Patient Handbook

WELCOME

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

Please visit our website, RFamilyMedicalGroup.com, or Facebook page for our current office hours. Our office is open Monday through Friday subject to the listed hours. Saturday availability varies monthly, and we ask patients to contact our office for these appointments. 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 15 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 time. If you are scheduled for a remote visit (TeleVisit, Duo, Facetime, etc.) please call our office 15 minutes prior to your scheduled time to confirm your status.

We strive to stay on time. In the event of a patient emergency, wait times may extend beyond your appointment time. 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 to best serve you. Our staff is here to provide you with quality primary care, and we look forward to caring for you.

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, 12/29/2020,11/12/2021 JM

PATIENT REGISTRATION FORM

Please Provide Insurance Cards with Picture ID to Receptionist

PATIENT INFORMATION (Please Print) **TODAY'S DATE: ____________**

First Name: ____ MI: ______ Last Name: ____

Preferred Name (If Applicable): ______________________________________ Date of Birth: ____________ SSN: __________________

Address 1: _________________________________ Address 2: _________________________________ City: ______________________

State: ________ Zip Code: ____________ Home Phone: _______________________ Cell Phone: _______________________

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Prefer not to Disclose

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BIRTH SEX: ☐ Male ☐ Female

GENDER IDENTITY: ☐ Male ☐ Female ☐ Genderqueer ☐ Transgender ☐ Other: _____________ ☐ Prefer not to Disclose

RACE: ☐ Asian ☐ Black/African American ☐ Native American ☐ White ☐ Other: _____________ ☐ Asian Indian ☐ Prefer not to Disclose

ETHNICITY: ☐ Honduran ☐ Hispanic/Latino ☐ Mexican ☐ Does not Apply ☐ Prefer not to Disclose

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Email (Required for Portal Access): ____

SPOUSE INFORMATION (If Applicable)

First Name: ___________________________________ Last Name: ___________________________________

Home Phone: ____________________ Cell Phone: ____________________

EMERGENCY CONTACT

First Name: ___________________________________ Last Name: ___________________________________ Relation: _____________

Address: ____

City State Zip

Home Phone: ____________________ Cell Phone: ____________________

RESPONSIBLE PARTY (If Patient is Under 18 Years of Age)

First Name: ___________________________________ Last Name: ___________________________________ Relation: _____________

Address: ____

City State Zip

Date of Birth: ____________ Home Phone: ____________________ Cell Phone: ____________________

PRIMARY PHARMACY INFORMATION

Primary Pharmacy: _______________________________________ Phone: ____

Pharmacy Address: ____

City State Zip

SECONDARY PHARMACY INFORMATION (If Applicable)

Secondary Pharmacy: _______________________________________ Phone: ____

Pharmacy Address: ____
City State Zip

Pharmacy Purpose: ☐ Compounding ☐ Mail In ☐ Military

EMPLOYMENT INFORMATION

Employer: ____ Phone: ____

Address: ____
City State Zip

PHYSICIAN REFERRAL INFORMATION

How did you hear about our practice?

☐ Employer ☐ Word of Mouth ☐ Insurance ☐ Google Search ☐ Website ☐ Other: ___________

INSURANCE INFORMATION

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

PRIMARY INSURANCE INFORMATION

Primary Insurance Name: _____________________________________

Primary Subscriber Name: _______________________________________

Subscriber Birth Date: _____________

Primary Subscriber ID: _______________________________________

SECONDARY INSURANCE INFORMATION (If applicable)

Secondary Insurance Name (If Applicable): _____________________________________

Secondary Subscriber Name (If Different from Primary): _______________________________________

Subscriber Birth Date (If Different from Primary): _____________

Secondary Subscriber ID: _______________________________________

COMMUNICATION AUTHORIZATION- PLEASE COMPLETE

Please indicate your preferred method(s) of contact, should we need to reach you regarding your appointments, results, insurance benefits, and/or patient/account balance(s). Place check the appropriate box(es):

☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email
☐ Patient Portal ☐ Decline all forms of communications

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.

INDIVIDUAL #1	**INDIVIDUAL #2**
NAME: ______________________________	**NAME:** ______________________________
ADDRESS: ______________________________	**ADDRESS:** ______________________________
PHONE: ________________________	**PHONE:** ________________________
RELATIONSHIP TO PATIENT: ________________	**RELATIONSHIP TO PATIENT:** ________________
INDIVIDUAL #3	**INDIVIDUAL #4**
NAME: ______________________________	**NAME:** ______________________________
ADDRESS: ______________________________	**ADDRESS:** ______________________________
PHONE: ________________________	**PHONE:** ________________________
RELATIONSHIP TO PATIENT: ________________	**RELATIONSHIP TO PATIENT:** ________________

Additional pages can be provided upon request

I acknowledge that I have been provided the "Notice of Privacy Practices" for *ll*. 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

1

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 to your insurance occurs. Verification of benefits is required. If benefits cannot be verified, you are responsible for payment in full for services rendered. All charges are your responsibility whether covered by insurance or not. We will not be involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, etc. **Not all services are covered benefits in all contracts. Insurance companies may elect not to cover certain services.**

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 is due at check-out. 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 (ex. 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, 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 your responsibility.

4. **ACCOUNTING PRINCIPALS:**

   Payment and credits are 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. Our office is not required to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate regarding treatment and payment with the parent who signs 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 are free of charge. On the third request for the same statement, we are entitled to charge a service fee.

7. **FINANCIAL ASSISTANCE:**
   Our office treats patients regardless of financial status. If you do not have 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 Manager.

