Cinco Family Medicine 24510 Kingsland Blvd. Katy, TX. 77494

REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Last Name: First: Middle:		○Mr. ○Miss ○Mrs. ○Ms.	Marital Status(circle one) Single / Mar/ Div. / Sep / Wid.		
Is this your legal Name? ○ YES ○ NO	If not, what is your legal name?	(Former Name):	Date of Birth: / /	Age:	Sex: circle M / F
Street Address:	Social Security No:		Home phone no: ( )		
P.O. BOX:	City:	State:	Zip Code:		
Occupation:	Employer:	Employer's Phone No: ( )			
Chose clinic because/Referred to clinic by (please circle one) Dr. / Insurance Plan / Hospital / Family/ Friend/ Yellow Pgs. / Close to home or work / other / other family seen here:					
Email Address:		Cell Phone No:			

Insurance Information

(please give your insurance card to the receptionist)

Person Responsible for Bill:	Birth date / /	Address(if different)	Home No. ( )

Is this person here? ○Yes ○No

Occupation:	Employer:	Employer Address:	Employer Phone No. ( )

Is this patient covered by insurance: ○Yes ○No

Please Write Primary Insurance:				
Subscriber's Name:	Subscriber's SSN & Birth Date / /	Group No.	Policy No.	Co-payment $
Patient's Relationship to Subscriber(please Circle) : Self Spouse Child Other:_____				

In Case of Emergency

Name of local friend or Relative:	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. Cinco Family Medicine or insurance company to release any information required to process my claims.			

_____ _____

Patient/Guardian Signature *Date*

I,_____, DOB_____, do hereby agree and give my consent for Cinco Family Medicine to furnish medical care and treatment to _____ that is considered medically necessary and proper in diagnosing or treating physical or mental condition.

_____ _____

Signature Date

Cinco Family Medicine 24510 Kingsland Blvd. Katy, TX 77494 281-394-2390 Fax 281-394-2395

New Adult Patient History Form

Today's Date:_____Name:_____Date of Birth:_____Age:_____

Patient Information

Reason for being seen today:_____

Please list allergies to medicaition:_____

Please list all medications, dosage, and frequency of medication (below)

Medication	Dosage	Frequency

Medical History

Please list any chronic medical problems

Please list any surgeries/hospitalization and date they occurred

Surgery/Hospitalization	Date	Surgery/Hospitalization	Date

Family History

Family Members	Status	Medical Problems	Family Member	Status	Medical Problems
Mother	Living Deceased		Grandmother	Living Deceased	
Father	Living Deceased		Grandfather	Living Deceased	
Sister	Living Deceased		Other:	Living Deceased	
Brother	Living Deceased		Other:	Living Deceased	

Social/Lifestyle History

Do you use any of the following? (please circle all that apply)

Alcohol: **Yes No** What type?_____ How much?_____ How often?_____ If quit, when?_____

Tobacco(all types): Yes No What type?_____ How much?_____ How often?_____ If quit, when?_____

Caffeine? **Yes No** What type?_____ How much?_____ How often?_____ If quit, when?_____

Recreational Drugs? Yes No What type?_____ How much?_____ How often?_____ If quit, when?_____

Do you exercise? Yes No What type of exercise?_____ How often?_____

Marital Status:_____ Who lives with you?_____ Do you feel safe at home? **Yes No**

Current Occupation:_____ Highest Level of education completed:_____

Please list any social or lifestyle concerns you would like to discuss with the doctor:_____

Cinco Family Medicine 24510 Kingsland Blvd Katy, TX. 77494 281-394-2390 Fax 281-394-2395

Immunization History

Immunization	Date last Received	Immunization	Date last Received
Tetanus or Tetanus/Pertussis Shot		Flu Shot	
Pneumonia Shot		Gardasil/HPV Cervical Cancer Shot	
Shingles Shot		Other:	

Preventive Health History

Female: Last Mammogram:_____ Last pap smear:_____ Last Bone Density:_____ Last Colonoscopy:_____

Breast: Do you do self-breast exam monthly? **Yes No** Have you been properly trained for self-breast exam? **Yes No**

Do you wear your seatbelt at all times while in a car? **Yes No** Do you wear sunblock? **Yes No**

Male: Last Colonoscopy:_____ Last Prostate Exam:_____ Last PSA screening test:_____

Testicles: Do you do a self-testicular exam monthly? **Yes No** Have you been properly trained for

testicular self-exam? **Yes No** Do you wear a seatbelt at all times while in the car? **Yes No** Do you wear sunblock? **Yes No**

Please list ant preventive health concerns you would like to discuss with the doctor:_____

Reproductive History

Female: Last menstrual period:_____ Age at first period:_____ Age at menopause:_____

Number of pregnancies:_____ Number of Children:_____ Age at first pregnancy:_____ Did you breast feed: **Yes No**

Do you use birth control: **Yes No** Which type do you use?_____ Would you like to discuss birth control options? **Yes No**

Have you had a hysterectomy? **Yes No** If yes, do you have ovaries remaining? **Yes No**

