care at Humphreys Diabetes Center. I voluntarily consent to the rendering of such care as ordered by my physician or health care provider.

FINANCIAL RESPONSIBILITY

Insurance:

It is my responsibility to contact my insurance company for verification of covered services.

I will pay all co-payments and/or deductibles at time of services as required by my insurance carrier. By providing necessary information, HDC will bill my insurance in my behalf. My insurance policy is a contract between my insurance company and me. HDC is not a party to that contract. If I am without insurance coverage, I will pay in full at the time of service, if this is not possible, I will contact the HDC credit manager and make payment arrangements.

Charges:

I accept personal responsibility and agree to pay charges for services and/or diabetes supplies incurred on my behalf at HDC, regardless of third party coverage. If legal collection action is required, I will pay any additional expenses incurred. A \$25 charge will be imposed for appointments cancelled without 24 hour advance notice.

Finance Charge:

A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to patient responsibility. The FINANCE CHARGE will be computed at the rate of 1% per month or an ANNUAL PERCENTAGE RATE of 12%. The finance charge on your account is computed by applying the periodic rate (1%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed 30 days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is \$.50.

Required Payments:

Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Returned Checks:

There is a fee (currently \$25) for any checks returned by the bank.

Past Due Accounts:

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

Waiver of Confidentiality:

You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if hour past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Privacy Practices Acknowledged and Release of Information

I have been provided a copy of the HDC Notice of Privacy Practices and I have been provided an opportunity to review it. I authorize HDC to release my medical information to my personal physician(s), consulting physician(s), or health care provider as I so designate.

Insurance Authorization and Assignment of Benefits:

I authorize Humphreys Diabetes Center to release information to any third party payer named in my registration. This included medical or related information about my treatment, which is needed for the purpose of claims processing.

I authorize my insurance company, or any responsible third party to pay benefits directly to Humphreys Diabetes Center.

I certify that I have read and understand all of the above listed consents and disclosures

Patient Signature

Date

Lifetime Medicare Authorization

I request that payment of authorize Medicare benefits be made either to me, or on my behalf to the Humphreys Diabetes Center for any services furnished to me by their educators. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information required to determine benefits or the benefits payable for related services.

Patient Signature

Date

HUMPHREYS DIABETES CENTER

Financial Policy

PATIENT NAME: (PLEASE PRINT) _____

We are committed to providing you with the best possible care, and we will be pleased to discuss our professional fees with you. Your clear understanding of our financial policy is important to our professional relationship with you. Please speak with a billing representative if you have any questions about our fees, financial policy, or your responsibility. **Billing Office: 208-331-1155 extension 22 and 26.**

All patients must complete our “*Patient Information*” form before seeing an educator for the first time. In addition to furnishing your insurance information, we will need copies of your insurance card(s) and driver’s license. You will also be requested to furnish your social security number. It is important you understand that your insurance coverage is a contract between you and your insurance company, and that HDC is not a party to this contract. Please verify your insurance coverage for our services. We are not responsible to certify your coverage for the services we will provide.

As a courtesy to our patients, we will bill their primary insurance company one time; however, you are financially responsible regardless of insurance coverage or whether or not HDC invoices you. Depending on your insurance plan, we may not bill you until after we receive payment from your insurance. You are responsible for the timely payment of your account, although we will help you as much as possible. Also, it may become necessary for you, the patient, to follow up with your health insurance company in the event your claim is not paid in a timely manner after submission. You are required to pay all deductibles and/or co-pays at the time of your visit. It is unlawful for HDC to waive any co-payments or deductible amounts due.

Payment is required in full at the time of your visit if you do not have insurance coverage, if you choose to file your own insurance, or your insurance company sends payment directly to you. ***If you cannot afford to pay for our service, please request a financial aid form or payment plan. We do not refuse service due to inability to pay.***

PPO’S & HMO’S: If your insurance plan is one of our contracted insurance plans (PPO or HMO), you are required by your insurance plan, to pay your co-payment at every visit.

MEDICARE: We are a participating Medicare provider. As such, you are only responsible for your annual deductible plus 20% of the allowed amounts, due at the time of service, unless you have a supplemental Medicare policy. Please understand federal law requires us to collect any deductible and 20% of allowable fees. We are able to file most Medicare supplements for you; however, some companies will not pay us directly. In those cases, we appreciate your payment immediately following Medicare’s payment.

RETURNED CHECKS AND APPOINTMENT CANCELLATION: Returned checks are subject to a \$30.00 service fee payable by the patient. Cancellation of appointments will need to be arranged 24 business hours in advance by contacting HDC at 331-1155. If you fail to contact HDC to cancel your appointment, your account will be assessed a \$25.00 administration fee to cover the expense of administrative preparation for your appointment.

We find communication between our office and you, the patient, help us succeed in providing the best health care/education experience to you. Our financial policy is a communication tool and our commitment to assist you to the best of our ability. If you have special needs, please bring them to our attention immediately. Please advise us if your insurance company has pre-certification and/or prior authorization requirements and/or policy restrictions and limitations. For our mutual benefit, a copy of this form will be retained in your record.

I have read and understand the above. I understand that I am financially responsible for all charges regardless of third party involvement. I agree to pay any deductible, co-insurance, co-pay, or any service deemed as "non-covered benefit" by my insurance carrier at the time services are rendered. I understand that failure to pay outstanding balances within 90 days of notification of amount due will be sent to an outside billing service.

Payment arrangements may be set up with the billing service for a \$20.00 set-up fee and finance charge (1.0% per month/APR 12%). (*Medicare patients will not be charged the set-up fee or finance charge should they desire a payment plan*). If payment arrangements cannot be agreed upon, the amount due will be considered delinquent and may be subject to legal action or assignment to a collection agency.

In consideration for medical/education services rendered, I acknowledge that I have received notice of Humphreys Diabetes Center's financial policy and agree to pay for said services according to such terms.

Patient/Responsible Party Signature / Date Patient Name (Print Please)

Form: RWS73109

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