BALANCE
DIABETES & ENDOCRINOLOGY

6533 Preston Rd Suite 100
Plano, TX 75024
P: (469) 277-2700
F: (844) 709-2941
W: www.bdendo.com
E: info@bdendo.com

Authorization for the Use or Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office at 6533 Preston Rd., Suite 100, Plano Texas, 75024.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands the following:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

I agree that Dr. Sindura K. Alloju, M.D., may request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefits payers for treatment purposes.

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Practice Policies

Welcome to Balance Diabetes and Endocrinology, office of Sindura K. Alloju, M.D. We strive to provide the highest quality of medical care. In an effort to foster a collaborative relationship, we ask that you accept some responsibilities as well. Please read the following policies and acknowledge your understanding be signing below.

All co-payments, deductibles and other fees are due at the time of your visit.

- We accept cash, checks, MasterCard, Visa and American Express.
- Be aware that Medicare and many insurance plans do not cover preventative or annual eye examinations. In such cases, you are responsible for payment.

Authorizations and Referrals

- As a courtesy, we will assist you with obtaining authorizations for your exams and testing. However, you are ultimately responsible for ensuring your visit is authorized prior to your appointment. If an authorization is not obtained, you must recognize that you will be held financially responsible for all costs, or your appointment may be canceled. The office will not retro-authorize vision plans after the appointment time.
- If you have an HMO and require referral or authorization, please call your insurance or primary care doctor before your appointment to verify if an authorization or referral has been processed. This includes all new patient consults/exams and follow up appointments.
- If you have PPO plan, your insurance will be billed as courtesy. You are responsible for any non-covered services, deductibles, or co-insurance amounts.

Please notify us at least 24 hours in advanced if you need to cancel or change your appointment time.

- If we know 24 hours ahead of time that you will not be able to make your appointment, then we will be able to accommodate another patient in your time slot.
- Failure to give us 24 hour notice will result in a fee charged to your account. That amount will be $50.00
- While we attempt to confirm your appointment a few days prior to your scheduled date, it is your responsibility to remember your appointment time and date.
- Repeated missed appointments or late cancellations will result in termination of our relationship with you.

If you have an outstanding balance, you must make a payment at time of visit.

- We ask that you make a payment on your outstanding balance at each visit
- We cannot schedule further care in the office if you do not make payments on your bill.

There is a fee to complete forms, including DMV, disability forms or letters.

- Please inform the office staff if you have any forms when you arrive, or by phone when you schedule an appointment.
- The length and complexity of the form or letter determines the amount of the fee ($10-$75)

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Co-payment Notice

Copays and Deductibles
Both of these are due at the time of service.

I understand that insurance does not typically cover the items detailed on this page, and I am personally responsible for payment of types of services.

Financial Responsibility

I, the undersigned below, request that payment of authorized medical insurance benefits be made on my behalf to Sindura K. Alloju, M.D., A Professional Corporation (Doing business at Balance Diabetes and Endocrinology) for services furnished to me by any provider associated with Balance Diabetes and Endocrinology). I authorize any holder of medical information about me to release to the appropriate medical insurance administration and its agents any information needed to determine benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other claim forms, my signature authorizes releasing the information to the insurer or agency shown.

If so determined by written contract between Balance Diabetes and Endocrinology and my medical insurer, then Balance Diabetes and Endocrinology accepts the charge determination of the insurance carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the medical insurance carrier. If no contract exists between Balance Diabetes and Endocrinology and my insurance, then I agree to accept full responsibility for the difference between the insurance reimbursement received by Balance Diabetes and Endocrinology and the charges for services rendered.

If I represent that I have medical insurance, I accept responsibility of all charges for services furnished to me by Balance Diabetes and Endocrinology in the event that is determined that I was not eligible or authorized to receive such services at the time of service.

If I provide insurance information that is incorrect or invalid, I accept responsibility of all charges for payment for services. I understand that at the time of service, I am responsible for payment in full of any copay, out-of-network visit cost, prior outstanding balances, deductibles, and coinsurances. If I do not pay the due balance at the time of service, I agree that a convenience fee of $40 will be added to my balance.

If I do not fulfill my financial obligation to Balance Diabetes and Endocrinology, I will be sent written invoices detailing my obligation by Balance Diabetes and Endocrinology LLC. At the discretion of Balance Diabetes and Endocrinology, my account may be referred to a collection agency for failure to clear an outstanding balance. If I am referred to collections, a $100 collections fee will be added to my balance due along with any costs (including attorney fees, courts costs, and filing fees) necessary to enforce collection of the amount due.

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Balance Diabetes and Endocrinology accepts cash, and credit cards. Personal checks are accepted from established patients and are never accepted for new patients. If a personal check is returned by the bank for any reason, I will be responsible for a returned check fee of $40.00, which includes the bank's returned check fee and office administrative cost for handling the returned check.

A copy of this policy is available upon request.

Consent for Treatment

I authorize, Sindura K. Alloju, M.D., to provide me with medical care consistent with reasonable and current community standards. (If patient is under 18 years of age - must be signed by parent and/or legal guardian)

Notice of Privacy Practices

We respect our legal obligation to keep private any health information that identifies you. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for additional services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose the health information for payments purposes are: asking you about health plans, or other sources of payment; preparing and sending bills or claims: and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use health information inside our offices for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

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USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, law allows or requires us to disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when state or federal law mandates that certain health information be reported for specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notice to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violation of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or suspected to be a victim of crime; to provide information about a crime at our office; or to report a crime that happened somewhat else
- disclosure to a medical examiner to identify a dead person tor to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for law national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures relating to worker's compensation programs;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OTHER USES AND DISCLOSURES

We will make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

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If we initiate the process and ask you to sign an authorization, form you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocation must be in writing. Send them to this office.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to this office at the address, fax or Email shown at the beginning of this Notice.

- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using Email to your address. We will accommodate these request if they are reasonable, and if you pay us for extra cost. If you want to ask for confidential communications, send a written request to the office at the address, fax or Email shown at beginning of this Notice.

- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to [permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advanced. If we deny your request, we will send you written explanation, and instructions about how to get an impartial review of your denial if one is legally available. By law we can one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to this office at the address, fax, or Email at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the correct information to persons who we know got the wrong information, and others to specify. If we do not agree, you can write a statement of your position, and we will included it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment to this office at the address, fax, Email shown at the beginning of this Notice.

- Get a list of the disclosure that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to

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one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to this office at the address, fax, or Email shown at the beginning of this Notice.

- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to this office at the address, fax, or Email shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it in our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or Email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have reviewed the following documents:

- **Authorization for the Use or Disclosure of Protected Health Information**
- **Practice Policies**
- **Co-payment notice**
- **Consent of treatment**
- **Notice of Privacy Practices**

And I have been provided an opportunity to obtain copies as desired.

Patient Name (Print): _____

Patient Signature: _____Date: _____