DGD Clinic
Diabetes & Glandular Disease Clinic, P.A.
LEADING THE SEARCH FOR BETTER HEALTH

Please note: A driver's license from at least one parent will be required for the first visit

Child's First: _____ Middle _____ Last _____

Sex: □ Male □ Female Date of Birth: _____ Nickname _____

Address of Child's Primary Residence: _____

City _____ State _____ Zip _____

Referring physician or PCP: _____

Telephone Numbers

- Primary phone (#1) is the one to be used first for messages and reminder calls. this does not have to be the home phone.
- Please list phone numbers in the order to be called

1(____)_____☐ Home ☐ Cell ☐ Work ☐ Other/Ext:_____ ☐ Mother Other: Name: _____
☐ Father Rel: _____

2 (____)_____☐ Home ☐ Cell ☐ Work ☐ Other/Ext:_____ ☐ Mother Other: Name: _____
☐ Father Rel: _____

3. (____)_____☐ Home ☐ Cell ☐ Work ☐ Other/Ext:_____ ☐ Mother Other: Name: _____
☐ Father Rel: _____

By providing us with your wireless or land line phone numbers, you are giving us your prior express consent to call those numbers for business purposes

Parent/Guardian Information

Mother's Full Name _____ **Date of Birth** _____/_____/_____

Social Security #_____-_____-_____ **Relationship:** ☐ Mother ☐ Foster ☐ Legal Guardian ☐ Step ☐ Other
Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Remarried ☐ Widowed
Address: ☐ Same as child _____City_____ST_____Zip _____
Employer _____ Phone (_____) _____
Occupation _____Email _____

Father's Full Name _____ **Date of Birth** _____/_____/_____
Social Security #_____-_____-_____ **Relationship:** ☐ Mother ☐ Foster ☐ Legal Guardian ☐ Step ☐ Other
Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Remarried ☐ Widowed
Address: ☐ Same as child _____City_____ST_____Zip _____
Employer _____ Phone (_____) _____
Occupation _____Email _____

Step parents' name(s), if applicable:_____
Custodial Parent, if applicable: _____

Emergency/Alternate Contacts

Full Name_____Address/City/Zip_____

Relationship _____Ph# _____

Financial Responsibility

Invoices/Statements should be mailed to ☐ Mother ☐ Father ☐ Other_____(must be listed above)

(Both parents or legal guardians are responsible for any charges regardless of where the statements are mailed)

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Insurance Information

Child's First: _____ Last: _____ Date of Birth_____

Primary Insurance

Cardholder's Full Name: First _____Last: _____

Social Security_____ Date of Birth: _____Relationship To Child _____

Address (if different than child's)_____

City _____ State _____ Zip _____

Phone _____ Work _____

Employer _____ Business Phone _____

Employers Address _____ City/State _____ Zip _____

Insurance Company _____ID# _____ Group# _____

Effective Date of Insurance _____

Secondary Insurance

Cardholder's Full Name: First _____Last: _____

Social Security_____ Date of Birth: _____Relationship To Child _____

Address (if different than child's)_____

City _____ State _____ Zip _____

Phone _____ Work _____

Employer _____ Business Phone _____

Employers Address _____ City/State _____ Zip _____

Insurance Company _____ID# _____ Group# _____

Effective Date of Insurance _____

PAYMENTS AND INSURANCE AUTHORIZATION / ASSIGNMENT OF BENEFITS

It is the policy of this office that all payments for medical services be made at the time of your visit, or before in some cases. This payment is required regardless of who brings the child in to be seen. In the case of separated or divorced parents, responsibility and payment shall belong to the guardian bringing the child in for treatment. For example, if parent # is financially responsible for medical expenses, and parent #2 is bringing that child in for treatment, payment will still be expected from parent # 2 at the time of service.

Initial _____ I understand and agree that regardless of what benefits are quoted, or misquoted, by my insurance company when you check my insurance status, I am ultimately responsible for any deductible, co-insurance/co-pays, or any other balance not paid by my insurance company. This includes services provided that the insurance company deems not medically necessary.
Initial _____ I understand that I must pay my co-pay or my co-insurance at the time of service, regardless of who accompanies my child to his/her visit. Without my co-pay or co-insurance, I may be charged a late fee.
Initial _____ I understand that I must pay my deductible responsibility, if I have one, at the time of service. If I cannot pay the entire deductible balance, a $50 deductible deposit will be required at each visit until my deductible has been met. If I request to be billed for a deductible balance, I must pay within 30 days, or I will lose the privilege of being billed. I will then be required to pay in full at each visit.
Initial _____ I must have proof of insurance at every visit or I will have to pay in full to be seen.
Initial _____ I understand that I am responsible for any costs incurred in the collection of my child's account in case of default, including reasonable attorney fees, court fees and agency fees.
Initial _____ I understand that bad checks are sent to Check Services, USA for which there will be a $30 charge from our office. Failure to pay the check and all fees could result in arrest and criminal prosecution.
Initial _____ I understand that cancellations are required 24 hours prior to the appointment. In the event that I fail to cancel a scheduled appointment, I will be billed $25.00. Excessive abuse of cancellations of scheduled appointments may result in discharge from the practice. Payment is due upon receipt of a statement from our office.

