R Family Medical Group
Here To Serve Your Family

Patient Handbook

WELCOME

Welcome to R Family Medical Group, Inc. We are honored that you have chosen us as your health care provider. Our mission is to serve the San Antonio Community with the highest quality of care while improving healthcare outcomes.

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 information 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, Inc. has two convenient locations to serve you. Your provider may practice at one or more of these locations. You will be asked at the time of scheduling your appointment which location you wish to be seen.

Office Hours:

Our ***Huebner*** office hours are 8AM to 5PM Monday thru Friday. Our ***Nogalitos*** office hours are 8AM to 5PM Monday thru Friday and 8:30AM to 12:45PM on Saturdays. Our offices will close for the usual national holidays such as Thanksgiving and Christmas. These closings will be posted in the lobby of the clinic in advance.

Making an Appointment:

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

We are requesting that you show up 5 to 10 minutes prior to your scheduled appointment time. This allows the 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 be running late for your visit. You will have the option to re-schedule or stay to be seen. We will keep you informed of how long of a delay you may experience.

We welcome your suggestions 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, Inc. for all your health care needs.

Sincerely,

David A. Ramos, MD
DAR/mcg

Revised 05/01/2018
Revised by: MCG

Family Medical Group
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REGISTRATION FORM

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: _____

Do you have an E-Mail? □ No □ Yes E-Mail: _____

MARITAL STATUS: PLEASE CIRCLE: SINGLE MARRIED DOMESTIC PARTNER DIVORCED WIDOWED SEPARATED

Race/Ethnicity: (Check all that apply) □ **Decline**

□**American Indian** □**Hispanic/Latino/Spanish**
□**African American** □**Cuban**
□**Asian/other** □**Puerto Rican** □**Pacific Islander/Other**
□**White** □**Other: _____**

Language:
□**English**
□**Spanish**
□**Other: _____**

NAME OF PHARMACY: _____ PHONE: _____

PHARMACY ADDRESS: _____
City State Zip

EMPLOYMENT INFORMATION

EMPLOYER _____ PHONE: _____

ADDRESS: _____

SPOUSE INFORMATION □ **Not Married**

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: _____

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

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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

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.

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 □ brief message □ detailed message (results, treatment) □ with individual □ No message
□ Work □ brief message □ detailed message (results, treatment) □ with individual □ No message
□ Cellular □ brief message □ detailed message (results, treatment) □ with individual □ No message

In certain instances it may be necessary to comunícate via email or text message. Yes, ☐ email Yes, ☐ text message

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 health care 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.

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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 health care provider or affiliate, to disclose the following information:

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care 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 health care opertions. My protected health information may be released to the following individual (s):

Name: _____ **Address:** _____

Phone: _____ **Relationship to patient:** _____

Name: _____ **Address:** _____

Phone: _____ **Relationship to patient:** _____

Name: _____ **Address:** _____

Phone: _____ **Relationship to patente:** _____

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 chat I am the patient or duly authorized to finish the information requested.

_____ Date: _____/_____/_____

Patient or Responsible Party Signature

R Family Medical Group
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Please read and initial every section!

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. _____ **(initials)**

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 payment for the said 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.** _____ (initials)

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. _____ (initials)

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. _____ (initials)

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. _____ (initials)

5. **DIVORCED PARENTS of PATIENTS:**
   By initialing below, the adult who signs a minor child into our practice on 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. _____ (initials)

6. **STATEMENTS AND RECEIPTS:**
   David A. Ramos, M.D., P.A., dba R Family Medical Group **does not mail patient statements.** If you provide us with your email then we will send you a statement via the patient portal. 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. You are entitled to a receipt for any payment made at *R Family Medical Group*. _____ (initials)

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 health care benefits.**
   - Contact human resources with your employer for further clarification of your benefits and obligations. _____ (initials)

8. ***Financial Assistance:***
Our office treats patients regardless of financial status. If you do not have insurance, have maximized your benefits, have a high deductible, are currently medically indigent or financially indigent but not eligible for Public Assistance or Medicaid, please ask to speak with the Office Manager regarding our **Direct Primary Care Plan.** _____ (initials)

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 are 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.** _____ (initials)

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. _____ (initials)

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, adjustments, discounts and no charges. Our Provider(s) require you to direct all financial concerns to the Administrative Staff. _____ (initials)

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. _____ (initials)

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 Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. _____ (initials)

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.
_____ (initials)

A PHOTO COPY 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 will 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)

INFORMATION OF 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 may 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 may prevent your insurance company from applying additional charges to you for services outside or unrelated to your preventative care. _____ (initials)

OFFICE PROTOCOL AGREEMENT:

