Saint Agnes Care Center

Patient Registration Form

☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Domestic Partner ☐Other
First Name:_____Middle:_____Last:_____Suffix:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____
Contact Preference: ☐Home Phone ☐Work Phone ☐Cell Phone Email:_____

Social Security Number:_____Driver's License Number:_____

Date of Birth:_____ Age:_____Gender: ☐Male ☐Female

Race: ☐Caucasian ☐Black ☐Hispanic ☐Asian ☐Native American ☐Other_____
Ethnicity: ☐Latino/Hispanic ☐Other: _____ ☐Not Reported/Refused
Language: _____

☐Self Employed ☐Unemployed ☐Disabled ☐Retired ☐Student ☐Homemaker
☐Employed – Employer Name:_____
Employer Address:_____City:_____State:_____Zip:_____
Employer Phone:_____ Occupation: _____

Referring Physician:_____Phone Number:_____
Primary Care Physician:_____Phone Number:_____
Pharmacy Name:_____Location:_____
Preferred Lab Name: _____Location:_____

Emergency Contact:_____Relationship:_____

Home Phone:_____ Mobile Phone:_____

If married, minor, or special dependent, please complete relationship information below:
Relationship: ☐Spouse ☐Parent ☐Court Appointed ☐Other_____
Full Name:_____ Date of Birth:_____

Address (if different from above):_____

City:_____State:_____Zip:_____Work Phone:_____Cell Phone:_____

Social Security Number:_____Employer Name:_____

Employer Address:_____

Primary Insurance Company:_____
Subscriber Name:_____Subscriber Date of Birth:_____
Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other_____

Secondary Insurance Company:_____
Subscriber Name:_____Subscriber Date of Birth:_____
Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other_____

I verify that this information is true and correct as of this date.

Signature:_____Date:_____

Saint Agnes Care Center

Consent and Release Form

Patient Name:_____ Date of Birth:_____

By initialing each statement and signing below the patient is acknowledging that patient has read, understands and agrees to the terms of Saint Agnes Medical Providers financial and HIPAA policies and procedures.

1. I hereby authorize the release of information regarding my medical treatment, care and charges as may be required to complete all claims for benefits. I also authorize my insurance benefits to be paid directly to Saint Agnes Medical Providers.

   Initials_____

2. I understand I am financially responsible for all copayments, deductibles, and co-insurance, as well as any services not covered by my insurance, including but not limited to denials for:
   a. Non-covered services
   b. Non-plan benefits
   c. Non-participating insurance plans/groups
   d. Services deemed as experimental/investigational for any reason
   e. Limits on screening/preventative services

   Initials_____

3. I understand that if my insurance requires a referral for specialist's services or authorization for surgical services, that it is my responsibility as a patient to inform Saint Agnes Medical Providers regarding limitations on referrals and authorizations, and to verify that referrals have been issued by the physician referring me to Saint Agnes Medical Providers, and to verify authorization of surgical services with my insurance company. I also acknowledge that Saint Agnes Medical Providers will not be responsible for charges incurred for any referral/authorization not received. I also understand per insurance rulings, receipt of a referral/authorization is never a guarantee of payment.

   Initials_____

4. **Notice of Privacy Practices (NPP) Acknowledgment**: I have received a copy of the Saint Agnes Medical Providers' Notice of Privacy Practices.

   Initials_____

5. I consent to allow the following person(s) access to my protected health information. I understand that I may revoke this access at any time.
   Name(s): _____
   _____

   Initials_____

6. **Medicare Authorization Statement and Claims Submission.** I request that payment of authorized Medicare benefits be made on my behalf to Saint Agnes Medical Providers for any services furnished by the physician/supplier. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

   Initials_____

Patient Signature:_____ Date:_____

Saint Agnes Care Center

FINANCIAL POLICY

Patient Demographics:

Please bring your insurance card(s) with you and update the office of any changes in your insurance, address, and email or contact phone number.

Initials_____

Insured Patients:

If our office is contracted with your health plan, we will submit your claim to your carrier. You are expected to pay your co-pay and/or deductible per your contractual agreement with your insurance carrier at the time of service. You are responsible for payment of all services provided by our office, which are not covered by your insurance.