8. **PAST DUE AND DELINQUENT ACCOUNTS:**
   Failure to meet your financial obligations may result in reporting to our contracted collections agency who in turn may report you to the credit bureau, filing a judgment in small claims court, or other collection actions against you. In certain circumstances, this may result in termination as a patient from this facility. All attorney fees, court costs and other expenses related to collecting your account will be added to your outstanding balance.

9. **PROFESSIONAL COURTESY POLICY:**
   There is zero tolerance for "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 remain 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 any questions that have not been answered by this packet, or would like to file 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**

All physicals, well-woman exams, and well-child exams are considered preventative care visits and may be covered by insurance. These visits cover general check-ups, routine cancer screenings, immunization and counseling on diet and exercise, child development and vitamin supplements. Subsequently, 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 for medical concerns unrelated to your preventative care. Doing so allows our staff to schedule the appropriate amount of time to address your medical concerns and may prevent your insurance company from applying additional charges for services unrelated to preventative care.

We thank you for your understanding in this matter.

OFFICE PROTOCOL AGREEMENT

We are pleased 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 need you to fill out paperwork that pertains to your patient information, insurance coverage, communication and HIPAA authorization, and Pre-Authorized Credit Card Information.

We request you arrive **15 minutes** prior to your appointment time to check in and complete paperwork. We also request you bring all medications, including over the counter medications and supplements, picture ID, and insurance cards. If your address on the picture ID is incorrect, we request another type of identification to confirm an accurate address If you are scheduled for a remote visit (TeleVisit, Facetime, Duo, etc.), please call our office 15 mins prior to your appointment time to confirm your availability. Our office may provide further instructions as needed.

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

1. I understand that refill requests may be sent through the Patient Portal and over the phone. I understand I may need to schedule an appointment to have a refill request approved. _______ **(initials)**

2. I understand that lab results are available on the Patient Portal after being reviewed by my provider. I understand I need to schedule a follow-up appointment for in-depth discussion on lab and test results. _______(**initials**)

3. I understand that I am an active participant in my healthcare and agree to abide by the treatment plan given and reviewed 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's 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 conditions, medications, and treatment options. _____ (**initials**)

5. I understand that my access to care remotely and on site will require my behavior to be in a manner that is respectful to staff. I agree to refrain from behavior such as: yelling, cursing, name calling, or multiple calls in the same day. I understand that this behavior may terminate my relationship with this practice. _____(**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

Supplements purchased at our practice 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, and email to provide appointment reminders, notice of programs/events, and other services that may benefit the patient experience.

OUR PROMISE TO YOU

We are required by law to protect the privacy of your medical information, to provide you 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 make payment by check or electronically 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**)

PRESCRIPTION REFILL PROTOCCOL

To better serve our patients, David A. Ramos. MD PA DBA R Family Medical Group has adopted the following policy. Upon notifying our office of your prescription refill request, either by phone or electronically, please allow 24 to 48 hours for your prescription to be called into the pharmacy.

REFILLS FOR CONTROLLED SUBSTANCES WILL ONLY BE PERFORMED ON SCHEDULED APPOINTMENTS. It is the patient's responsibility to track their remaining prescription and determine if they are low**.** To facilitate this process, we ask patients schedule a follow up appointment at each visit for controlled substances. 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 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 intended to alleviate ailments as determined by your provider; however, they also hold a high potential for abuse. Controlled substances of concern include narcotics (TRAMADOL, 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. 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 forged prescriptions, substance abuse, or aberrant behavior (including verbal abuse to our 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

If requested, patients may have testosterone administered by our staff for a $15 administration fee. Patients who elect to self-administer their testosterone injection understand that David A. Ramos, MD PA DBA R Family Medical Group requires said patient to schedule an appointment for training on how to 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 into the Provider-to-Provider Information exchange. ______ (**initials**)

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

PATIENT PORTAL CONSENT FORM

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

R Family Medical Group strives to keep all patient medical records complete and accurate. If you identify any discrepancy in your records, you agree to notify us immediately.

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 medical staff
- Receive health maintenance reminders
- Perform TeleVisits

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

- No portal-based triage and treatment requests. Diagnosis and treatment can only be performed when the provider sees the patient physically or through a remote visit.
- 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 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**.

The Patient Portal is provided as a courtesy to our patients. If abuse or negligent usage of the Patient Portal occurs, R Family Medical Group reserves the right, at our discretion, to terminate user access, modify services available through the Patient portal, or permanently discontinue portal service.

Stored data is HIPAA compliant with high level encryption that exceeds HIPAA standards. In the event of a security breach occurs, our office will notify patients in a timely manner and may provider further instructions. Please read our HIPAA policy for information on how private health information is used in our office. All patients are requested to sign HIPPA agreement in our annual Patient Registration Packet. If you do not recall having signed a HIPAA agreement or need to reacquaint with the HIPAA policy, you may request a copy from our front staff or visit rfamilymedicalgroup.com/forms.html

Upon signing the Patient Portal User Agreement and have providing our office with a secure email address, you will be given our system generated unique user identification and password.

The site may be accessed as follows:

1. Visit www.rfamilymedicalgroup.com and click patient portal in the upper right corner
2. Directly by going to 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; however, refusal to access the patient portal may limit my ability to access my medical records expediently.

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.

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 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

____
Patient or Representative Signature

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

____

Patient/Parent/ or Legal Representative

____

Description of Legal Representative

____

Date

Should you have any questions and/or concerns, please contact our office at (210) 533-0257 and we will be happy to assist you.

If submitting this document electronically, please email your completed form to forms@rfamilymedicalgroup.com with the subject "NEW PATIENT PACKET".

Thank you,

David A. Ramos, MD