R Family Medical Group
Here To Serve Your Family

Patient Handbook

WELCOME

Welcome to R Family Medical Group! We are honored that you have chosen us as your healthcare provider. Our mission is to provide the highest quality of care in a timely and respectful manner.

Please take the time to thoroughly read our Patient Handbook. R Family Medical Group's Patient Handbook was developed to inform our patients of our general practices and office policies. Our staff is here to assist you, please feel free to ask our front desk staff if you have any questions.

Office Locations

R Family Medical Group has two convenient locations to serve you. Your provider may practice at one or both locations.

Office Hours

Our Huebner office hours are 8AM to 5PM Monday thru Friday and closed on Saturdays. Our Nogalitos office hours are 8AM to 5PM Monday - Thursday and 8AM to 1PM Friday - Saturday (**Please note** Saturday availability varies monthly). Our offices will close for the following holidays: Battle of Flowers, July 4th, Memorial Day, Labor Day, Thanksgiving, Day after Thanksgiving, Christmas Eve, Christmas, New Year's Eve and New Year's Day. Our schedule is always subject to change. We will post in advance any office closings on our Facebook page, website, and clinic.

Making an Appointment

We do our best to provide you with same-day office visits and accept walk-ins for first available slots for sick visits. You will be asked to fill out new registration forms annually so we may update your information.

We request that you arrive for appointments 5 to 10 minutes prior to your scheduled appointment time. This allows staff the time to check you in and greatly increases your doctor's ability to see you at your scheduled appointment time. We will strive to stay on time. From time to time, a patient emergency arises, and we may run late for your visit. In this scenario, our staff will update you on the expected wait time and offer to reschedule if you would prefer a more convenient time.

We welcome your comments and feedback on how we may serve you better. Our staff is here to provide you with quality primary care, and we look forward to caring for your healthcare needs.

Welcome to our practice and thank you for choosing R Family Medical Group for all your healthcare needs.

Sincerely,
David A. Ramos, MD
DAR/mcg

Revised: 12/21/2017, 12/26/2018, 1/3/19, 2/1/19/1/1/2020/mcg, 12/29/2020 JM

Family Medical Group
Here To Serve Your Family

PATIENT REGISTRATION FORM

Please Provide Insurance Cards with Picture ID to Receptionist

PATIENT INFORMATION (Please Print)

Today's Date: _____

PATIENT'S NAME: _____ **DOB:** _____ **SEX:** ☐ M ☐ F
LAST FIRST MI

ADDRESS: _____
CITY STATE ZIP

HOME PHONE: _____ **CELL PHONE:** _____ **SOCIAL SECURITY#:** _____

EMAIL: _____

RACE/ETHNICITY:
(CHECK ALL THAT APPLY)
- ☐ Decline to State
- ☐ American Indian
- ☐ Hispanic/Latino
- ☐ African American
- ☐ Asian/Other
- ☐ White
- ☐ Other: _____

LANGUAGE:
(CHECK ALL THAT APPLY)
- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ French
- ☐ Other: _____
- ☐ Deaf or Hard of Hearing?

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Domestic Partnership
- ☐ Separated
- ☐ Widowed

PHARMACY INFORMATION

PREFERRED PHARMACY: _____ PHONE: _____

PHARMACY ADDRESS: _____
CITY STATE ZIP

EMPLOYMENT INFORMATION

EMPLOYER: _____ PHONE: _____

ADDRESS: _____
CITY STATE ZIP

SPOUSE INFORMATION ☐ **NOT APPLICABLE**

NAME: _____ DATE OF BIRTH: _____

WORK PHONE: _____ HOME PHONE: _____ CELL PHONE: _____

EMERGENCY CONTACT OR RESPONSIBLE PARTY (IF PATIENT IS UNDER 18 YEARS OF AGE**)**

NAME: _____ RELATION: _____

ADDRESS: _____
CITY STATE ZIP

WORK PHONE: _____ HOME PHONE: _____ CELL PHONE: _____

PHYSICIAN REFERRAL INFORMATION

How did you hear about us? ☐Employer ☐ Family Member ☐ Friend ☐Insurance ☐Television ☐ Website ☐ Other: _____

3110 Nogalitos, Ste. 105
San Antonio, TX 78225
Phone: (210) 533-0257
Fax: (210) 534-0890

Rfamilymedicalgroup.com

9811 Huebner Rd. Bldg. 2
San Antonio, TX 78240
Phone: (210) 561-8169
Fax: (210) 561-8178

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INSURANCE INFORMATION

A copy of your insurance card(s) and Driver's License (photo ID) is required.

Please Indicate (P) for Primary Insurance and (S) for secondary insurance					
Medicare	Medicaid	Blue Cross	Aetna	Cigna	UHC
Humana	Private Pay	Tricare	Other:		

Primary Subscriber's name:	**Subscriber's ID #:**	**Subscriber's Birth date:**
Secondary Subscriber's Name:	**Subscriber's ID #:**	**Subscriber's Birth date:**

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Other:

COMMUNICATION AUTHORIZATION- PLEASE COMPLETE

We are committed to providing private and efficient communication with you. Please indicate the preferred method (s) of contact, should we need to reach you by phone regarding your appointments, results, insurance benefits, and/or patient/account balance (s). Place an X in the appropriate box (es).

□ Home □ message to return call □ detailed message (results, treatment) □ NO message □ voice mail □ with an individual
□ Work □ message to return call □ detailed message (results, treatment) □ NO message □ voice mail □ with an individual
□ Cellular □ message to return call □ detailed message (results, treatment) □ NO message □ voice mail □ with an individual □ Text

In certain instances, it may be necessary to communicate via email. □ Yes –email □ No – email

Release of Information Policy – Please Read

HIPAA AUTHORIZATION

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) a covered entity (being a healthcare provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

AUTHORIZATION

I, _____, an individual, hereby authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath,) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other healthcare provider or affiliate, to disclose the following information:

> All healthcare information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers, whether past, present, or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

I hereby authorize David A. Ramos, M.D., P.A., dba R Family Medical Group to use and/or disclose my health information which specifically identifies me, or which can reasonably be used to identify me to carry out my treatment, payment, and other healthcare operations. My protected health information may be released to the following individual (s):

INDIVIDUAL #1

NAME: _____

ADDRESS: _____

PHONE: _____

RELATIONSHIP TO PATIENT: _____

INDIVIDUAL #2

NAME: _____

ADDRESS: _____

PHONE: _____

RELATIONSHIP TO PATIENT: _____

INDIVIDUAL #3

NAME: _____

ADDRESS: _____

PHONE: _____

RELATIONSHIP TO PATIENT: _____

Additional pages can be provided upon request

I acknowledge that I have been provided the "Notice of Privacy Practices" for *David A. Ramos, M.D., P.A., dba R Family Medical Group*. I acknowledge that I have completed this form and certify that I am the patient or duly authorized to finish the information requested.

_____ _____

Patient or Authorized Representative Signature Date

Financial Policy

Proof of Insurance:

Payment is due at the time of service, which includes applicable co-pays, deductibles, and coinsurance. Please bring your insurance card(s) with you to every appointment. It is your responsibility to inform the front desk when a change of insurance has occurred. Verification of benefits is required. If benefits are unable to be verified, you are responsible for payment in full for services rendered. All charges are your responsibility whether your insurance company pays or does not pay. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, etc. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.**

1. **PAYMENT IS DUE AT THE TIME OF SERVICE:**

   We accept cash, debit and credit cards. **All deductibles, copays, and non-covered services are due at time services are rendered.** If you have Medicare, but Medicare may deem the treatment as "medically unnecessary" according to HCFA payment guidelines, you will be required to sign a waiver (**advanced beneficiary notice**) prior to treatment and the service is due at the check-out counter. All Medicare patients will be required to pay the 20% copay based upon the current Medicare Fee Schedule at the check-out counter unless proof of a secondary policy is evident. Pre-determined copays are due when you check-in for your appointment. If your copay is based on a percent (example 20% is patient responsibility) and you do not have a secondary policy, please be prepared to pay. Insurance claims are filed as a courtesy; you are ultimately responsible for the rendered services. **If the insurance balance is not paid within 90 days, the balance may be released to you.**

2. **NON-COVERED SERVICES:**

   You are responsible for services that are considered non-covered by your plan, are denied due to benefit limits or termination of coverage, and for deductibles, co-insurance and/or co-pay balances not collected at the time services are rendered

3. **THIRD PARTY INSURANCE:**

   David A. Ramos, M.D., P.A., dba R Family Medical Group does not accept Third Party Insurance & Worker's Compensation as a form of payment. This includes automobile insurance and third-party liability. We will provide you with the information needed to submit a claim for reimbursement, but we will consider all charges to be your responsibility.

