DIET OF HOPE INSTITUTE®

Dr. Gann's Diet Of Hope®

520-696-DIET (3438)

Welcome To Our Office

DATE _____ SOCIAL SECURITY # _____ BIRTHDATE _____

NAME _____
LAST FIRST

ADDRESS _____ HOME PHONE # _____

CITY _____ STATE _____ ZIP CODE _____

PERMANENT ADDRESS (IF DIFFERENT) _____

CITY _____ STATE _____ ZIP CODE _____

SEX M F (CIRCLE ONE) MINOR SINGLE MARRIED DIVORCED WIDOWED RACE _____ ETHNICITY _____

EMPLOYER _____ EMP. PHONE # _____

EMERGENCY CONTACT _____ PHONE # _____

REFERRING PHYSICIAN _____

DO YOU HAVE AN ADVANCE DIRECTIVE WILL? ☐ YES ☐ NO

PRIMARY INSURANCE

PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS AVAILABLE (PRIMARY, SECONDARY, ETC.)

PRIMARY INSURANCE COMPANY NAME _____

POLICY HOLDER _____ D.O.B. _____ REL. TO PT. _____

SUBSCRIBER ID # _____ GROUP # _____

SECONDARY INSURANCE

SECONDARY INSURANCE COMPANY NAME _____

POLICY HOLDER _____ D.O.B. _____ REL. TO PT. _____

SUBSCRIBER ID # _____ GROUP # _____

IF YOU WISH TO AUTHORIZE COMMUNICATION VIA THE PATIENT PORTAL PLEASE PROVIDE YOUR E-MAIL.

ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DIET OF HOPE INSTITUTE, ALL INSURANCE BENEFITS OTHER THAN TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, CO-PAYS, DEDUCTIBLES AND CO-INSURANCE THAT ARE NOT PAID BY INSURANCE, FOR SERVICES RENDERED TO ME.. I AUTHORIZE THE ABOVE NOTED OFFICE ANY INFORMATION REQUIRED TO SECURE THE PAYMENT OF BENEFITS.

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

Dr. Gann's Diet of Hope

Name: _____ D.O.B_____

To allow patients to easily access their statements and communicate with Providers we are glad to provide you access to our Patient Portal. Please provide your email address to gain access to your portal.

Email_____

We are also now confirming your appointment via text. Please let us know how you prefer to be contacted. If you prefer not to receive appointment reminders via text, please let us know which phone number you would like us to use to contact you.

Text YES_____ NO_____

PHONE NUMBER_____

Voice YES_____ NO_____

PHONE NUMBER_____

To update your preference in the future, please let our front office staff know

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment *

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify):

_____
_____
_____
_____

DIET OF HOPE INSTITUTE®

Dr. Gann's Diet of Hope®

Disease Management and Prevention

NO SURGERY-NO DRUGS-NO GIMMICKS

FINANCIAL RESPONSIBILITY

Insurance: We participate with many insurance plans. However, insurance plans change, so we ask you to know your benefits (co-pays, deductible, network, coinsurance, covered services, etc.) and to bring your insurance card to each visit. If your insurance changes please notify us before your next visit. If there is a lapse in insurance coverage, you will be expected to pay in full at the time of service for all appointments until insurance coverage is reinstated.

Copayments/Deductibles: It is your obligation to pay your co-payments and any outstanding balance at the time of service. Whoever brings the patient (mom, dad, grandparent, aunt, etc.) into the office is expected to pay at check-in. Some insurance plans allow us to collect a PCP copay, however, because insurance plans can change, if your insurance company decides to consider us a specialist you will be responsible for the difference. If you have a balance you will receive up to two consecutive statements from our office. If your bank returns your check to our office as unpayable there will be a $25 return check fee charged to you. If we haven't received full payment on your account after two statements have been sent, the account will be sent to an outside collection agency.

Claims Submission: We will submit your claims and assist in any way we can to get them paid. Your insurance company may need additional information from you directly. Please provide this information promptly. Please be aware, any unpaid balance (copays, deductibles, coinsurance, and non-covered services) is your responsibility.

Cancellation/No Show Policy for New Patients: Due to the large block of time needed for New Patients, last minute cancellations can cause problems and added expenses to the office.*If a New Patient appointment is not cancelled at least 24 hours in advance, or you no show, you will be charged a two hundred and fifty dollar ($250) fee; this will not be covered by your insurance company.

Cancellation/No Show Policy Follow Up Appointments: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointmet, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. *If an appointment is not cancelled at least 24 hours in advance, or you no show, you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

I have read this document and agree to the terms of financial responsibility.
I understand my responsibility for payment to Dr. Gann's Diet of Hope and have been given the opportunity to ask questions about it. If additional information is needed to ensure insurance coverage, I will provide it in an accurate and timely basis.

_____ _____

Signature of Patient or Legal Guardian **Date**

DIET OF HOPE INSTITUTE®

Dr. Gann's
Diet of Hope®

Disease Management and Prevention
NO SURGERY-NO DRUGS-NO GIMMICKS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME:_____DATE OF BIRTH:_____

ADDRESS:_____CITY/STATE/ZIP_____

TELEPHONE:_____SOCIAL SECURITY #:_____

PURPOSE OF CONSENT: Under Federal Privacy Laws and as stated in our NOTICE OF PRIVACY PRACTICES, we may use your protected (personal) health information for treatment, payment activites and healthcare operations. You have either requested we disclose your protected health information to someone outside our immediate healthcare associates or the information needs to be disclosed to an entity not automatically covered under the current rules. **Reasonable fees may be charged for duplication of information or test results. You will be informed of any fees prior to duplication.**

I request the following restrictions to the use of disclosure of my health information:
Medical information can be discussed with:

- □Patient Only
- □Family Member or Friend:_____
- □Other:_____

A detailed message regarding health information may be left on my voicemail:

□ Yes
Phone Number:_____
□ No

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation and sending it to us.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices. We reserve the right to change our Privacy Practices and post new Privacy Practices that may or may not affect your consent.

I, _____ have had the full opportunity to revirew the contents of this Consent form and have received a copy of the Notice of Privacy Practices. I understand that by signing this Consent form, I am authorizing thos healthcare practive to disclose my protected health information as stated above.

_____ _____ _____

SIGNATURE OF PATIENT OF LEGAL RESPRESENTITIVE RELATIONSHIP TO PATIENT DATE

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT