PATIENT DEMOGRAPHICS

MRN: **Date:** _____

Name: _____ **Age:** _____ **Sex:** ___ **Social Security:** _____

Email: _____ **DOB:** _____

Address: _____**Marital Status:** _____

Home Phone: _____ **Cellphone:** _____

Emergency Contact: _____ **Emergency Tel:** _____

How did you hear about the office? _____

Preferred Pharmacy: _____ **Tel:** _____

Primary Insurance: _____ **Member ID:** _____

Secondary Insurance: _____ **Member ID:** _____

Employment Status: ____ **Full-Time** ____ **Part-Time** _____ **Non- employed** _____ **Retired** _____ **Student**

Employer Name: _____ **Work Tel:** _____

AUTHORIZATION OF RELEASE OF INFORMATION

I authorize release of medical information pertaining to my medical history, services rendered or treatment given to me or to my dependents for purposes of review, investigation or evaluation of exam

AUTHORIZATION TO PAY PHYSICIAN

I authorize all payment of surgical and/or medical benefits, be paid directly to physician.

PRACTICE POLICY ON INSURANCE CHARGES AND PAYMENTS

No SHOW POLICY and LATE CANCELLATION POLICY: We request that if you cannot make your appointment, you give us 48-24 hours advance notice. If an appointment is missed without giving the office notice within 48-24 hours, a $35 will be charged to your account. This is an administration fee, not a charge that will be billed to, or paid by the insurance carrier. I authorize Marissa T. Santos MD PC to charge outstanding balances to my credit card on file.

Patient Signature: _____ **Date:** _____

PATIENT PORTAL INFORMATION AND AGREEMENT

Marissa T. Santos MD PC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

Patient Name and Signature: _____ Date: _____

Notice of Privacy Practices and Patient Acknowledgement

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so they may understand and comply with government rules and regulations regarding the Health Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics an integrity performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment or health care operations.

As our patient we want you to know that we support your full access to your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operation.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPAA Privacy Officer. You have the right to review our entire notice of privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name: _____ Signature: _____

(Signature of Guarantor or guardian)

Date: _____

For Office Use Only

A "good faith effort" was made to get a signature from the patient. Signature was not obtained due to the following;

_____

MARISSA T. SANTOS, MD

Board Certified in Internal Medicine

PRACTICE POLICY ON INSURANCE PAYMENTS AND CHARGES

As a courtesy service to you, our office employs a billing service and participates with several insurance carriers. Please familiarize yourself with your insurance practices and policies.

1. If your insurance carrier requires you to pay a portion of your healthcare visits. (i.e., Co-payments, Deductible, Co-insurance), we are legally required to collect these and no exceptions will be made. You are required to pay your Co-payment at the time of your visit. **_____** ***(Please write initials in the blank)***

2. If your insurance carrier requires you to have a referral to be seen in our office, you must provide a referral or you will not be seen. **_____** ***(Please write initials in the blank)***

3. If your insurance requires you to meet an annual deductible before your health care is covered, you will be billed for the services rendered if you have not met your deductible. **_____** ***(Please write initials in the blank)***

4. **No Show Policy: We request that if you cannot make your appointment that gives us 48-24 hours advance notice. If an appointment is missed without giving the office notice, a $35 charge will be billed to your account. This is an administration fee, not a charge that will be billed or paid by your insurance carrier. _____** ***(Please write initials in the blank)***

Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment. Unless otherwise specified, we will contact you via email regarding your balance. Please check here ____ if you do not wish to be contacted via email and prefer correspondence via regular postal mail.

DO YOU HAVE AN HRA OR FLEX SPENDING ACCOUNT? YES ____ NO ___ (This card may be used to pay copays, coinsurance and/or deductible.)

I have read the above information carefully and acknowledge these terms. I hereby assume all responsibility for any outstanding balance and (if selected) understand that these charges will be billed appropriately to my account.

Sign: _____ Date: _____

PRINT NAME: _____ DOB: _____/_____/ _____

MARISSA T. SANTOS, MD

Board Certified in Internal Medicine

Past Medical History

Today's Date: _____

Name of Patient: _____ DOB: _____ Age: _____

Allergies: ☐ Yes _____ ☐ None If yes, _____

Medication(s): *(Please list name/dose/frequency if known)*

_____ _____
_____ _____
_____ _____
_____ _____

Family History: *(Please indicate parents,siblings,grandparents medical history/medical issues)*

- Father: _____ Mother : _____
- Siblings: _____ Grandparents:_____

Habits: ☐ **Alcohol** *Frequency?* _____ *What Kind?* _____ ☐ **Tobacco** *How many/day?* _____
☐ **Other Recreational Drugs** _____ *How many/day?* _____

Past Surgical History (indicate date if known):

☐ None ☐ Cataracts ☐ LASIK ☐ Tonsillectomy ☐ Pacemaker
☐ Cardiac Stents ☐ Coronary Bypass ☐ Adenoidectomy ☐ Thyroidectomy
☐ Heart Valve ☐ Gall Bladder ☐ Appendectomy ☐ Bowel/Stomach Resection
☐ Hemorrhoidectomy ☐ Bariatric Surgery ☐ Hysterectomy ☐ Endoscopy
☐ Colonoscopy ☐ Hernia Repair ☐ Spinal Surgery ☐ Tubal Ligation
☐ Bladder Surgery ☐ Prostate Surgery/resection ☐ C-Section
☐ Orthopedic/Joints ☐ other, please specify: _____

Past Medical History: *(Please check that apply)*

__ Headaches	__ Stroke	__ Seizures	__ Pneumonia
__ Diabetes 1 or 2	__ Thyroid Dis (High/Low)	__ Glaucoma	__ Mac. Degen.
__ Hearing Loss	__ High Bld. Pressure	__ Blood Clots	__ Heart Burn
__ Stomach Ulcers	__ Heart Disease, Specify: _____		__ High Cholesterol
__ GI Bleeding	__ Hepatitis (A, B, C)	__ HIV/AIDS	__ Chronic Wounds
__ Cancer Type: _____		__ UTI	__ Incontinence
__ Kidney Stones	__ COPD	__ Asthma	__ Depression
__ Bipolar Disorder	__ Anxiety	__ Fibromyalgia	__ Arthritis
__ Fatigue	__ Gout	__ Osteoporosis	__ Prostate Disease
__ Breast Disease	__ Erectile Dysfunction	__ other, specify: _____	

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian _____ Date: _____