4. **ACCOUNTING PRINCIPALS:**

   Payment and credits applied to the oldest charges firsts, except for insurance payments which are applied to the corresponding dates of service.

5. **DIVORCED PARENTS OF PATIENTS:**

   By signing below, the adult who signs a minor child into our practice in the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

6. **STATEMENTS AND RECEIPTS:**

   David A. Ramos, M.D., P.A., dba R Family Medical Group does not routinely mail statements. You are entitled to a receipt for any payment made at *R Family Medical Group*. You may also request a statement for your account with *R Family Medical Group* at any time by

calling our office at 210-533-0257. Up to two requests for the same statement will be free of charge. On the third request for the same statement, we are entitled to charge a service fee.

7. **OUR RESPONSIBILITY TO REPORT NON-COMPLIANCE**:

It is our obligation under many of the managed care contracts to report patients who repeatedly refuse to pay copays and deductibles at time of service or who are repeatedly "No-Show" for appointments. Please know that if you are reported, you could possibly lose your healthcare benefits. Contact human resources with your employer for further clarification of your benefits and obligations.

8. **FINANCIAL ASSISTANCE:**

Our office treats patients regardless of financial status. If you have no insurance, have maximized your benefits, have a high deductible or you are currently medically indigent or financially indigent but not eligible for Public Assistance or Medicaid, please ask to speak with the Office

9. **BILLING, PAYMENTS, AND OVER PAYMENTS:**

If an overpayment is made by you on the account, a refund will only be issued in a timely fashion if there are no other outstanding debts on the other accounts containing the same guarantor or financial responsible party. Patient balances unforeseen at time of service are due at the time services are rendered. All balances are due in full within 14 days of the billing date. Miscellaneous applicable fees include, but not limited to: **$25.00-$50.00 for Appointment "No-Shows" and designated document request fee(s). Please refer to our Office Protocol Agreement or ask administration for further details.**

10. **PAST DUE AND DELINQUENT ACCOUNTS:**

Failure to meet your financial obligations may result in reporting you to our contracted collection agency who in turn may report you to the credit bureau, filing for a judgment in small claims court or other collection action against you and you may be terminated as a patient from this facility. All attorney fees, court costs and other expense related to collecting your account will be added to your outstanding balance.

11. **PROFESSIONAL COURTESY POLICY:**

There will be a zero tolerance to "professional courtesy" extended to any office staff, members of the physician's family, friends, colleagues, clients, patients, or referrals. The purpose of this policy is to be compliant with the Civil False Claims Act and the Anti-Kickback Statutes when making write-off's, adjustments, discounts, and no charges. Our Provider(s) require you to direct all financial concerns to the Administrative Staff.

COMPLAINTS AND QUESTIONS

If you have questions that have not been answered by this information or would like to make a compliant, please contact our **Billing Department at 210-533-0257**. If you would like to file a complaint about the services received at *David A. Ramos, M.D., P.A., dba R Family Medical Group*, you may call the Texas Medical Board at 1-800-201-9353 or write to:

Texas Medical Board
Investigations Department, MC-263,
P.O. Box 2018
Austin, Texas 78768-2018.

INFORMATION ON PREVENTATIVE CARE VISITS

Due to insurance regulations, all physicals, well-woman exams and well-child exams are considered preventative care visits. Most insurance companies cover 100% of one preventive care visit per year. The visits cover general check-ups, routine cancer screenings, immunization and counseling on diet and exercise, child development and vitamin supplements. Unfortunately, insurance companies will not cover non-preventative care issues raised

during a preventative care visit. As such, we strongly encourage you to make a separate, follow-up appointment with your provider, if you have medical concerns that fall outside or unrelated to your preventative care to ensure our staff and providers schedule the appropriate amount of time to address your medical concerns. This will prevent your insurance company from applying additional charges to you for services outside or unrelated to your preventative care.

We thank you for your understanding in this matter.

