



Prescription Order Form for i-port® Injection Port

PATIENT INFORMATION

Preferred Language: English Español

First Name _____ MI _____ Last Name _____ Male _____ Female _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Date of Birth _____

The following information is required for processing by most health insurance plans.

Diagnosis Code: 250. _____ Blood Glucose Tests per Day: _____ to _____ Last 3 HbA1c readings: _____ % on _____

Injections per Day: _____ to _____ Blood Glucose Range: _____ to _____ _____ % on _____

INSURANCE INFORMATION (Please attach copy of insurance card)

Primary Insurance _____ Policy Holder's Name _____

ID # _____ Group # _____ Phone # _____

Secondary Insurance _____ Policy Holder's Name _____

ID # _____ Group # _____ Phone # _____

MEDICAL PROVIDER INFORMATION

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip _____ Phone # _____

Fax # _____ UPIN _____ NPI _____

Staff Contact _____

Patient Signature and Authorization

I authorize Patton Medical Devices (PMD) to release any personal health information or other information to medical device distributors that is necessary for processing my prescription(s), filing any insurance claim(s) on my behalf, and arranging for the delivery of my medical device(s) and/or supplies.

I authorize PMD to release any personal health information or other information necessary for PMD, its affiliates, and/or medical device distributors to process and submit all past, present, and future claims to Medicare and/or my health insurance or medical benefits provider, effective the date of this signature.

I authorize PMD, its affiliates and medical device distributors to contact me to coordinate/arrange for delivery of my medical device(s) and/or supplies.

I understand that my health insurance or medical benefits provider or Medicare may impose co-payments and/or deductibles for which I am responsible. If I have any questions about these amounts I may be responsible for, I should contact my insurance company.

I authorize payment of Medicare and/or health insurance or medical benefit to PMD, its affiliates or medical device distributors for the service(s) and supplies I receive.

I have received and read PMD's Notice of Privacy Practices.

SIGN HERE

PATIENT OR GUARDIAN SIGNATURE

PATIENT OR GUARDIAN NAME (Please Print)

DATE

Prescription Information

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for the I-PORT™ and any other associated medical supplies. The supplies may be filled as necessary for one year. Please dispense as written.

I certify that the above patient has demonstrated one or more of the following:

- Possesses motivation and support to achieve or maintain improved glycemic control
- Currently maintains suboptimal or poor glycemic control
- Challenged with widely fluctuating blood glucose levels
- Needed hospitalization or emergency assistance

I-PORT™ Injection Port – 6mm
(HRI/NDC 08519-0101-10) 10 units for 30 days

I-PORT™ Injection Port – 9mm
(HRI/NDC 08519-0102-10) 10 units for 30 days

SIGN HERE

MEDICAL PROVIDER SIGNATURE

MEDICAL PROVIDER NAME (Please Print)

DATE

FAX COMPLETED FORM TO:

1-866-286-1401

For questions about completing this form, please call 1-877-763-7678.



3108 North Lamar Boulevard
Austin, Texas 78705

Notice of Privacy Practices

Patton Medical Devices, LP

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.

How PMD Will Use Your Information

PMD is committed to the protection of your health information because we understand that medical information about you and your health is personal. "Protected health information" is individually identifiable health information which relates to your past, present, or future physical or mental health or condition, or related to your past, present, or future payment for health care.

PMD will generally obtain your written authorization before using your protected health information or disclosing it to third parties. You may revoke your written authorization at any time, and such revocation will be followed to the extent action on the authorization has not yet been taken. To revoke an authorization, please provide a written request including a copy of the authorization being revoked (or, if not available, a detailed description of the authorization, including the date) to the Privacy Officer indicated at the end of this Notice.

