DIABETIC SUPPLIES INTERNATIONAL, INC.
PO Box 629 South Sutton, NH 03273-0629
1-800-799-9974 | DSI@dsidiabeticsupplies.com

Patient Intake Form

Date: _____

Patient Name: _____

Mailing Address: _____

Shipping Address (if different): _____

City: _____ State: _____ Zip: _____

Phone: _____ Type: ○ Cell ○ Home ○ Work

Email: _____

Patient Date of Birth: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

Does the patient take insulin? ○ Yes ○ No

Insurance Information

Name of Insured: _____

Insured's Date of Birth: _____

Primary Insurance: _____

Provider Phone (back of card): _____

Policy Number: _____

Secondary Insurance: _____

Provider Phone (back of card): _____

Policy Number: _____

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Doctor Information

Doctor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Supplies

Please select the supplies you are interested in receiving and indicate which system you will be using.

☐ CGMS:

○ Dexcom G6 ○ Dexcom G7 ○ Freestyle Libre 2 ○ Freestyle Libre 3

☐ Receivers/Readers ☐ Sensors ☐ Transmitters

☐ Pump Supplies:

○ MiniMed ○ Tandem

Infusion set #: _____ Reservoir/Cartridge #: _____

☐ Testing Supplies:

○ Accu-Chek Guide ○ Contour Next ○ EasyMax

○ OneTouch Ultra ○ OneTouch Verio

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Policy Revised: November 16, 2021

Notice of Privacy and Confidentiality Practices

1. We may use and disclose your protected health information to a healthcare provider providing treatment to you.
2. We may use and disclose your protected health information to insurance companies in order to obtain payment for products and services we provide to you.
3. We will not use your protected health information for marketing communications without your written authorization.
4. We may use or disclose your protected health information when we are required to do so by law.
5. We may disclose your protected health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence.

Patient Rights

1. You have the right to be informed in advance about services to be provided, specific limitations on those services, and any modifications to your plan of care. You have the right to participate in the development and revisions of your care plan and to receive appropriate care without discrimination in accordance with physician orders.
2. You have the right to be fully informed of your responsibilities, to refuse care at any time, and to choose a health care provider, including choosing an attending physician.
3. You have the right to be informed, both orally and in writing, in advance of care being provided, and of the charges, including payment for services expected from third parties and charges for which you are responsible. You will also be informed of any financial benefits when referred to an organization.
4. You have the right to be treated with respect and dignity, be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of property.

5. You have the right to voice grievances and complaints regarding treatment, lack of respect for property, or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal, and to have such complaints investigated.
6. You have the right to review or obtain copies of your protected health information through a written request, with limited exceptions.
7. You have the right to confidentiality and privacy of all information contained in your records and to receive a list of instances in which we disclosed your health information within the last six years, other than those made for treatment, payment, or healthcare operations.
8. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree, but if we do, we will abide by our agreement, except in an emergency.
9. You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations.
10. You have the right to request in writing that we amend your health information. You must provide a satisfactory reason why the information should be amended.
11. Contact information for the office of attorney general for NH:
    a. Phone number: 1-888-468-4454
    b. Email: DOJ-CPB@doj.nh.gov
12. Contact information for the Accreditation Commission for Health Care:
    a. Phone number: 1-855-937-2242
    b. Email: customerservice@achc.org

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. We support your right to the privacy of your health information and we will work with you to resolve any concerns you may have.

Medicare DMEPOS Supplier Standards

The products and/or services provided to you by Diabetic Supplies International are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained from the U.S. Government Printing Office website. Upon request we will furnish you a written copy of the standards.

(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-D/section-424.57)

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Patient Release Form

Dear DSI Patient,

Thank you for contacting Diabetic Supplies International. This form gives DSI permission to contact your doctor and bill your medical insurance. Please provide your signature in order to start receiving services and keep a copy for your records.

Terms:

- Supplies will be billed to your insurance and shipped either: (1) on a regular quarterly basis OR (2) when you call to request a shipment.
- You are responsible for your yearly deductible and coinsurance if applied to your supplies.
- You are responsible for informing DSI of any changes in insurance coverage.
- Please contact DSI immediately if your insurance company directs a payment to you in error. All payments for supplies and services should be paid directly to DSI by your insurance company.
- Unwanted supplies must be returned within 15 days for credit.
- You may cancel services at any time.

Your signature below indicates your understanding of the above terms and receipt of DSI's notice of patient rights and responsibilities, privacy and confidentiality practices, and supplier standards.

Release of Payment and Medical Information

I authorize payment of medical benefits to this provider for supplies and services. I also authorize the release of pertinent medical information required by my insurance company to process claims.

Patient signature (Parent or Legal Representative if applicable)	Date	Printed name

Emergency contact	Emergency contact phone number

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Information about Email Communication

You may fill out the following form by hand and return it through the mail, or email DSI@dsidiabeticsupplies.com to receive an electronic version of the form.

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires providers like DSI to protect patient health information.
- Email is an appropriate manner of communication with patients as long as reasonable precautions are taken to protect patient privacy.
- DSI uses TLS encryption to protect electronic protected health information (ePHI).
- Most major email service providers (such as Gmail, Yahoo, Outlook, etc.) support TLS encryption.
- Patients using noncompliant email services may not be able to use this service, but many compatible services provide free accounts that can be used to contact DSI at any time.
- Even with encryption, there is always some risk involved with electronic communications.
- DSI will continue to use mail, telephone, and fax services for certain purposes and for patients who prefer not to communicate electronically.
- Once electronic information has been transmitted, the patient is responsible for maintaining privacy. Always be aware when accessing private information in public and use safe data practices.
- Patients may revoke consent to use email services at any time by contacting DSI through a preferred communication method.

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Email Consent and Communication Preference Form

Please indicate whether or not you'd like to communicate with DSI through email.

Allow Email Communication

I understand and accept the risks of electronic communication and give permission for Diabetic Supplies International, Inc. to contact me through email with personal information regarding our services.

_____	_____	_____
Patient signature (Parent or Legal Representative if applicable)	Date	Printed name

_____
Email address

Do Not Allow Email Communication

I do not give permission for Diabetic Supplies International, Inc. to contact me through email.

_____	_____	_____
Patient signature (Parent or Legal Representative if applicable)	Date	Printed name

Please indicate which method of communication you would prefer for DSI to use if we need to reach out to you with questions or information.

Email	**Mail**	**No Preference**
Telephone (Mon-Fri, 10-4)	**Fax**	