OFFICE PROTOCOL AGREEMENT

We are pleased that you have ***chosen David A. Ramos, MD PA DBA R Family Medical Group*** as your healthcare provider. As part of the new patient (initial) visit, we will need you to fill out paperwork that pertain to your patient information, insurance coverage, communication and HIPAA authorization, and Pre-Authorized Credit Card Information.

We request that you arrive 1**5 minutes** before your appointment time in order check in and to allow you enough time to fill out the paperwork. We request that you bring all your medications, including over the counter medications, and supplements, picture ID card and insurance cards. If your address on the picture ID is not correct, we will request another type of identification in order to confirm an accurate address.

The following protocols are necessary to provide appropriate care to all our patients. Please review, initial each entry and sign below indicating that you understand these office protocols and agree to abide by them. Lack of signature does not invalidate these protocols.

1. I understand that refills are given at time of office visit. Refills are not done over the phone or over the weekend**. _____ (initials)**

2. I understand that I will need to schedule a follow-up appointment with my provider to review results for labs and test results (radiology …). _____**(initials)**

3. I understand that I am an active participant in my healthcare and agree to abide by the treatment plan given and reviewed with me at each visit. I understand that any changes in condition may need an office visit for reassessment. _____**(initials)**

4. I understand that this practice utilizes mid-level practitioners; such as Physicians' Assistant and Nurse Practitioners. They provide care in terms of assessing new patients; assessing patients on routine follow ups; assessing any changes in conditions; education of patient on condition, medications, and treatment options. _____ **(initials)**

5. I understand that my access to care via telephone or on site will require my behavior to be in a manner that is not abusive to staff. I agree to refrain for behavior that reflects yelling, cursing, name calling or multiple calls in same day. I understand that this behavior may terminate my relationship with this practice. _____**(initials)**

6. I agree to cancel my appointments **24 hours** in advance to benefit other patients that are in need of earlier appointments. I understand that not showing up for an appointment without calling in advance may result in a charge fee of **$25.00**

for an office visit and **$50.00** for a procedure. I also understand that failure to cancel may become a factor in the continuation or discontinuation of my care with ***David A. Ramos, MD PA DBA R Family Medical Group.*** _____ (**initials**)

7. I understand that I am to arrive 15 minutes before my appointment time to check-in and complete any necessary patient paperwork. _____ (**initials**)

AFTER HOUR CALLS

After-hours calls will be answered by our automated service. In case of an urgent matter that cannot wait for the next business day, you may reach the on---call provider. There will be a $25.00 fee for after-hours consultations. We will not call in new prescriptions or refill prescriptions after hours. Please make prescription refills and appointment requests during regular office hours.

SUPPLEMENT PURCHASE

Formula (s) purchased are not intended to diagnose, treat, cure, or prevent any disease and have not been evaluated by the FDA. The Purchase of these supplements from *David A. Ramos, MD PA DBA R Family Medical Group* is strictly optional.

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND OTHER HEALTH-RELATED BENEFITS

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

OUR PROMISE TO YOU

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information and to abide by the terms of the notice of privacy practices in effect. Please consult with our front desk for an up-to-date copy of our privacy policy.

CONTACT PERSON FOR REQUESTS

If you have any questions or want to make a request pursuant to the rights described above, please contact:

David A. Ramos, MD PA DBA
R Family Medical Group
Privacy Officer
3110 Nogalitos Suite 105
San Antonio, Texas 78225
Phone: 210-533-0257 Fax: 210-534-0890

This notice is effective on the following date: January 1, 2018. We may change our policies and this notice at any time and have those revised policies apply all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR (PRIVATE, GROUP ACCIDENT AND HEALTH INSURANCE)

I hereby instruct and direct _____ (**Insurance Company**) to pay by check made out and mailed directly to: David A. Ramos, MD PA for professional and/or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered

MEDICARE ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I request that payment of authorized Medicare benefits be made on my behalf to David A. Ramos, MD PA DBA R Family Medical Group for services furnished to me by the provider. 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 for related services.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment.

I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from my obligation to pay professional fees.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.
_____(**Initials**)

APPOINTMENT POLICY

In an effort to provide efficient treatment to all of our patients, it is the policy of this company that if you are unable to make your scheduled appointment, you must call to cancel the appointment no later than 24 hours before the scheduled time. If you fail to cancel your appointment and/or fail to show up to the appointment, you may be charged with a "NO SHOW" fee of $25.00 for office visits and $50.00 for procedures, per occurrence.

