SantéPlus
MEDICAL CENTER

PATIENT INFORMATION

If not the patient, name of Personal Representative: First Name:______________________ Last Name:_________________________

If not the patient, relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Legal Representative

Patient Name (the "Patient"): First Name:_________________________ Middle Initial: ______ Last Name:_______________________

SS: ____-____-____ Date of Birth: ____-____-____ Address: ____

Home Phone: ____-____-_______ Cell Phone: : ____-____-_______ Email Address: _____________________________________

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersexual ☐ Declined

Current Gender: ☐ Female ☐ Male ☐ Trans: Male to Female ☐ Trans: Female to Male ☐ Declined ☐ Other: ________________

Sexual Orientation: ☐ Heterosexual ☐ Homosexual (Gay/Lesbian) ☐ Bisexual ☐ Declined ☐ Other: ______________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Race: ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian ☐ Other ☐ Declined

Preferred Language: ☐ English ☐ Spanish ☐ Creole ☐ Other: _________________________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other ________________________

Occupation: ☐ Full-Time Employee ☐ Part-Time Employee ☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Active Military

Employer Name: ____ Work Phone: _______-_______-__________

Emergency Contact: _____________________________________ Emergency Contact Phone: _______-_______-__________

Relationship to Patient: _______________________ Consent to disclose medical information to Emergency Contact: ☐ Yes ☐ No

DISCLOSURE TO FRIENDS AND/OR FAMILY MEMBERS

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below.

Name	Relationship	Phone Number

Do you have a: ☐ Living will ☐ Advanced Directives ☐ DNR ☐ Power of Attorney ☐ None ☐ Decline

Legal Guardian/Proxy or Caregiver: ____________________________________ Contact Phone: ____-____-_______

Pharmacy Name: ____ **Pharmacy Phone Number**: ________-________-__________

Pharmacy Address: ____

INSURANCE INFORMATION

Primary Insurance: ____ Phone Number: ____-____-_______

Insurance Address: ____ Group Number: _________________

Subscriber Name: ________________________ Date of Birth: ____-____-____ Subscriber ID: __________________

Responsible Party: ☐ Self ☐ Guarantor ☐ Check here if information is same as patient

Responsible Party Name (First): ______________________ (MI): ____ (Last): ______________________

Guarantor SS: ____-____-____ Guarantor Date of Birth: ____-____-____

Guarantor Address: _____________________________________ City_______________________ State _____ Zip Code: ________

Guarantor Home Phone: ____-____-_______ Guarantor Cell Phone: : ____-____-_______

By signing below, I certify all information above is true and correct to the best of my knowledge.

Patient or Patient's Personal Representative: ______________________________________ **Date**: _______________________

FINANCIAL POLICY

____ (Initials) The doctors and the healthcare providers of Santé Plus charge fees for the care provided to you. The fees may not be the same as the estimate given. This includes any deductibles and coinsurances. Copays are due at the time of service. You are also responsible for any deductibles and coinsurances on your insurance plan.

In the event your health insurance company does not pay the full amount of fees charged by Santé Plus, you (patient or responsible party) would have to pay Santé Plus for the cost of care not paid by the health insurance company. This also applies for patients within their grace period.

If the insurance information provided to Santé Plus is not correct, you may have to pay the fees associated with your care.

If you do not have health insurance, then you will have to pay the fees for the medical services rendered to you.

Medicare will only pay for the care that is acceptable and needed under section 19862(a)(1) of the Medicare Law. By signing below, you certify the facts you have given to Santé Plus or payment under Tittle XVIII and XIX of the Social Security Act are correct.

____ (Initials) Santé Plus can bill my health insurance company for my care. Payments will be made to Santé Plus on my behalf.

Patient or Patient's Personal Representative: ______________________________________ **Date**: ___________

CONSENT TO TREATMENT

____ (Initials) I am a patient of Santé Plus By signing below, I give my consent to be treated by Santé Plus healthcare providers.

____ (Initials) I understand treatment and services may include: lab tests, routine exams, screening tests (tests that can find an illness early, before a person shows signs of having the disease), diagnostic tests (tests that shows if a person has a certain illness or health problem)

____ (Initials) I understand that no promises have been made to me about the results of any treatment or services.

____ (Initials) I understand that I have the right to refuse any treatment or procedure and have the right to discuss all medical treatments with my provider.

____ (Initials) I acknowledge that I have read and understood each of the above provisions appearing in this section. I have also had the opportunity to ask any questions, and by my signature, I consent and agree to such provisions individually and collectively. A copy may be used in lieu of the original.

