TREASURE VALLEY METABOLIC MEDICINE

Patient Name: DOB:

Reason for visit:

Whom may we thank for referring you to our clinic?

☐ Billboard/Sign/Location ☐ Medical Provider ☐ Insurance Provider ☐ Newspaper/Magazine ☐ Radio
☐ Return Patient ☐ Television ☐ Website ☐ Family or Friend ☐ Other: ______________________

ALLERGIES: Circle **No Known Allergies** or complete below

MEDICINE	REACTION

SURGICAL HISTORY: Circle **NONE** or complete below

Surgery	Date	Location

MEDICATIONS: Circle **NONE** or complete below

Name	Dose	Frequency	Prescriber

TOBACCO USE: Circle

Yes	No	Quit Date:	How many years smoked:

ALCOHOL USE: Circle

Yes	No	Quit Date:

Amount per week/month

Patient Information

Patient Name *(Last, First Middle Initial)*	DOB *(Date of Birth)*	Sex ☐M*(Male)* ☐F*(Female)*

Email	Home or Cell Phone

Street Address *(Mailing Address)*	City, State, Zip

Guarantor Information

Guarantor Name	Guarantor Relationship to Patient	Guarantor Phone

Guarantor Address *(Billing Address if different than above)*	City, State, Zip

Guarantor SSN *(Social Security Number)*	Guarantor DOB *(Date of Birth)*	Other Information

Consent For Care and Treatment

I, the undersigned, do hereby agree and give my consent for TVMM, LLC to furnish medical care and treatment as considered necessary and proper in diagnosing or treating his/her physical and condition.

Benefit Assignment/ Release of Information

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payers to TVMM, LLC. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full, from you. Any unpaid balance after the first 30 calendar days of treatment accrues 1.5% interest each month thereafter. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes and internal usual and customary fee schedule, you will be responsible for the remaining difference.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to TVMM, LLC.

The above does not apply for those patients that are treated under Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that my account if paid within 90 days of my discharge will be interest free, after 90 days my account will be subject to a 12% interest (APR). If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Telephone Consumer Protection Act

I, the undersigned, do authorize Treasure Valley Metabolic Medicine and its designees to deliver messages containing account, marketing, or other non-health care messages to the phone number(s) identified above via an automatic telephone dialing system or an artificial or prerecorded voice. I understand that I am not required to agree to receive such automated calls and my agreement is not a condition to receiving items or services from Treasure Valley Metabolic Medicine. Treasure Valley Metabolic Medicine does not waive and expressly reserves the right to contact patient for any purpose as otherwise permitted by law.

Signature for all four consents listed above

Patient Signature or Guarantor Signature:	Date:
Print Name:	Date:

This document is Effective September 16th, 2019

Statement of HIPAA Compliance

HIPAA (Health Insurance Portability and Accountability Act) was signed into law on August 21, 1996. Public Law 104-191. This was designed to provide insurance portability, to improve the efficiency of health care by standardizing the exchange of administrative and financial data. It will also protect the privacy, confidentiality, and security of health care information. It affects all areas of the health care industry.

Treasure Valley Metabolic Medicine (TVMM) upholds the HIPAA objectives and is proactively enhancing our existing HIPAA compliance.

TVMM has committed to track and provide coordination, education, and communication for all HIPAA activities. This is for monitoring and verifying that all HIPAA efforts for readiness are proceeding successfully within our organization.

Our software programs have been reviewed in order to determine how to best assist our clinics and customers with their HIPAA readiness issues.

The complete text of the proposed and finalized rules, along with comments, is available at:
http:\\aspe.hhs.gove/adminsimp

If you have any further questions regarding TVMM's processes or HIPAA readiness issues, please the Front Office Coordinator.

When making your inquiry, please mention that you are requesting additional information,

May we leave detailed voicemails on your phone with medical information? (Circle) Yes No

May we release your medical information to family members? (Circle) Yes No

Patient Print Name ____ Patient DOB ___________________

Patient Signature ____ Today's Date _______________

Protected Health Information Release

Patient Name: ______________________________________ DOB: __________________

o Only release information to me personally.

o You DO NOT have my permission to leave information on my voicemail regarding my medical care and test results.

o You have my permission to speak with my spouse about my medical care and test results.

Name: ____ Phone number: ____________

o You have my permission to talk with my children or other family members involved in my medical care and test results.

Name: ____Phone number: _____________

Relationship: ____

Name: ____Phone number: _____________

Relationship: ____

Name: ____Phone number: _____________

Relationship: ____

o Other, please describe:

____

____

Emergency Contact:

Last Name: ____________________________________ First Name: _________________________

Relationship to Patient: ______________________________ Phone number: ______________________

Patient/Guarantor Signature:

____ Date: ___________________

No Show / Late Cancellation Appointment Policy:

This notice is to ensure that you are aware of the late cancellation/ no show policy at Treasure Valley Metabolic Medicine. We realize your time is valuable. TVMM will do everything to honor your appointment and provide incredible care to you during your time with us. In return, our expectation is you attend each appointment on time and please provide a minimum of 24 hours' notice when rescheduling or cancelling your scheduled appointment. This courtesy from you will allow us the ability to offer the appointment time to other patients that are seeking to schedule or may be on our wait list.

Not cancelling or rescheduling your appointment within this required time frame will subject you to the following policy:

1. First missed appointment we will provide a courtesy reminder call. We will review this policy with you during this phone call.

2. Second missed appointment you may be subject to a fee of 50.00 which would be collected prior to the next scheduled appointment.

3. Third missed appointment you may be subject to a fee of 150.00 or be discharged from the practice as a patient of TVMM. If you are subject to the 150.00 fee this would be collected prior to your next scheduled appointment.

We understand that unexpected scheduling changes can occur. Exceptions can be made for appointments late canceled or no showed do to matters out of your control. These exceptions may require documentation or letters as proof of the reasons you provide. Keeping your scheduled appointment and following the advice of your provider is critical to your success at TVMM.

My signature acknowledges that I understand TVMM's no-show and late cancellation policy, and I agree to pay the fees associated with such policy.

______________________________	____________________________________	__________
Signature	Printed Name	Date

**Unless specifically prohibited by our contractual agreement with your health insurance provider

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:		DOB:	
Phone (H):		Phone (W):	
Address:		City/State/Zip:	

Please Note: Copy Fee May Be Charged for Medical Records

Above listed patient authorizes all healthcare facilities to make record disclosure.

Dates and type of information to disclose:

- ☐ 2 years prior from last date seen
- ☐ Dates: ____________________
- ☐ Specific information requested: _________________________

The purpose of the disclosure is:

- ☐ Change of insurance or provider
- ☐ Continuation of care
- ☐ Referral
- ☐ Other: ___________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To:	Treasure Valley Metabolic Medicine		
Address:	951 E Plaza Drive, suite 110		
City/State/Zip:	Eagle, ID 83616		
Fax:	208-274-9581	Phone:	208-274-9580

- ☐ Please mail records
- ☐ Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: If I fail to specify an expiration date, event, or condition, this authorization will expire I year from the date signed.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization; I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provider in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Guarantor Signature: ____ Date: __________________