West County Diabetes and Endocrinology Center

1023 Executive Parkway Dr, Suite 2
Creve Coeur MO, 63141
Phone: 314-627-1627; Fax: 314-485-2374

HIPAA Privacy Rule of Patient Authorization Agreement
Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment.
- a means of communication among the health professionals who may contribute to my health care.
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were provided.
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement
Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent.
- That this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested.
- I have the right to object to the use of my health information for directory purposes.
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this Practice has already acted in reliance thereon.

Signature of Patient or Legal Representative Witness:

Print Patient Name: _____ Date: _____/_____/_____

Consent For Treatment

I hereby give permission for **Dr. Gurkiran Dhindsa** to give me Medical Treatment.

I allow the Practice to file for insurance benefits to pay for the care I receive.

I understand that:

- The Practice will have to send my medical record information to my insurance company.
- I MUST pay my share of the costs (Copays/Balances)
- I MUST pay for the cost of these services if my insurance does not pay, or if I do not have insurance coverage.

I Understand:

- I have the right to refuse any treatment.
- I have the right to discuss all medical treatments with my provider.
- I understand that if payment recovery services are required, all associated fees and interest are also my responsibility; 35% interest fee (This fee is charged by the collections company per their policy) if patient responsibility needs to go to Collections and including but not limited to reasonable attorney fees.

Consent To Obtain Patient Medication History

Patient Medication History is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers contribute to the collection of this history.

The collected information is stored in the practice medical records system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly to avoid potentially dangerous drug interactions.

It is important that you and your provider discuss all your medications to ensure that your recorded history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Over the counter drugs, supplements, and herbal remedies that you take on your own may not be included.

I give permission to allow my healthcare provider to obtain my medication history from my pharmacy, health plans and other healthcare providers.

Patients/Guardian Signature

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WEST COUNTY DIABETES AND ENDOCRINOLOGY CENTER
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Patient demographics

Name _____

Date of birth _____

Address _____

_____

Phone number _____

Email _____

Insurance name _____

subscriber ID _____

Current Primary Care Physician _____

Physician's office phone number _____

Physician's office fax number (if known) _____

Preferred pharmacy _____

West County Diabetes and Endocrinology Center

24-hour Cancellation & "No Show" Fee Policy
2023

Recognizing that everyone's time is valuable, and the appointment time is limited, we ask that you provide at least 24-hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, West County Diabetes and Endocrinology Center reserves the right for any missed (No Show) or cancelled appointments with less than 24 hours' notice, to charge a fee of **$50.00**.

Fees will be billed to the patient. This fee is not covered by insurance and **MUST** be paid prior to scheduling your next appointment. Multiple **"No Shows"** will result in termination from our practice.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____
Name

_____
Signature

Date: _____/_____/_____