



PATIENT & BILLING INFORMATION

Phone (866) 710-7679

Fax (800) 218-7670

1. Patient Information *(Please fill out)*

Name		
Address		Apt. #
City	State	Zip
Home Phone		Alt. Phone
SS#		Birth Date
Email		

2. Shipping Information *(complete if different)*

Name		
Address		Apt. #
City	State	Zip
Special Instructions if any		

3. Primary Insurance Information

Company		Phone	
Address			
City	State	Zip	
Phone			
Subscriber		Relationship to Insured	
Policy Number		Group Number	

4. Secondary Insurance Information

Company		Phone	
Address			
City	State	Zip	
Phone			
Subscriber		Relationship to Insured	
Policy Number		Group Number	

VISA

 MASTERCARD

 AMEX

 CHECK/MONEY ORDER

Card Holder _____ Amount _____
 Card # _____ Expiration Date _____

I understand that services rendered by Direct Medical Inc. are separate from my referring physician's services and may or may not be covered by my insurance policy. I understand that benefits quoted by my insurance company are not a guarantee to pay and that assignment of insurance benefits does not guarantee my insurance company will provide coverage. I further understand that all costs of supplies and services not paid by my insurance carrier will become my responsibility. If litigation or collections is necessary to collect unpaid debts, the undersigned agrees to pay for all costs incurred.

I agree to use all products only in the manner for which they were intended and not to attempt to make any modifications or changes of any kind to the product. These products are prescription only and are to be utilized only as directed by my physician. I agree to hold Direct Medical harmless on all liabilities for all products.

I understand that all items are single patient use only. Items are refundable within 30 days of purchase, if returned unopened

Patient's Guardian (patient under 18)

Patient's and/or Insured's Signature **X** _____ Date _____

For office use only:

NOTICE OF HEALTH INFORMATION AND PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Direct Medical Inc., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 4/14/03 and applies to all protected health information as defined by federal regulations.

Each time services are provided to you by Direct Medical Inc., a record of these services is made. Typically, this record contains your diagnoses, treatment and billing information. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A source of data for our planning and marketing, and --
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Although your health record is the physical property of Direct Medical Inc., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request, Inspect and copy your health record as provided for in 45 CFR 164.524, Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Direct Medical Inc. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact us at (877) 493-7092. If you believe your privacy rights have been violated, you can file a complaint with our practice, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I, _____, understand that as part of my healthcare, Direct Medical Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, and treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A source of information for applying my diagnosis and surgical information to my bill, and
- A means by which a third-party payer can verify that the services billed were actually provided

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Direct Medical Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Direct Medical Inc. reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Direct Medical Inc. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail, or if I agree, email.)

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax, telephone, U.S. Mail and electronic mail.

Patient's Signature _____

Date _____