Mid-Missouri
DIABETES & ENDOCRINOLOGY

Sean Hamlett, DO, FACOI
1205 West Broadway
Columbia, Mo 65203
Ph: (573)355-0929 Fax: (573)234-6301
www.midmodiabetes.com

Patient Information

Date_____

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex**: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Asian/Pacific Isl. ☐ Hispanic ☐ Other: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Email Address: _____

Birth Date: _____ Age: _____ Social Sec. No: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Emergency Contact

Emergency Contact: _____ Relationship: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Responsible Party or Bill-To Information

Is this visit Workers Comp. related? _____

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

How Did You Learn About Us?

☐ Internet ☐ Physicians Referral Service ☐ Friend/Relative

Referring Physician Name: _____ Phone: (_____)_____

Name_____ DOB _____

Please provide complete insurance information.
Please have your insurance card(s) available. We will need to copy them for your file.

All HMO's and some group plans require prior authorization for each office visit or service. You are responsible to see that you have the proper authorization. Please remember, if we do not receive the authorization, you are responsible for all fees, regardless of insurance coverage.

Primary Insurance Information

MEDICARE PATIENTS: Are you covered for Part B? Yes No

Medicare ID#:_____ Effective Date: _____

Name of Insurance: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____ Policy ID #: _____

Group #: _____ Soc. Sec. #: _____

Effective Dates: _____ Insurance Phone: (____)_____

Is your insurance through your employer? ☐No ☐Yes If yes, employer: _____

ARE YOU USING YOUR VA BENEFITS INSTEAD OF PRIVATE INSURANCE? Y or N

Is this an HMO? If so, please provide the name of your primary care physician (PCP) below:

Dr.:_____ Phone: (____)_____

Does your insurance have a co-pay? ☐ No ☐ Yes If yes, $ _____

Secondary Insurance Information

Name of Insurance: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____ Policy ID #: _____

Group #: _____ Soc. Sec. #: _____

Effective Dates: _____ Insurance Phone: (____)_____

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Medical History

Name: _____ Date of Birth: _____

Pharmacy: _____

Address: _____ City, State_____

MEDICATIONS: List medications (include dosage and frequency)	
Currently Taking	**Dosage & Frequency**

List any allergies or side effects to medications or other substances:

_____

_____

What is your occupation? ☐ Retired ☐ Disabled ☐ Unemployed ☐ Student ☐ Employed

If employed, current employer_____

_____

Have you been immunized for:

Influenza NO YES Year: _____

Pneumovax NO YES Year: _____

Name_____ DOB _____

Please indicate any illness or condition YOU have had:

	Illness / Condition	Approximate Date of Onset
	Asthma	
	Bleeding Tendency	
	Cancer	
	COPD / Emphysema / Chronic Bronchitis	
	Diabetes	
	Glaucoma	
	Heart Trouble	
	High Blood Pressure	
	Kidney Disease	
	Pneumonia	

PAST SURGERIES	
YEAR	SURGERY

Social History

Tobacco Use: ☐ No ☐ Current User ☐ Former User Packs per day _____ Length of use _____

Alcohol Use: ☐ No ☐ Yes – Explain: _____

Caffeine Use: ☐ No ☐ Yes – Explain: _____

Please indicate if one of the following relatives has (or had) one of the following illnesses:

	Diabetes	Cancer	Stroke	Kidney Disease	Heart Disease	High Blood Pressure
Mother						
Father						
Sister						
Brother						
Aunt						
Uncle						
Child						
Grandparent						

Females Only	
Onset of last menstrual period:	Periods are: Regular Irregular
Number of Pregnancies:	Oral Contraceptives? Yes No
Males Only	
Date of last Prostate Exam:	

HIPAA Notice of Privacy Practices

Revised 2024

Effective as of 3/1/2024

Mid-Missouri Diabetes & Endocrinology
1205 West Broadway
Columbia, MO 65203
(573) 355-0929