Repeated "NO SHOWS" and cancellations of your scheduled appointments may result in you being DISCHARGED from care at the offices of David A. Ramos, MD PA DBA R Family Medical Group. If you have any questions or concerns about this policy, our staff is available to answer your questions. _____(**Initials**)

PRESCRIPTION REFILL PROTOCCOL

In order to better serve our patients, David A. Ramos. MD PA DBA R Family Medical Group will be adopting this policy effective immediately. The increasing volume and short notice has become too great and has affected our ability to properly triage urgent versus non-urgent telephone calls. Once you have notified the office that you are in need of a prescription refill please allow 24 to 48 hours for your prescription to be called into the pharmacy

Refills on CONTROL SUBSTANCE will ONLY be made during business hours and on SCHEDULED appointments. It is YOUR responsibility and is required of you to keep track of your remaining prescription and dose, so as to ensure you have enough time to schedule an appointment. Call 7 days prior to your prescription running low and schedule an appointment. David A. Ramos, MD PA DBA R Family Medical Group will NOT refill prescriptions after hours, on weekends or on holidays. If the prescription is lost, misplaced, stolen or you use the prescription more rapidly than what it is directed it will NOT be replaced.
_____(**Initials**)

CONTROLLED SUBSTANCE POLICY STATEMENT

Controlled substances are excellent medications which serve a purpose. Unfortunately, they are also heavily abused in our society. We do not feel that "pain" or "anxiety" patients are "bad" patients. However, we must remain on alert for those who are looking to abuse their prescriptions. Controlled substances of concern include narcotics (MORPHINE, OXYCODONE, DILAUDID, etc.) and anti-anxiety medications (ATIVAN, XANAX, VALIUM, etc.).

- I understand with controlled substance therapy (narcotics), it is expected that I may need to undergo random urine drug testing as part of my treatment plan.
- Refills will occur on a monthly basis and ONLY after a visit and random urine drug screen. NO REFILLS WILL BE MADE OVER THE TELEPHONE, GIVEN AFTER HOURS, ON WEEKENDS, AND/OR HOLIDAYS.
- Renewals are contingent on keeping scheduled appointments.
- If refill requests are made after hours, you will be instructed by the answering service to go to an emergency room of your choice.
- Any evidence of prescriptions, forged prescriptions, substance abuse, or aberrant behavior (including verbal abuse to my office staff) will result in termination of patient-physician relationship.

NOTE: Patients who are prescribed a Controlled Substance will be required to sign an annual Controlled Substance Policy Form.

_____**(Initials)**

TESTOSTERONE POLICY

Any patient who elects to self-administer his testosterone injection understands that R Family Medical Group, Inc. requires said patient to schedule an appointment to receive patient education on how to properly self-administer the testosterone injection.

_____ **(Initials)**

PHYSICIAN DISCLOSURE

As required by Section 102.006 of the Texas Occupations Code Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified, or registered by a Texas healthcare regulatory agency.

The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to certain diagnostic testing laboratories, pharmacies and/or other ancillary healthcare providers, for certain toxicology and pharmacogenomic testing services, compounding pharmacy products, diagnostic imaging services and other ancillary healthcare services.

Accordingly, I hereby acknowledge that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation, if any, with the diagnostic testing laboratory, pharmacy, or other ancillary healthcare provider for whom, I, the patient, am being referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such diagnostic testing laboratory, pharmacy, or other ancillary healthcare provider. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving ancillary healthcare services from any ancillary healthcare provider and/or facility that I choose.

PROVIDER TO PROVIDER INFORMATION EXCHANGE

Our electronic medical records provider, eClinicalWorks, is part of a Provider-to-Provider Information Exchange. This Exchange allows providers to exchange patient information.

