



To schedule please call  
Karen DeLozier @ 817-849-8296  
or email @ [kdelozier@mcnt.com](mailto:kdelozier@mcnt.com)

### Locations available:

Arlington South  
811 W. I-20, Suite 120  
Arlington, TX 76017

Ben Hogan Center  
800 Fifth Ave, Suite 300  
Fort Worth, TX 76104  
(parking fee during the week)

Carrollton Family Practice  
4360 N. Josey Lane  
Carrollton, Texas 75010

Denton R&E  
2501 Scripture, Suite 300  
Denton, Texas 76201

MacArthur  
6750 N. MacArthur, Suite 305  
Irving, Texas 75039

Plano Internal Medicine  
4108 W. 15<sup>th</sup> Street, Suite 200  
Plano, Texas 75093

## Welcome to the Diabetes Self-Management Training Program

Your physician has referred you to this program, and we are committed to helping you understand how diabetes can affect your health and how you can more effectively manage the disease to reduce your risk of complications.

The Diabetes Self-Management Program is recognized by the **American Diabetes Association** and is structured to help you learn how to manage your diabetes, reduce your risk of complications, and enjoy life to the fullest.

### ***Please bring the following items with you to your first appointment:***

- 1. Completed assessment form.**
- 2. Your meter and logbook (if you do not have a meter, we will help you obtain one).**
- 3. Your correct co-pay (co-pays will be collected at the beginning of each session).**

**Before your appointment you will need to: Double-check your insurance benefits by calling the number on the back of your insurance card. Be sure to ask if you have benefits for diabetes education as well as medical nutritional therapy. If yes, then ask what your responsibility would be.**

Please note that our appointments are at least one hour. We have dedicated that time slot especially for you, so if you must reschedule, **please give us 48-hours notice to avoid the \$25.00 no-show charge** and please call **Karen at metro 817-849-8296**.

Again, we are glad that you have taken this step to take control of your diabetes.  
We look forward to meeting you.

# Diabetes Self-Management Program

## **Following is an outline of the DSMP training:**

1<sup>st</sup> appointment is: *(Assessment)*

One hour individual training by a Certified Diabetes Educator

2<sup>nd</sup> appointment is: *(Meal Plan)*

One hour individual training by a Certified Diabetes Educator

3<sup>rd</sup> appointment is:

Eight hours of DSMP class training

Class schedules are flexible to meet the patient's work hours and family needs. Times offered will be discussed during one of the two initial visits to determine the most convenient time for you.

4<sup>th</sup> appointment is:

Follow-up Class

Patients are scheduled to return two months after completion of class for a one-hour follow-up class. The educator will assess the need for further education at this class.

*(Patients are encouraged to bring a support person to individual consults and class)*



## Great Outcomes, Impel Management Program Intake Questionnaire

Name		(Circle one) Mrs. Ms. Mr.
Address	City/State	Zip
Day Phone	Evening Phone	
Personal Physician's Name:	Social Security Number:	
Best Time(s) to Reach You by Phone	Today's Date:	

Please answer the following questions as best you can. This information will be used by the Diabetes Program to help you in your effort to manage your diabetes and to help determine the effectiveness of this program. All information will be kept confidential. Thank you.

### PERSONAL CHARACTERISTICS

- Your sex:  Male  Female
- a. Your age: \_\_\_\_\_ b. Date of birth: \_\_\_\_\_ (month/day/year)
- Which of the following best describe your race and ethnicity? (Check ALL that apply)  
 White  Other Asian (specify: \_\_\_\_\_)  
 Black/African American  Pacific Islander (specify: \_\_\_\_\_)  
 Hispanic/Latino (from: \_\_\_\_\_)  Native American (e.g., Indian, Aleut)  
 Japanese  Chinese  
 Other (specify: \_\_\_\_\_)
- What is the HIGHEST level of formal schooling you completed? (Check only ONE answer)  
 Grade school (8<sup>th</sup> grade or less)  Some college or technical school  
 Some high school (9<sup>th</sup> – 11<sup>th</sup> grade)  4-Year college graduate (e.g., BA, BS)  
 High school graduate (12<sup>th</sup> grade)  Postgraduate degree/professional training
- Are you employed?  
 No  Yes If you answered yes, please write when you start work \_\_\_\_\_ & when you leave \_\_\_\_\_.
- Your marital status:  
 Single  Married/in marriage-like relationship  Other: \_\_\_\_\_
- With whom do you currently live and share meals? (Check all that apply)  
 Spouse or domestic partner  Parents  
 Adult children  Other (describe): \_\_\_\_\_  
 Children under age 18  No one else
- Do you have a family history of diabetes?  No  Yes If yes, who has diabetes? \_\_\_\_\_