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party including but not limited to physicians, pharmacies, nursing homes, and other clinics or hospitals involved in your care. For example, your protected health information may be provided to a physician who you see to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Or, if a pharmacy requests your information to obtain a prior authorization for supplies, we may send that to them.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most

psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Pamela Dodge	(573) 355-0929	pdodge@nhacolumbia.com
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Mid-Missouri
DIABETES & ENDOCRINOLOGY

We are required to maintain the privacy of your medical information. We are also required to follow the terms of this Notice of Privacy Practices. The most current copy of the notice will be available to you at your next appointment following its implementation or by calling the office manager at (573) 355-0929 and requesting one be sent to you by mail. The most recent version of the notice will also be posted in the waiting area of this medical office.

☐ **By checking this box you are allowing Mid-Missouri Diabetes & Endocrinology to download your medication history from your pharmacy. The purpose is to have the most current medication information for the best continuity of care**

Signature below acknowledges that you have received our Notice of Privacy Practices:

Print Name: _____

Signature: _____

Date: _____

Consent to Treat

I hereby authorize Mid-Missouri Diabetes & Endocrinology, and/or any physician or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

Assignment of Benefits and Authorization to Release Medical Information

I request that payment of authorized benefits (Medicaid, Medicare, and/or insurance companies) be made either to me or on my behalf to Mid-Missouri Diabetes & Endocrinology, for any services furnished to me by that physician supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, Center for Medicare and Medicaid services, insurance companies, and/or agents of these companies, and/or listed responsible person(s), any information needed to determine these benefits or the benefits of related services.

Signature _____ Date _____

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Patient Authorization to Release Medical Information

This Authorization grants permission to the person(s) named below to:

	make or confirm appointment
	have access to x-ray, laboratory, or test findings
	receive telephone communication and answering machine messages or other common means of communication
	pick-up sample medications or prescriptions
	pick-up lab requisitions
	be aware of my diagnosis, prognosis, and treatment plans
	have access to my health-related financial information

I hereby authorize Mid-Missouri Diabetes & Endocrinology to disclose my protected health information as described above. I understand that this authorization is voluntary. Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

PATIENT NAME: _____ ***SS#:*** _____

Name:	Relationship:
Address:	Phone:(H#) (C#) (W#)

Name:	Relationship:
Address:	Phone:(H#) (C#) (W#)

Name:	Relationship:
Address:	Phone:(H#) (C#) (W#)

_____ _____
Signature of Patient or Patient Representative Date

Effective for the lifetime of the patient, unless revoked. You may revoke or terminate this authorization by submitting a written revocation to our office.

Mid-Missouri
DIABETES & ENDOCRINOLOGY

1205 West Broadway
Columbia, MO 65203
Phone: 573-355-0929
Fax: 573-449-1787

Authorization to Release Medical Records

DATE: _____

*PATIENT: _____

*DOB: _____ *Social Security #: _____

I hereby authorize Mid-Missouri Diabetes & Endocrinology – Dr. Sean R. Hamlett:

____ To Obtain From: _____

_____

_____

Medical records, including below, regarding the diagnosis and records of any treatment or examination rendered to me including, but not limited to HIV related information, mental health records, and substance abuse records.

Time Period: _____Past 0-1 yrs. _____ Past 2 yrs. _____ Past 5yrs. _____Other

____ Physicians Progress Notes
____ Hospital Records – ALL
____ Operative Notes
____ Consult Notes
____ History & Physical
____ Discharge Summary
____ Labs
____ Other _____

For the purpose of: ____ continuity of care _____ transfer of care _____ referred

I release you from all legal responsibility or liability that may arise from the release of this information. I know that I have the right to revoke this release at any time. To revoke this release, I should contact the Office Manager for this office. I also know that this is subject to re-disclosure. I agree that these provisions will remain in effect until I provide written revocation. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

*Signature of Patient/Legal Guardian: **X** _____

Witness: _____ Date: _____

If we have requested medical records and there is a charge for them, please call our office for approval before making the copies.