Do you wish to be tested for any sexually transmitted disease? **Yes No** If yes, please state here:_____

Male: Do you have any concern with low libido or erectile dysfunction? **Yes No**

Do you wish to be tested for any sexually transmitted disease? **Yes No** If yes, please state here:_____

Please list any specific reproductive concerns you would like to discuss with the doctor:_____

Current or Present Problems

Problems/Condition	How Long?	Problems/Condition	How Long?	Problems/Condition	How Long?
Allergies		Digestion Problems		Joint Problem	
Sore Throat		Urinary Problems		Menstrual Period	
Breathing Problems		Rash/Skin Itching		Fatigue	
Headaches		Vision Problem		Other:	
Dizziness		Chest Pain		Other:	
Fainting		Blood in Stools		Other:	
Hearing		Constipation		Other:	

Please List any other specific current problems you would like to discuss with the doctor:_____

_____

Patient Signature:_____ Date:_____

If someone other than the patient is completing this form, please give name and relationship:_____

Notice of Privacy Acknowledgment Form HIPAA

I acknowledge that I have received a copy of the **Cinco Family Medicine** Notice of Privacy Practices and have an opportunity to review it. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communication relating to my health information.

Patient Signature:_____ Date:_____

Consent for Purpose of Treatment, Payment, and Health Care Operations

I understand that, as a condition to my receiving treatment from **Cinco Family Medicine** may use or disclose my personally identified health information for treatment to obtain payment for the treatment provided and as otherwise necessary for the operations of **Cinco Family Medicine**, these uses and disclosures are more fully explained in the Notice of Privacy Practices that has been provided to and reviewed by me. While I am here, I permit the employees, the doctor and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition, his or her recommended treatment and any associated risk involved. I also understand that he or she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examination, and medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

'Personally identifiable health information' refers to health and demographic information collected about me by my physician(or other health care provider, public health authority, health plan, employer, life insurer, school or university, or health care clearinghouse) that relates to my past, present, or future physical or mental health or condition or payment for provision of health care. The information identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that privacy practices described in the Notice of Privacy Practices may change over time that I have a right to obtain any revised Privacy Notice by contacting **Cinco Family Medicine** to make such a request. I may receive a revised Notice of Privacy Practices by calling the office and requesting a revised copy by mail or by asking for one at my next visit.

I also understand that I have the right to request **Cinco Family Medicine** to restrict how my health is used or disclosed. **Cinco Family Medicine** does not have to agree to my request for the restriction, but if **Cinco Family Medicine** does agree, **Cinco Family Medicine** is bound to abide by the restriction as agreed. Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that **Cinco Family Medicine** has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

Signature_____ Date_____

If **Medicare lifetime consent:** I certify that the information given by me applying under Title XVII of Social Security is correct, I authorize any holder of medical or other information about me to release it to Social Security Administration or its intermediaries or carriers for this or related Medicare claim, I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorizes such physician or organization to submit a claim to Medicare for payment to me.

Signature_____ Date_____

Authorization to Disclose Health Information to a Family Member/Friend

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name:_____ DOB:_____

Type of information to Disclose:_____

Type if Information

Cinco Family Medicine may discuss or release Personal Health Information to the Personal Representative(s) regarding the following information: eligibility, billing, payment status, benefits, and claims, medical information used to make payment decisions, provider's appeals, and complaints, about my health insurance coverage through **Cinco Family Medicine.**

I authorize Cinco Family Medicine to disclose my health information to:

#1 Contact name_____ Relationship_____ Contact Phone:_____

#2 Contact name_____ Relationship_____ Contact Phone:_____

Cinco Family Medicine personnel may share information with these primary contacts that is consistent with the Notice of Privacy Practices.

Authorized use and / or disclosure

I authorize **Cinco Family Medicine** to release Personal Health Information to the person(s) named above, my Personal Representative for the purpose of assisting with or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider or other person subject to federal privacy laws, my Personal Health Information may no longer be protected by those privacy laws and may be subject to redisclosure by my Personal Representative. **Cinco Family Medicine** is not responsible should my Personal Representative further disclose my protected Personal Health Information. I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating "no limitation" on disclosure of Personal Health Information.

Disclosure Limitations:

_____

Expiration and revocation

The authorization to release information to my Personal Representative(s) will automatically expires 365 days following the termination of my health plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to the plan Administrator. Revocation will not affect any action that **Cinco Family Medicine** has taken or any information that has already been released based upon prior authorizations.

Signature_____ Date_____

(Patient, parent, authorized representative)

I give Cinco Family Medicine the authorization to leave me a recorded message at the following numbers for myself, regarding any medical information/diagnosis and the confirmation of appointments

_____Please leave a recorded message ( )_____-_____

(Please list numbers) ( )_____-_____

_____Do Not Leave Recorded Messages

Thank you for choosing Cinco Family Medicine as your primary care provider. Because we feel that clear communication is imperative to the physician-patient relationship, we have developed the following information. We are committed to providing you with the best health care. We respect your rights as a patient and want you to understand your responsibility as a partner in your care.