### HEALTH AND LIFESTYLE

- Are you pregnant?  No  Yes Weeks Gestation \_\_\_\_\_ Due Date \_\_\_\_\_ Wt before pregnancy \_\_\_\_\_  
If you are pregnant and have never had diabetes before, skip 10 through 16 and go to question 17.
- Are you newly diagnosed?  No  Yes If no, approximately how long have you had diabetes? \_\_\_\_\_

**HEALTH AND LIFESTYLE *Continued***

11. Please designate all other health problems: **No** **Yes** **Please describe each listed below, as necessary**
- a. Heart attack   \_\_\_\_\_
  - b. Stroke   \_\_\_\_\_
  - c. Poor Circulation   \_\_\_\_\_
  - d. High Cholesterol   \_\_\_\_\_
  - e. High Blood Pressure   \_\_\_\_\_
  - f. Kidney Problems   \_\_\_\_\_
  - g. Liver Disease   \_\_\_\_\_
  - h. Depression   \_\_\_\_\_
  - i. Sexual Dysfunction   \_\_\_\_\_
  - j. Glaucoma   \_\_\_\_\_
- Other: \_\_\_\_\_

12. Has your M.D. prescribed the following medications?

	No	Yes	<u>Name</u>	<u>Amount (dose)</u>	<u>Frequency</u>
a. Insulin	<input type="checkbox"/>	<input type="checkbox"/>			
b. Pills for Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
c. High Blood Pressure Medicine	<input type="checkbox"/>	<input type="checkbox"/>			
d. Cholesterol medicine	<input type="checkbox"/>	<input type="checkbox"/>			

13. Are you taking any other medications or nutritional supplements/vitamins?  No  Yes  
 If you answered yes, please list the names and amounts of each. \_\_\_\_\_

14. During the past 4 weeks, have you experienced any episodes of hypoglycemia (low blood sugar)?  
 No  Yes ⇒ How often? \_\_\_\_\_ How did you treat this? \_\_\_\_\_

15. Are you currently monitoring your glucose at home?

- No
- Yes ⇒

How do you monitor it? <input type="checkbox"/> Urine <input type="checkbox"/> Blood sugar meter <input type="checkbox"/> Other: _____ What meter do you use? _____ How often do you monitor your blood sugar? _____ What has been your average blood sugar level during the last 4 weeks? _____ What has been your range (lowest to highest)? _____ What was your last HA1c? _____ Date it was done? _____
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**HEALTH AND LIFESTYLE *Continued***

32. Thinking about the past two months, how would you rate:
- |  | Excellent | Very Good | Good | Fair | Poor |
|--|-----------|-----------|------|------|------|
| a. Your overall physical health?           | 1         | 2         | 3    | 4    | 5    |
| b. You're overall emotional/mental health? | 1         | 2         | 3    | 4    | 5    |
33. Have there been any changes in your life that have affected your ability to manage your diabetes?  No  Yes  
If you answered yes, please describe what happened and how it affected you. \_\_\_\_\_
34. Do you have any food intolerances or food allergies?  No  Yes  
If you answered yes, please list and describe the reaction. \_\_\_\_\_
35. Do you have any customs or religious beliefs or wishes that might affect care( i.e. fasting)?  No  Yes  
If you answered yes, please describe. \_\_\_\_\_
36. How many meals do you eat out per week?  None  0-5meals  6-10 meals  11-15 meals  16-21 meals

**Please bring your completed questionnaire to the Diabetes Program.**



**Acknowledgement of Receipt of  
Notice of Privacy Practices**

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that Great Outcomes reserves the right to change their Notice of Privacy Practices.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's/Legal Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Impel Management Services, L.L.C. to share my protected health information with:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship



## Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to the Great Outcomes Diabetes Program unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needlestick (any such test shall be conducted pursuant to Impel Management Services' infectious disease protocol); or 2) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Impel Management Services, L.L.C. if any of these situations occur during your treatment period.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# GREAT OUTCOMES DIABETES SELF-MANAGEMENT PROGRAM

## FINANCIAL POLICY

Thank you for choosing the Impel Management Services L.L.C. as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

**All patients must read and sign this form prior to receiving services.**

❖ **It is your responsibility to provide us with your most current insurance information.**

- ☞ If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- ☞ We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- ☞ We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- ☞ Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
- ☞ We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- ☞ Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

❖ **It is your responsibility to provide us with your most current billing information.**

- ☞ You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
- ☞ We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call (817)514-5200 or 1-800-555-1429.
- ☞ **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be subject to a \$5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- ☞ If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- ☞ If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
- ☞ In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add \$25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.
- ☞ We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.
- ☞ **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

Signature of Responsible Party

Date