The following protocols are necessary to provide appropriate care to all our patients. **Please review, and sign the agreement at the end of this Patient Hand book.** Your signature indicates 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 health care 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 Physician Assistants 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 from behavior that reflects yelling, cursing, name calling or multiple calls on the 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 a no-show Appointment without calling in advance may result in a charge fee of **$25.00** for an office visit and **$50.00** for a procedure, and can also be 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 the New Patient / Established patient forms. _____ (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. _____ (initials)

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. _____ (initials)

HIPPA POLICY

TREATMENT, PAYMENT, HEALTH CARE OPERATIONS

We are permitted to use and disclose your medical information to those involved in your treatment. For example: the physician/provider (s) in our office. When we provide treatment we may request that your specialist share your medical information with

us. Also, we may provide your specialist with information about your condition so that he or she can appropriately treat you for the other medical conditions, if any.

PAYMENT:
We are permitted to use and disclose your medical information to bill and collect payment for services provided to you. For example, we may complete a claim form to obtain payment from your insurance carrier. The form will contain medical information such as a description of the medical service provided to you that your insurance carrier needs to approve payment to us.

HEALTH CARE OPERATIONS:
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to ***aid David A. Ramos, MD PA DBA R Family Medical Group*** in its compliance with regulations and the law.

DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION:
There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written Authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you may later revoke that authorization in writing to stop future uses and disclosures. However, revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

PUBLIC HEALTH, ABUSE OR NEGLECT, AND HEALTH OVERSIGHT

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state or local government for the collection of information about disease, vital statistics (births & deaths), or injury by a public health authority.

We may disclose medical information, if authorized by law, to a person who may have been exposed to disease or may be at risk for contracting or spreading a disease or condition.

We may disclose your medical information to report reactions to medications, problems with products that may be recalled.

We may also disclose medical information to a public agency authorized to receive reports on child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.
We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure application and inspections which are all government activities undertaken to monitor the healthcare delivery system and compliance with other laws, such as civil rights laws.

LEGAL PROCEEDINGS AND LAW ENFORCEMENT:
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or of the appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official we may disclose your medical information under the limited circumstances provided that the information:

1. is released pursuant to legal process, such as a warrant or subpoena
2. pertains to a victim of crime and you are incapacitated
3. pertains to a person who has died under circumstances that may be related to criminal conduct
4. is about a victim of crime and we are unable to obtain the person's agreement is released because of a crime that has occurred on these premises or
5. Is released to locate a fugitive, missing person or suspect.
6. We may also release information if we believe the disclosure is necessary to prevent or relieve immediate threat to the health or safety of a person.

MILITARY, NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES, PROTECTION OF THE PRESIDENT

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, request by appropriate military command officers (if you are in the military), authorized national security and intelligence activities; as well as authorized government officials, or foreign head of state.

ORGAN DONATION, CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS

When a research projects and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye or tissue donation if you are a donor. Also we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such disclosure is necessary for the director to carry out his duties.

REQUIRED BY LAW

We may release your medical information where the disclosure is required by law.

YOUR RIGHTS UNDER FEDERAL PRIVACY REGULATIONS

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

REQUESTED RESTRICTIONS

You may request that we restrict or limit how your protected health information is disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to restriction, but if we do agree, we will comply with your request except under emergency circumstances. To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosed information or both), and (c) to whom the limits apply. Please send the request to the office and person listed below.
You may also request that we limit disclosure to family members, other relatives, or personal friends that may or may not be involved in your care.

RECEIVING CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests, Please specify in your correspondence exactly how you want us to communicate with you and, if you are directly sending it to a particular place, the contact/address information.

INSPECTION AND COPIES OF PROTECTED HEALTH INFORMATION

You may inspect and/or copy health information that is within the designated record set or the information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.
We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- ☐ Includes psychotherapy notes.
- ☐ Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- ☐ Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- ☐ Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make such review. Texas law requires that we will be ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the lower of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

AMENDMENT OF MEDICAL INFORMATION

You may request an amendment of your medical information in the designated record set. And such request must be made in writing to the person listed below. We will respond within 60 days of such request. We may refuse to allow an amendment if the information:

- ☐ Wasn't created by this practice or the physicians here in this practice.
- ☐ Is not part of the Designated Record Set?
- ☐ Is not available for inspection because of an appropriate denial.
- ☐ If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know they have the incorrect information.

ACCOUNTING OF CERTAIN DISCLOSURES

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an account to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

COMPLAINTS

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04 Baltimore, MD 21244

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.

QUESTIONS AND 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**: 210-531-9488

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.

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 A RANDOM. 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 health care 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 pharmacogenomics 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 health care 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.

_____

Patient or Legal Representative Signature

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.

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.

Thank you,

David A. Ramos, MD