Diabetes and Endocrine Care of Virginia, LLC
"Excellent care always"

Diabetes and Endocrine Care of Virginia, LLC
9001 Digges Road Suite 101
Manassas, VA, 20110
P:571-363-3082 F:844-634-2547

NEW AND ESTABLISHED PATIENT POLICY

We welcome you to our practice. We strive to provide quality care in a pleasant, comfortable atmosphere . We have found that an important part of your comfort is a clear understanding of the financial aspects of Diabetes and Endocrine Care of Virginia. We will do our best in advance of each procedure to work out satisfactory arrangements to handle the cost of your future treatment arrangement. **Please read the following and Initial each one of them.**

_____ We offer financing through a financial institution (3 months maximum), that will allow you to make interest free monthly payments, in order to help you to get your treatment completed. No Show or late arrival policy fees do not apply in this case.

_____ Although Insurance can be helpful in covering some costs, please be aware that almost all insurance plans only cover a certain percentage under Endocrinology Specialists treatment. This will inform you, the patient, responsible for non-covered services, copays, coinsurance and deductibles. We encourage you to know and understand your benefits and limitations before receiving any services including if your treatment needs a referral Prior your treatment.

_____ Although my primary care physician or other specialist Doctor referred me to this facility, I understand that I am fully responsible for verifying that my insurance will cover these services prior to my treatment by calling my insurance company.

_____ I understand that this office cannot accept any retroactive or expired referrals after receiving my treatment. Any unpaid amounts from the insurance are the patient's responsibility.

_____ I understand that I will request my prescription refills 5 business days before running out of medicines. I will also inform the Doctor of what refill medicines will be needed during my visit. Additional fees may apply for late requests.

_____ I understand that if I request a hard copy of my record such as; past visits, lab orders, cd's, imaging results it would be a fee of $25.00. **No fees would be applied if you would like to receive it by email.**

_____ I am responsible for informing the Front desk Staff of any changes on my Insurance Policy, address, phone number, preferred pharmacy and Laboratory Centers.

_____ I understand that the provider would not be able to prescribe my refills for my treatment if I am overdue for a visit (12 months). I am informed that I will need to request my medicines with my primary care physician until I schedule an appointment and be seen by the specialist Doctor.

_____ A reserved appointment time in our office is valuable, therefore we require a **24 hour notice** to cancel/reschedule an appointment. Failure to give 24 hours advance notice will result in a minimum charge of **$25.00. The office staff will not provide an appointment unless this amount is paid in full.**

_____ I certify that I have received a copy of the No-Show Policy. **(placed at the end of the paperwork).**

We hope that this explanation of our financial and new patient policy will assist you in feeling comfortable about this important aspect of your care. We look forward to a long and happy relationship with you in our practice. If you have any questions regarding our policy or your account, Please do not hesitate to discuss it with us. Your cooperation is deeply appreciated. Thank You.

Signature X_____ Date:_____

Print Name X_____

Please verify the front and back of each paper →

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Patient Information Form

1.Last N.		**2.Name:→**	
2.Middle N.		**3.Preferred name**	
4. Sex→	**❑ F ❑ M**	**5.Day of Birth→**	(mm, dd, yyyy)
6. Marital Status	**❑Single ❑Married ❑Widowed ❑separated ❑other**	**7. Language:→**	**❑English ❑Spanish ❑other:_____**
8. SOCSEC.	(only for out of pocket services)	**9. Cell Phone:→**	
10.H.Phone		**11. Work phone:→**	
12. Address:			
13. ZipCode:		**14. City:→**	
15. Contact preference	**❑Home ❑Cell Phone ❑Work ❑Portal ❑Mail**	**16. Would you like to receive text messages or reminder calls?→**	**❑Text ❑Call ❑BOTH**
17.E-mail:* →		**18.Emergency Contact**	**Name: Phone: Relationship:**
19. Where do you prefer to receive laboratory results?→		**❑Mail ❑Patient portal account (email required)***	

20. Person authorized to receive my private information *(only to request or reschedule appointments):*	Name: Relationship: Phone:
21.Referring providers name:	Name: Phone:
22. Preferred Pharmacy:	Name: Phone:
23. Preferred Laboratory:	Name : Phone:

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Authorization for Release of Medical/Billing Information
((((Historical Medical Record Request))))

Patient Name:_____ Patient DOB:_____

Patient Address:_____

Phone number:_____

I authorize, (Facility name, doctor or person who refers me to this office (Please write the NAME OF THE PHYSICIAN here→),_____, to release my Protected Health Information (PHI) to:Diabetes and Endocrine Care of Virginia, LLC FAX: 844-634-2547

Via (please circle one):→ (mail) (fax) (hard copy) (Verbal Exchange)

Please specify information to be released (please check-mark one):

- ❑ Medical records (all including other providers records on file, HIV test and results and mental health provider's notes)
- ❑ Clinical notes
- ❑ Immunization records
- ❑ Laboratory or X ray reports
- ❑ Other:_____

Mental health provider's notes
HIV test and results
Billing statements

This authorization is valid until _____. Unless otherwise specified, this authorization is valid for 90 calendar days after the date of signing this form.

