OPTIMUS MEDICAL GROUP

870 Market St. Suite 600, San Francisco, Ca. 94102
phone (415) 397-0700 fax (415) 397-6805

PATIENT REGISTRATION

Name _____
Last First Middle

Home Address _____
Street City State Zip Code

Mailing Address (if different from above) _____
Street City State Zip Code

SOCIAL SECURITY NO.: **DATE OF BIRTH:**

Gender Identity: ☐ M ☐ F ☐ TG Home Phone: Work Phone:

Cell Phone: **Text reminders:** ☐ Y ☐ N **Email Address:**

Can we leave a message/lab results at home? ☐ Y ☐ N **At Work?** ☐ Y ☐ N **On Cell ?** ☐ Y ☐ N

Employer: Occupation:

Name of Significant Other: Phone:

Emergency Contact: Phone:

Durable Power of Attorney name: Physician Orders for Life-Sustaining Treatment? ☐ Y ☐ N Request Form ☐ Y ☐ N

How were you referred to this office?

Primary Insurance Co. _____ Secondary Insurance Co. _____

Plan type ☐ HMO ☐ PPO ☐ Other _____

Name of Insured (if different from patient)_____

Insured's (if different from patient) DOB: _____ ID #_____

CO-PAY? ☐ Y ☐ N **Amount:**

Pharmacy: Phone: Fax:

Mail Order Pharmacy: Phone: Fax:

I understand that **I** am responsible for my copay or coinsurance at the time of visit and acknowledge that **I** will be billed a fee for Copay billed to my home.
Assignment of Benefits: **I**, the undersigned, have insurance coverage with the above named carrier and assign directly to Dr. Shawn K. Hassler all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. **I** understand that if this or any other visit precedes the effective date of my enrollment in my insurance company, I will be held responsible for any and all fees incurred, **I** hereby authorize Optimus Medical Group, Allscripts and CHMB (a billing company) to release all information necessary to secure the payments of benefits.

Signature_____ Date_____

CONFIDENTIAL

OPTIMUS MEDICAL GROUP

Patient Consent Form

The Health Insurance Portability and Accountability Act of 1996 (**HIPPA**) established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patients to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of 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 or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding, treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

There are several circumstances in which we may use and disclose health information about you. **FOR TREATMENT.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and your health. **FOR PAYMENT.** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. **APPOINTMENT REMINDERS.** We may contact you as a reminder that you have an appointment for treatment or medical care at our office.
There are several **SPECIAL SITUATIONS** we may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations. **TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **REQUIRED BY LAW.** We will disclose health information about you when required to do so by federal, state or local law. **RESEARCH.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care at the office.

You may refuse to consent to the use or disclosure of your personal health information, but this MUST be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose you Personal Health Information. If you choose to give consent n this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to Paul Gilea our HIPAA Compliance Officer. You have the right to review our Notice of Privacy Practices, to request restrictions and revoke consent in writing.

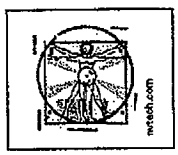
_____ _____

Print Name Date

_____

Signature

SHAWN HASSLER, MD
870 MARKET STREET, SUITE #600
SAN FRANCISO, CA 94102
415-397-0700



COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information has been identified as a national problem. Dr. Hassler would like you to know that it is our policy to properly determine appropriate uses of Personal Health Information in accordance with the government rules, laws and regulations.

Because we believe there is always room for improvement. Our policy is to listen to our patients if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any service problems so that we may remedy the situation promptly.

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office contact **Paul Gilea**, Office Manager at 415-397-0700 or write to 870 Market Street, Suite 600, San Francisco, CA 94102. You will not be penalized for filing a complaint.

_____

HIPAA Compliance Officer

Office Changes
12/1/2017

Starting January 2018 an update will be performed to our office EMR (electronic medical record). At that time, we will have to be fully compliant and adhere to the Department of Justice Regulations for controlled substance dispensing for follow-up appointments. Chronic illnesses/diagnoses such as HIV/AIDS, hypertension, diabetes will require frequent follow up appointments.

1. Controlled substance medications/opioids such as Vicodin (hydrocodone), Norco, Percocet, Morphine will require every **90 day/3months follow up visits for refills. No exceptions.**

2. Medications such as Adderall, Vyvanse, dextro-amphetamine products, Lyrica, sleep/anti-anxiety medications such as Ambien (Zolpidem), Ativan, Lorazepam, Xanax (alprazolam), Valium (diazepam), Klonopin (clonazepam) and all testosterone products such as Androgel, Testim, Axiron, Fortesta, and injectable testosterone cypionate/enanthate will require every **120 days/4 months follow up visits for refills. No exceptions. Testosterone refills will require current labs to complete prior authorization.**

3. Chronic illness patients with diagnoses such as HIV/AIDS, diabetes, uncontrolled hypertension, will require follow up appointment every **3-6 months**.

4. PrEP patients will still require every 90 days follow up for brief check-in appointment and labs for refill per CDC guidelines.

5. Missed appointment/late cancellation appointment are set at $75 Please note reminder calls are a courtesy from our office. Patient are responsible for their appointments.

Due to insurance requirements, referrals and prior authorizations are not always possible without a medical evaluation by a provider. Please expect to make an appointment for evaluation when requesting referral or prior authorization.

_____ _____

Signature Date

_____

Printed Name

NO-SHOW FEE

OPTIMUS MEDICAL GROUP CHARGES A $75.00 NO-SHOW FEE FOR APPOINTMENTS WHICH ARE NOT CANCELLED OR ARE FAILED TO BE CANCELLED WITHIN 24 HOURS.

THIS FEE IS THE PATIENTS RESPONSIBILITY AND CANNOT BE BILLED TO INSURANCE.

I, _____ D.O.B. _____ HAVE BEEN MADE AWARE OF THIS NO-SHOW FEE AND CANCELLATION POLICY.

X_____ DATE_____

Authorization for Use and/or Disclosure of Patient Health Information

I Hereby Authorize: (Previous Physician)

_____
Name of Disclosing Party

_____
Address

_____
City, State Zip

_____
Telephone # Fax #

OPTIMUS MEDICAL GROUP
Shawn K. Hassler, MD
870 Market Street, Suite 600
San Francisco, CA 94102-3014
P 415.397.0700

(PLEASE DO NOT FAX RECORDS!)

Records and Information Pertaining To:

Patients Name _____
Last First Middle

Patients Date of Birth _____ Telephone # _____

Home Address _____
Street City, State Zip

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of the signature unless a different date is specified here _____(date)
Revocation: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.
Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
Specify Records: Check the box ☐ specify which type of information is to be disclosed: then sign and date your selection.

	Signature	Date
☐ Medical Information	_____	
☐ Psychiatric Information	_____	
☐ HIV/AIDS Test/Treatment	_____	
☐ Other Health Information	_____	
Specify Records to Disclose	_____	

A copy of this authorization is a valid as the original. Patient has a right to a copy of this authorization.

Patient's Signature _____ **Date** _____

BROWN & TOLAND PHYSICIANS

Register for our
Online Patient Portal

A service provided by Brown & Toland Physicians

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH (DOB) _____ E-MAIL ADDRESS _____

After turning in this card, you will receive an e-mail from our office.
Click the link to continue the registration process.

For internal use. MRN # _____