____ (Initials) Consent for Treatment of Minor or Incapacitated Patient. As the Personal Representative of the minor or incapacitated patient, I hereby give consent for the Patient to receive medically necessary treatment and care, including emergency treatment, by Sanitas. **We reserve the right to require proper identification of the Personal Representative prior to the provision of treatment and care to a minor or incapacitated patient.**

Patient or Patient's Personal Representative: ______________________________________ **Date**: _______________________

PATIENT HIPAA ACKNOWLEDGMENT & HEALTH INFORMATION EXCHANGE OPT-IN

___ (Initials) Notice of Privacy Practices. I acknowledge that I have received the Santé Plus *Notice of Privacy Practices* which describes my rights and Sanitas' duties with respect to my protected health information (my "PHI"), and specifically notifies me that Santé Plus is permitted to use, disclose, receive and exchange my PHI for (i) treatment, payment and healthcare operations purposes; (ii) as I may authorize in writing; and (iii) as otherwise allowed pursuant to the regulations of the Health Insurance Portability and Accountability Act ("HIPAA) and relevant state laws (collectively, the "Permitted Uses"). I understand that I may contact the Privacy Officer (info@santeplusmedical.com) if I have a question or complaint. To the extent permitted by law, I voluntarily consent to the use, disclose, receive and exchange of my PHI for the purposes described in the *Notice of Privacy Practices*.

___ (Initials) Medical Students. Santé Plus is proud to be an Academic Center for Health Care Students. With your consent, as part of the program, a student may be invited to speak to you about your visit and/or overall health before you are seen by your physician. Critical

to the experience is the awareness and education of the importance of patient's privacy and confidentiality. As a result, all students participating in this program will have completed HIPAA compliance training, signed an agreement to adhere to the Sanitas *Code of Conduct,* and will have signed an agreement of confidentiality, prior to commencing, as to ensure that your patient rights are protected.

___ (Initials) Health Information Exchange. Health information exchanges ("HIEs) allow your PHI, from all sources of treatment, to be available, viewed and transmitted electronically by your providers and care teams. HIEs are designed to provide quick access to your medical records to make treatment and care coordination more effective and efficient. Accessing HIEs with respect to your PHI will meet the requirements under HIPAA and relevant state laws. I understand that Santé Plus participates in one or more HIEs.

Florida *Patients Only*: By my consent and signature below, **I consent, opt-in** and **voluntarily authorize** Santé Plus to use, disclose, receive and exchange my electronic PHI through HIEs for Permitted Uses only. **___ (Initials)**

New Jersey, Tennessee and Texas Patients: Pursuant to relevant state law, patients are automatically enrolled in HIEs which allows Santé Plus to use, disclose, receive and exchange my PHI for Permitted Uses only.

My participation in HIEs is voluntary and is not a condition to receive care. **I may opt-out of HIE participation at any time** by providing written notice to Santé Plus. My consent will remain valid until revoked by me and any subsequent revocation of consent will not apply to my health information that has previously been received, used, disclosed or exchanged through HIEs for Permitted Uses.

Patient or Patient's Personal Representative: ____ **Date**: ________________________

CONSENT FOR COMMUNICATIONS

___ (Initials) By providing my phone number and email address, I voluntarily and expressly authorize Santé Plus (or third parties acting on behalf of Santé Plus and subject to patient confidentiality restrictions) to communicate with me at the phone number and email address that I provided above, using automated/autodialed phone calls, prerecorded messages, artificial voices, voicemail, automated SMS messages and email for information related to my treatment and care as well as marketing purposes for healthcare products and services recommended by Santé Plus which may be beneficial to Santé Plus patients. I understand that such communications may not be encrypted or secure. Santé Plus will use appropriate safeguards to protect my PHI in accordance with HIPAA and relevant laws. Message and data rates may apply.

I acknowledge that **I have the right to opt out of receiving future Santé Plus communications** at any time by using the opt-out mechanism provided in the communication. I understand that **I may revoke this consent for communications at any time**, either by completing a new patient registration form or notifying Santé Plus in writing. I also understand that **I am not required to sign this consent as a condition to receiving treatment or services from Santé Plus** and that **opting out of Santé Plus communications will not affect my treatment or the services available to me**. I confirm that I own or control the phone number and email provided by me and agree to notify Santé Plus in writing within thirty (30) days if I change my phone number or email address.

___ (Initials) I acknowledge, understand and agree to receive communications concerning my treatment and care from Santé Plus (or third parties acting on behalf of Santé Plus), which may occur more than once per day or three-times per week, in excess of the limitations under applicable law.

Patient or Patient's Personal Representative: ____ **Date**: ______________________

PHOTO IDENTIFICATION

I voluntarily and expressly authorize Santé Plus to take a photograph of me (or person for whom I am a Personal Representative) to be used for identification purposes and stored in my medical record in accordance with HIPAA and relevant laws. My refusal will not affect my treatment or the services available to me. If I prefer not to be photographed, I will be asked to provide photo identification at each visit. I may revoke this consent at any time by notifying Santé Plus in writing.

Patient or Patient's Personal Representative: ____ **Date**: ________________________

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND ALL OF THE INFORMATION CONTAINED IN THIS DOCUMENT.