It is prohibited by law to release/disclose information to anyone except those specified above and under the circumstances mentioned on your Notice of Privacy Practices.

X_____
Signed (Patient or Other Person authorized to Act for Patient) Date: Time:

X_____ _____ _____
Print Name Witness Name Signature Witness

Please verify the front and back of each paper →

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NOTICE OF RELEASE OF BILLING INFORMATION

I,_____ (patient's name) hereby authorize Diabetes and Endocrine Care of Virginia, LLC to disclose any and all written information from my primary insurance company _____, and my secondary insurance (if any) _____ and/or its designated representatives, at the determination of Diabetes and Endocrine Care of Virginia, LLC. Such disclosure shall be for reimbursement purposes for those services received.

I certify that I (or my dependent(s)) have active and valid insurance coverage as supplied above. I have supplied or will supply Diabetes and Endocrine Care of Virginia, LLC with an up-to-date and correct insurance identification card(s) as well as all necessary information regarding the guarantor of the insurance policy(ies) and the necessary information regarding the subscriber(s) eligible for insurance benefits which is required to submit medical claims for reimbursement. Failure to provide an update to any of the information supplied within may result in denial of payment(s) to Diabetes and Endocrine Care of Virginia, LLC and I understand that it will be my responsibility to pay Diabetes and Endocrine Care of Virginia, LLC for those medical services rendered to me or my dependent(s). I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that Diabetes and Endocrine Care of Virginia, LLC will report to commercial credit bureaus and may turn over my account to a collection agency when it becomes delinquent. Accounts having no payment within 60 to 90 days of the initial debt may be considered delinquent for payment purposes.

I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits. I release Diabetes and Endocrine Care of Virginia, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above named insurance company(s) or their designated representatives. I understand that I have the right to revoke this authorization at any time as long as I do it in writing.

X_____
Signed (Patient or Other Person Authorize to Act for Patient) Date: Time:

X_____
Print Name:

_____ _____
Relationship to patient Witness (Name and Signature) Date: Time:

Please verify the front and back of each paper →

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NOTICE OF PRIVACY PRACTICES

Diabetes and Endocrine Care of Virginia, LLC has provided me with a copy of the Notice of Privacy Practices. The HIPAA Notice of Privacy Practices explains your privacy rights and how we may use and disclose your protected health information.

If you have any questions about the information described in the HIPAA Notice of Privacy Practices, please contact the Privacy Officer at 571-363-3082.

I certify that I have been provided with a copy of the Notice of Privacy Practices.

X_____
Signed (Patient or Other Person authorize to Act for Patient) Date: Time:

X_____
Print Name:

_____ _____
Relationship to patient Witness (Name and Signature) Date: Time:

Please verify the front and back of each paper →

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9001 Digges Road, Suite 101
Manassas VA 20110
Dr. Alejandro Santos Leal M.D.

Policy for New and Established Patients

Cancellation/No Show Policy for Doctors Appointment:

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 appointment, you may be preventing another patient from utilizing that time. 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.

PLEASE NOTE:

- **Patients that can't keep their appointment, we request to reschedule your appointment within 24 hours, by calling us or by visiting our patient portal during business days. Holidays will not be considered business days.**
- **All patients will be seen in the order they were scheduled.**
- **If a patient is 10 minutes past their scheduled time, a $25.00 fee will be charged and they will be asked to reschedule the appointment.**

Appointment No-Shows and late arrivals (Missed Appointments)

Will result in a letter and a **$25.00** fee. We want to emphasize that the insurance company will not pay the No-Shows or Late Cancellations. This is a full responsibility of the patient.

- Medicaid Subscribers are not subject to this charge. However, it will be penalized for termination of services on the third No-Show. This will be solely based on the doctor's discretion.
- We will require that patients with balances of No-Show Policy pay their account balances to zero ($0.00) prior to receiving further services by our practice.
- The office Staff is not authorized to provide an appointment unless this fee is paid in full.
- Payment checks are subject to be reflected 15-20 days in the electronic medical record. This means that the office staff cannot proceed and give you an appointment unless your payment appears in the electronic medical record (EMR).
- The third No-Show - Will result in termination of physician-patient relationship, this will be determined by the doctor.
- Any new patient who fails to show for their initial visit, will reschedule for the next available appointment.

Please note, so that there is no misunderstanding:

- **If you consistently cancel within 24 hours or do not show up for your appointment, you will only be able to make appointments on a day-of basis.**
- **We reserve the right to determine what constitutes an urgent sick visit.**

Please verify the front and back of each paper →