I hereby grant permission to Diabetes & Glandular Disease Clinic to release any pertinent information to my insurance company upon request, and I also authorize transfer of benefits to Diabetes & Glandular Disease Clinic. A photocopy of this authorizations shall be considered as valid as the original.

Signature_____ Print Name _____Date _____

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HIPAA Acknowledgment Form
PATIENT ACKNOWLEDGEMENT

Health Insurance Portability and Accountability Act (HIPAA)

Our clinic's Notice of Privacy Practice provides information about how we may use and disclose protected health information about you, the patient. The Notice contains a Patient Rights sections describing your rights under the law. You have the right to review our Notice before signing this acknowledgment. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office.

The Summary of our Notice of Practices is posted in our main lobby. The complete Notice of Privacy Practices is also available in our main lobby for your review. If you would like to receive a copy of the Summary and complete Notice, we have one available for you at the front desk.

If you wish for persons other than those released under normal operations, as indicated in the Notice, to receive confidential information that is now protected under this law, you must release them in writing. Please indicate on your patient registration form a spouse, or any family or friends whom you wish to be able to receive information about you. You may, of course, choose not to release anyone. You may also be more specific in your restrictions for the persons you have released, provided that the request is made in writing. Parents or Guardians of minors do not need to be released.

Please be aware that our staff must follow federal law on information that we release by phone. We may at anytime choose not to release information of any kind by phone if we deem the person requesting information is not authorized or that the information is too sensitive.

By signing this form, you are acknowledging that the Diabetes & Glandular Disease Clinic has made our Notice of Privacy Practices available to you for review and that we have offered you a personal copy.

Patient Name: _____ Date of Birth: _____

Signature: _____ Acct.# _____

This acknowledgment was signed by:

_____ Date: _____
Printed Name (Patient or Representative)

Relationship to Patient: _____
(if other than patient):

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AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Name of Patient/ Minor(s) MRN	DOB	Allergies/Special Conditions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby authorize the treatment of the above minor(s).

I give the following people permission to bring my child to his/her appointment if I cannot make it:

_____	_____	_____
Name	Address	Phone #
_____	_____	_____
Name	Address	Phone #
_____	_____	_____
Name	Address	Phone #

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence. I understand the listed person(s) above are the only authorized person(s) on file.

Patients under the age of 18 unaccompanied by parent(s) or legal guardian(s) or written authorization will not be seen.

This document shall be presented to a physician, dentist or appropriate hospital representative at such as unexpected medical, dental surgical care or hospitalization may be required.

_____	_____
Signature of Parent/Guardian	Date
_____	_____
Signature of Parent/Guardian	Date
_____	_____
Signature of Parent/Guardian	Date

Medical/Hospitalization Coverage for above Named Minor(s)

Insurance Company or Government Program ID or Contact #:
_____

Primary Physician Name: _____ Phone: _____

Patient Information

Welcome to the Diabetes & Glandular Disease Clinic. We appreciate the opportunity to care for you. The following information is provided for your benefit so that we may better serve you. Please read carefully and sign at the bottom. You will be given a copy for your records.

1. **PAYMENTS:** All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your visit. We accept cash, checks, Visa, MasterCard, and American Express, Apple Pay
2. **CANCELLATIONS:** If you need to cancel your appointment, be sure to call us at least 24 hours before your scheduled appointment. There will be a $65.00 administrative charge to all patients who miss their appointment and do not call to cancel or reschedule their appointment at least 24 hours in advance. This charge is not payable by any insurance company and understand that this will be your responsibility. If you cancel or reschedule your appointment without a 24hr notice, this may be considered a no show or missed appointment. After two missed appointments or no shows we may decide to terminate care.
3. **APPOINTMENT TIME:** We ask that our patients arrive on-time for their appointments. In an effort to serve all our patients well, patients arriving past their appointment time may be rescheduled. We require you to confirm your appointments by text message, email or by phone in order to ensure your appointment time, if your appointment is not confirmed you may be asked to be re assigned or rescheduled at time of arrival.
4. **HMO & PPO REFERRALS:** If your policy requires written authorization from your Primary Care Physician, we will request authorization in advance **for established patients only**. This is done as a courtesy for our patients; however, we cannot guarantee authorization will be granted. Please keep in contact with your physician to ensure your visit is pre-approved, to avoid having to make payment in full.
5. **CHANGE OF INFORMATION:** Please provide us with any change regarding your address, phone number or insurance information as soon as possible. Change of insurance will require the completion of a New Patient Information Form and may not be changed over the telephone.
6. **PORTAL MESSAGES:** All our patients have the capability to send a portal message to your provider or providers staff. Please know that if the provider feels the matter should be discussed in a visit to ensure proper time to review an issue you may be asked to schedule an appointment.
7. **MEDICATION REFILL REQUESTS:** At your office visit, your doctor will give you enough medication to last you until your next appointment. To request a refill, you can send us a portal message or call us at 210-614-8612. We will no longer accept electronic medication refills from pharmacies.
8. **AFTER HOURS CARE** ***In a life-threatening emergency, please call 911.*** For urgent non-emergency matters, please dial the main office number (210) 614-8612 and leave a message with the answering service. The physician-on-call will return your phone call as soon as possible.
9. **MEDICAL RECORD/ LAB RESULTS COPY REQUEST** Requests for copies of your medical records must be made in writing on a form provided by our office. Our office will respond within 15 business days to a properly completed written request. **FEES:** As per the rules adopted by the Texas State Board of Medical Examiners, our office will charge the following for copying your medical records:
    9.1. $25.00 for the first 20 pages, $.50 cents for each page thereafter, and the actual cost of mailing, shipping or delivery, if applicable.