Initials_____

Cash-Pay Patients:

You are responsible for payment in full at the time of service, unless prior arrangements have been made with the billing manager.

Initials_____

Co-Payments:

Your co-payment is a personal obligation between you and your contracted insurance company. We are required to collect this amount at the time of your visit.

Initials_____

Annual/Preventative Exams:

Your exam consists of specific elements determined by your insurance company. Issues discussed outside these services will be billed to your insurance company and may result in additional fees to you. A list of included services will be provided upon request.

No Show & Cancellations: **Initials_____**

For scheduled office visits and procedures, there is a 24-hour cancellation notice required. There is a $50.00 fee for missed appointments without proper notice. Continual missed appointments will be cause for dismissal from the practice.

Initials_____

Returned Checks:

Returned checks are subject to a $30.00 fee. A returned check forfeits your ability to write future checks for services rendered.

Initials_____

Delinquent Accounts:

Accounts greater than 90 days are subject to being submitted to a collection agency for resolution. Patients sent to collections will be subject to dismissal from the practice.

Initials_____

Forms Completion:

A $25.00 fee applies for each form completion request.
A $30.00 fee applies for a dictated letter request beyond the customary office visit documentation.
A $50.00 fee applies for a residential care facility form **Initials_____**

Medical Records Request:

There is no fee to provide a copy of your medical record when requested by a physician. One copy of the medical record will also be provided to you at no cost. Thereafter, a $25.00 fee will apply for every medical record copy provided directly to you.

Initials_____

Prior Authorization:

There is a $15.00 fee to obtain a prior authorization if you request a brand name medication instead of generic. We will obtain one pre-authorization for any procedure you have done. Please note, prior authorization is not a guarantee of payment, your insurance Company will determine benefits once the claim is received and processed.

Initials_____

Acceptance: I have read and understand this office's financial and cancellation policy and agree to abide by the terms of this policy.

Signature: _____ **Date: _____**

Saint Agnes Care Center

Notice of Patients' Privacy Rights

The notice of privacy practices is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you or your legal dependent (as a patient of this practice) may be used and disclosed, and how you can access your individually identifiable health information.

Please Review This Notice Carefully

1. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Patient's Privacy Rights ("Notice") that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI;
- Your privacy rights in your PHI; and
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

If you have questions about this notice, please contact:

The Privacy and Security Officer at: 559-450-5616

2. The different ways in which we may use and disclose your PHI:

The following categories describe the different ways in which we may use and disclose your PHI:

A. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask

you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice — including, but not limited to, our doctors and nurses — may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your PHI to other healthcare providers for purposes related to your treatment.

B. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your PHI to bill you directly for service and items. We may disclose your PHI to other healthcare providers and entities to assist in their billing and collection efforts.

C. **Healthcare Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other healthcare providers and entities to assist in their healthcare operations.

    a. **Appointment Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.

    b. **Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

    c. **Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

    d. **Release of Information to Family/Friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatricians' office for treatment of a cold. In this example, the babysitter may have access to this child's medical

information.

e. **Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. **Sharing and Joint Use of Your Health Information.** In the course of providing care to you and in furtherance of Saint Agnes Medical Providers' mission to improve the health of the community. Saint Agnes Medical Providers will share your PHI with other organizations as described below who have agreed to abide by the terms described below:

a. **Medical Staff**. The medical staff and Saint Agnes Medical Providers participate together in an organized health care arrangement to deliver health care to you. Both Saint Agnes Medical Providers and medical staff have agreed to abide by the terms of this Notice with respect to PHI created or received as part of delivery of health care to you by Saint Agnes Medical Providers. Physicians and allied health care professionals who are members of Saint Agnes Medical Providers' medical staff will have access to and use your PHI for treatment, payment and health care operations purposes related to your care within Saint Agnes Medical Providers. Saint Agnes Medical Providers will disclose your PHI to the medical staff and allied health professionals for treatment, payment and health care operations.