As a patient you can opt IN or Out of the Provider-to-Provider Information Exchange. By opting IN, R Family Medical Group will be able to obtain your patient information from any hospital, pharmacy or physician that is part of the Commonwell or Care Quality Network.
(Choose One)

- I elect to opt In to the Provider-to-Provider Information exchange. _____ (**initials**)

- I elect to opt Out of the Provider-to-Provider Information exchange. _____ (**initials**)

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PATIENT PORTAL CONSENT FORM

Patient: _____
Last Name First Name MI

Date of Birth: _____

_____
Street Address City State Zip

R Family Medical Group provides a Patient Portal in partnership with our electronic medical records provider, eClinicalWorks for the exclusive use of our established patients. The Patient Portal is designed to improve the patient-provider communication.

R Family Medical Group strives to keep all of the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal provides access to the following services:

- Request appointments
- Request prescription refills
- View medical records
- Receive and/or download educational material
- View current and past billing statements
- Pay patient bills
- Send messages to the staff
- Receive health maintenance reminders
- Perform TeleVisits

The Patient Portal is not designed to provide internet based diagnostic medical services. The following limitations also apply:

- No internet based triage and treatment requests. Diagnosis can only be made and treatment rendered after the patient is SEEN by the provider.
- No emergent communication or services. Any emergent conditions should be handled by calling the office directly, going to the emergency room or calling 911 should the emergency be life threatening.
- No requests for narcotic/controlled medications will be accepted.
- No requests for new prescriptions or refills for conditions for which you are not being treated by our clinic will be accepted.

- It may take up to 72 hours to receive a response to an email request. If you do not receive a response within 72 hours you should contact the office at 210-533-0257.
- If you lose your password or username, you may request a new one through the web portal or in person at the office by providing valid identification.

- Always remember to log out and close your browser when you are finished accessing password protected Patient Portal services. This prevents someone else from accessing your personal information. YOU SHOULD NEVER USE A PUBLIC COMPUTER TO ACCESS THE PATIENT PORTAL.

This Patient Portal is provided as a courtesy to our patients. If abuse or negligent usage of the Patient Portal persists, R Family Medical Group reserves the right, at our discretion, to terminate Patient Portal offering, suspend user access and modify services available through the Patient Portal.

The Patient Portal is provided in partnership with eClinicalWorks, our EHR software vendor and provider. Stored data is HIPAA compliant with high level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent possible, our office has undergone rigorous IT implementation and security standards that meets industry recommendations.

Please read our HIPAA policy for information on how private health information is used in our office. All patients have signed a HIPAA agreement form as part of our annual Patient Registration Packet. If you do not recall having signed a HIPAA agreement or need to reacquaint with the HIPAA policy, we will be happy to provide you with a copy.

Once you have signed the Patient Portal User Agreement and have provided our office with a legitimate email address that is secure, you will be given our system generated unique user identification and password. The site may be accessed:

1. Our website: www.rfamilymedicalgroup.com
2. Directly by going to this URL: https://health.healow.com/rfmg

Patient Acknowledgment and Agreement:

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the Patient Portal and agree that I understand the risks associated with online communication between my provider and myself, and consent to conditions outlined herein.

I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal.

I acknowledge that my username and password will be unique to my health information and sharing my username and password may grant others access to my health information.

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I further understand that any health information disclosed as a result of sharing my username and password may no longer be protected under federal or state law and could be further released by the individual who receives the information.

In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been given an opportunity to ask questions related to this agreement and all of my questions have been answered to my satisfaction.

By Signing below, I authorize R Family Medical Group to send email communications regarding the Patient Portal to the email address identified below and give my expressed consent for my medical information to be made available to my Patient Portal. I acknowledge that I have the right to receive a completed copy of this consent.

Please clearly print the email address authorized to receive the email invitation:

Please clearly re-print the email address authorized to receive the email invitation:

_____
Patient or Representative Printed Name

_____
Date

_____
Patient or Representative Signature

YOU AFFIRM THAT YOU HAVE THE FULL RIGHT AND POWER TO SIGN AND BE BOUND BY THESE AGREEMENTS, AND THAT YOU HAVE READ, UNDERSTAND, AND ACCEPT ALL OF ITS TERMS OF THIS CONTRACT.

_____
Patient/Parent/ or Legal Representative

_____
Description of Legal Representative

_____
Date

Should you have any questions and or concerns feel free to call the office at 210-533-0257 and we would be happy to assist you.

If submitting this document electronically, please email your completed document to forms@rfamilymedicalgroup.com with the subject "New Patient Packet".

Thank you,

David A. Ramos, MD