9.2. Lab Results are available at no cost on DGD Clinic Patient's Portal. All Lab Result paper copy request will incur a $6.00 processing fee per visit.

9.3 Copies of medical records/ lab results will be retained until payment is received, unless requested by a licensed Texas health care provider or any American or Canadian licensed physician for acute or emergency medical care, or to support an application for disability or other benefits or assistance under Aide to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, Federal Old-Age and Survivor Insurance, or the Veterans Administration.

10. **COLLECTION AGENCY:** In the event of a delinquent account balance, you will be responsible for all collection fees assessed by the collection agency onto the account.
11. **STAFF SUPPORT:** The Diabetes and Glandular Disease clinic has a no tolerance policy for physical or verbal abuse from patients or family members/caretakers of patients. We understand the medical field can be very difficult but proper communication is needed for care. Any verbal abuse towards clinic staff, may result in ending the physician-patient relationship and you will be terminated from the practice.

"I, the Guarantor of Payment and Responsible Party, have read and agree to the above policies and terms regarding payment and payment responsibilities.

_____ _____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

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Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/ medical plan, to issue payment check (s) directly to Diabetes and Glandular Diseases Clinic, P.A., For medical services rendered to myself and/ or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by the insurance.

Authorization to Release Information

I hereby authorize Diabetes and Glandular Disease Clinic, P.A. to: (1) release any information necessary to insurance carrier(s) regarding my or my child's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Diabetes and Glandular Disease Clinic, P.A. on behalf of myself and/ or my dependents and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I have read and understand the Diabetes and Glandular Disease Clinic, P.A. Financial Policy. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentations of the appropriate statement. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the charge by the collection agency for costs of collections. A photocopy of this assignment is to be considered as valid as the original. I also understand and agree that the practice may amend such terms from time to time.

_____
Print Name of the Patient

_____ _____
Signature of Insured or Authorized Representative Date

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Patient's Name: _____ Age _____

Account No.: _____ DOB: _____

Emergency Contact Name & Telephone:_____

Child's Health History

(PLEASE PRINT)

Chief Complaint/ Reason for visit: _____

_____

_____

_____

Past Medical History:

(Please list all medical problems and approximate dates of onset)

_____

_____

_____

_____

Previous Hospitalizations, date and reason:

_____ _____

_____ _____

_____ _____

Birthing History

Pregnancy: _____ Delivery mode: Vaginal _____ Cesarean _____

Birth Weight: _____ Birth Length: _____

Breast or Bottle Fed: _____ Vaccinations: _____

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Patient's Name: _____

Medications

Name	**Dosage**	**Date Started**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Drug: _____

Food: _____

Social History

Pre-school, kindergarten or school _____ Grade: _____

Other activities and sports: _____

Smokers in household (please circle one) Yes No

Family History

Father: Age: _____ Height: _____ Health Condition: _____

Mother: Age: _____ Height: _____ Health Condition: _____

Health condition of siblings and other family members: _____

_____

_____

_____

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Patient's Name: _____

Review of Body Systems

(Please Print)

Please list any problems relating to the following:

Growth and weight gain, appetite: _____

_____

Energy level, heat/cold tolerance: _____

_____

Skin: _____

_____

Ears, nose and throat: _____

_____

Growth and weight gain, appetite: _____

_____

Vision: _____

_____

Neck: _____

_____

Chest, lung, and heart: _____

_____

Abdomen: _____

_____

Nervous system (headache, balance, gait): _____

_____

Urinary and bowel: _____

_____

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Patient's Name: _____

Menstrual Periods:

Age at onset: _____ **Frequency** _____ **Length** _____

Date of last period: _____

Sexually active: (please circle one) Yes No

Behavioral: _____
_____
_____
_____