b. **Membership in Trinity Health**. Saint Agnes Medical Providers and members of Trinity Health participate together in an organized health care arrangement for utilization review and quality assessment activities. We have agreed to abide by the terms of this Notice with respect to PHI created or received as part of utilization review and quality assessment activities of Trinity Health and its members. Members of Trinity Health will abide by the terms of their own Notice of Privacy Practices in using your PHI for treatment, payment or health care operations. As a part of Trinity Health, a national Catholic health care system, Saint Agnes Medical Providers and other hospitals, nursing homes, and health care providers in Trinity Health share your PHI for utilization review and quality assessment activities of Trinity Health, the parent company, and its members. Members of Trinity Health also use your PHI for your treatment, payment to Saint Agnes Medical Providers and/or for the health care operations permitted by HIPAA with respect to our mutual patients. Please go to Trinity Health's websites for a listing of member organizations at http://www.trinity-health.org/ and http://www.che.org/.

3. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your PHI:

A. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

   a. Maintaining vital records, such as births and deaths;
   b. Reporting child abuse or neglect;
   c. Notifying a person regarding potential exposure to a communicable disease;
   d. Notifying a person regarding a potential risk for spreading or contracting a disease or condition;
   e. Reporting reactions to drugs or problems with products or devices;
   f. Notifying individuals if a product or device they may be using has been recalled;
   g. Notifying appropriate governmental agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information; or
   h. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

B. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the healthcare system in general.

C. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

D. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:

   a. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
   b. Concerning a death we believe has resulted from criminal conduct;

c. Regarding criminal conduct at our offices;
d. In response to a warrant, summons, court order, subpoena, or similar legal process;
e. To identify/locate a suspect, material witness, fugitive, or missing person; and
f. In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identity, or location of the perpetrator).

E. **Deceased Patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

F. **Organ and Tissue Donation.** Our practice may release your PHI to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

G. **Research.** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain written authorization to use your PHI for research purposes except when the Practice's Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following:

a. The use or disclosure involves no more than a minimal risk to your privacy based on the following:

i. An adequate plan to protect the identifiers from improper use and disclosure;
ii. An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and
iii. Adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted.

a) The research could not practicably be conducted without the waiver.
b) The research could not practicably be conducted without access to and use of the PHI.

H. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or

the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

I. **Military.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

J. **National Security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.

K. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (1) for the institution to provide healthcare services to you; (2) for the safety and security of the institution; and/or (3) to protect your health and safety or the health and safety of other individuals.

L. **Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs.

4. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

A. **Confidential Communication.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy and Security Officer at: Saint Agnes Medical Providers, 1111 East Spruce Ave, Suite 431, Fresno, CA 93720 specifying the requested method of contact and/or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

B. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy and Security Officer, Saint Agnes Medical Providers, 1111 East Spruce Ave, Suite 431, Fresno, CA 93720.

Your request must describe in a clear and concise fashion:

- The information you wish restricted;
- Whether you are requesting to limit our practice's use, disclosure, or both; and
- To whom you want the limits to apply.

C. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Privacy and Security Officer, Saint Agnes Medical Providers, 1111 East Spruce Ave, Suite 431, Fresno, CA 93720 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed healthcare professional chosen by us will conduct reviews.

D. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Privacy and Security Officer, Saint Agnes Medical Providers, 1111 East Spruce Ave, Suite 431, Fresno, CA 93720. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (1) accurate and correct; (2) not part of the PHI kept by or for the practice; (3) not part of the PHI that you would be permitted to inspect and copy; or (4) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

E. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI. To obtain an accounting of disclosures, you must submit your request in writing to: Privacy and Security Officer, Saint Agnes Medical Providers, 1111 East Spruce Ave, Suite 431, Fresno, CA 93720. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not

include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs.

F. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact: Privacy and Security Officer, Saint Agnes Medical Providers, 1111 East Spruce Ave, Suite 431, Fresno, CA 93720.

G. **Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: Privacy and Security Officer, Saint Agnes Medical Providers, 1111 East Spruce Ave, Suite 431, Fresno, CA 93720. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

H. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care. If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy and Security Officer at: 559-450-5616.