Uses and Disclosures for Health Care Products and Services, Payment and Health Care Operations

There are some instances in which PMD may use or disclose protected health information it creates, receives or maintains about you without your prior written authorization. These instances include use or disclosure of your protected health information in connection with receiving health care products or services, collecting payment for such health care products or services, and/or running our business or otherwise operating in connection with services provided to you by another entity covered by HIPAA. For example, PMD may provide protected health information to your health insurance provider to verify that you are eligible for benefits under your plan. Additionally, PMD may provide your protected health information to other businesses with whom PMD has contracted to provide services for us in connection any of the above. However, we will require that such businesses agree to follow these privacy practices and take measures to reasonably protect the privacy of your health information.

Other Uses and Disclosures

PMD is permitted to use or disclose your protected health information in the following instances without your prior written authorization:

- To inform you of new or alternative products or services that may help you manage your health, or to contact you by telephone or by other means to advise you of products or services that may be available. However, your protected health information will not be disclosed to third parties for marketing purposes without your prior written authorization.
- To release protected health information about you to a friend or family member whom you have listed as a contact involved in your medical care or an individual who helps pay for your care.
- To release protected health information to a health oversight agency for activities authorized by law or to authorized federal officials for the protection of nation security.
- When required to do so by federal, state, local law, or law enforcement officials.
- In response to a court or administrative order.
- For certain public health activities or to avert threats to public safety, including the prevention of disease or the prevention of a serious threat to your health and safety or the health and safety of the public or another person, reporting of child abuse, reporting problems about products, or notification about recalls.
- For worker's compensation or similar programs that provide benefits for work related injuries or illness.
- When otherwise required by law.

Release of Information to Suppliers/Distributors

PMD may use or disclose your protected health information to fulfill your order(s) for medical devices. It may be necessary for supplier(s) or distributor(s) to contact you from time to time for fulfillment of your order.

Other Uses of Protected Health Information

PMD will not use or disclose your protected health information for instances not included in this Notice or by law without your written authorization.

Rights Regarding Your Protected Health Information

You have the right to:

- Inspect and receive a copy of your protected health information that may be used to make decisions concerning you. A request to inspect or to receive a copy of your information must be submitted in writing to PMD. PMD may charge a fee for the costs of copying, mailing, or other supplies associated with your request. Under certain circumstances your request may be denied; a reason for denial will be provided.
- Request that PMD limit how it uses or discloses your protected health information. PMD will consider your request, but is not legally bound to agree to the restrictions. PMD cannot agree to limit uses or disclosures that are required by law.
- Request that PMD contact you at an alternate address or by alternative means.
- Request that PMD amend, correct, or supplement your protected health information maintained by PMD.
- Request a detailed listing of disclosures other than instances for which you gave consent or signed an authorization. This request must be submitted in writing and must include your name, address, and a time period of disclosures, which may not be longer than six (6) years. PMD may charge a fee to cover the cost of preparing the list.
- Receive a paper copy of this Notice and/or an electronic copy by email upon request. Please note that copies are available at PMD's website www.pattonmd.com.
- File a complaint with the Privacy Officer at PMD or the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated or you are dissatisfied with our privacy policies or procedures. PMD will not take any action against you or change our treatment of you in any way if you file a complaint.

Changes to This Notice

PMD reserves the right to change the privacy practices described in this Notice. The right to change or revise its privacy practices is applicable to the protected health information in PMD's possession as well as information received by PMD in the future. A copy of the current Notice will be posted in all PMD offices and on its website, www.pattonmd.com.

PLEASE ACKNOWLEDGE RECEIPT OF THIS NOTICE OF PRIVACY PRACTICES ON THE ACCOMPANYING AUTHORIZATION TO RELEASE MEDICAL INFORMATION.

If you have questions about this Notice of Privacy Practices, please contact PMD's Privacy Officer:

William Ambruzs
V.P. & General Counsel
Patton Medical Devices
3108 North Lamar Boulevard
Austin, Texas 78705
wambruzs@pattonmd.com
(512) 279-0850

To contact the Secretary of Health and Human Services, write to:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Local: (202) 619-0257
Toll free: (877) 696-6775
<http://www.hhs.gov/contacts>