PATIENT RIGHTS AND PATIENT FINANCIAL and HEALTH RESPONSIBILTY STATEMENTT

Patient Bill of Rights

•The patient has the right to be fully informed of their rights.

• The patient has the right to respectful and consideration care and to be treated with dignity.

• The patient has the right to access to access to care without respect to race, creed, national origin, sex, age, sexual orientation, disability or source of payment

•The patient has the right to receive information about your diagnosis, condition, and treatment, in terms that you can understand.

• The patient has the right to reasonable continuity of care and the right to request a second opinion if you choose.

•The patient has the right to personal privacy and to receive care in a safe environment. Confidentially of your clinical and personal records will be maintained.

•The patient has the right to be fully informed of the practice's policies and procedures.

•The patient has the right to be given reasonable notice of anticipated termination of services or of plans to transfer to another provider.

•The patient has the right to express concerns or grievances regarding your care to the office.

I have read and understand my rights as a patient

Patient signature_____ Date_____

Patient Financial and Appointment Responsibility Statement

Payment of your medical bill for services rendered is considered part of your treatment, If you have medical insurance, we will file this insurance for you. We will continually strive to help you receive the maximum benefits. We need your help in understanding this financial statement.

•**Full payment is due at the time of service** unless you are enrolled in an insurance plan in which our practice participates.

•**Method of Payment** Cash, check, Visa, MasterCard, and American Express payments are accepted.

•**Insurance** We participate in most insurance plans, including Medicare. If you are not insured with an insurance plan we do business with, your payment is expected in full at the time of your visit. If you are insured by a plan we do business with, but you do not have an up-to date insurance card, payment is expected full at the time of service until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company if you have questions regarding your benefit coverage.

•**Co-payment and deductibles All co-payments and deductible must be collected at the time of service for all insurance plans.** This arrangement for co-payments is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us uphold the law by collecting your copay and deductible at each visit.

•**Non-covered services** Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

•**Proof of insurance** All patients must complete our patient information form prior to being seen by a physician, except in emergencies. We must obtain a copy of current insurance information as well as a valid driver's license to provide proof of insurance coverage. **I f you fail to provide us with the insurance information at the time of your visit, you will be responsible for the balance.**

•**Claim Submission** As a courtesy to you, we will submit your claims for you and assist you in any way we reasonably can to help get your claim paid. Please provide us with accurate and up to date information so we can properly process these claims. **Please be aware that the balance of the claim is your responsibility whether or not the insurance pays your claim.** Your insurance benefit is a contract between you and your insurance provider.

•**Coverage changes** If your insurance coverage changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximal benefits. If you your insurance does not pay claim within 45 days, the balance will automatically be billed to you.

•**Nonpayment** Please be aware that if your account is over 90 days due, you will receive a call stating you have 20 days to pay your balance in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains, you may be referred to a collection agency.

• **Returned Checks** If your check is returned for any reason, there will be a $35.00 charge added to your account. Repayment will be accepted in cash or money order only. Subsequent services will require cash payment in advance until the account is paid in full. In addition, if unpaid balance remains, you will be referred to an outside collection agency.

•By signing below, I acknowledge that I understand my responsibility for payment of my account.

Patient Signature_____ Date_____

NO SHOW POLICY CHARDGES AND MEDICAL RECORDS CHARGES

•Patient Health and Appointment Responsibility. It is your responsibility to keep your schedule appointment. If you do not call the office to reschedule or cancel 24 hours prior to your visit, you will be charged $25.00. This charge will not be recovered by your insurance plan. Please help us provide the best care to you and our other patients by respecting your appointment time. In addition, you are responsibility for following the instructions and advice of your health care team. I f you refuse treatment or do not follow instruction or advise by keeping appointment, you must accept the consequences. It is you responsibility to notify a member of your health care team if you do not understand information about your care and treatment.

•**Medical Records Charges :** Requests for medical records will be charged $25.00 for medical records and $25.00 for billing records. Medical records will be transferred to another medical provider free of charge after completion of appropriate patient signed consent.

•By signing, I acknowledge that I understand my responsibility for payment of my account as above and the NO Show Policy

Patient Signature_____ Date_____

Cinco Family Medicine/ Ami C. Foster, MD, PA 24510 Kingsland Blvd Katy, TX 77494 281-394-2390

Fax 281-394-2395

Authorization for Release and Disclosure of Protected Health Information

Today's Date:_____ Patient's Name:_____ Date of Birth:_____
Address:_____City:_____State:_____Zip:_____
Social Security No.:_____ Telephone:_____ Cell:_____

In accordance with state law and regulatory agency requirement the health records is the property of Cinco Family Medicine

I hereby authorize that my medical information be released:

To Name:_____ From Name:_____
Address:_____ Address:_____
City/State/Zip:_____ City/State/Zip:_____
Telephone:_____ Fax:_____ Telephone:_____ Fax:_____

I hereby authorize this to be released via_____ Fax_____ Pickup_____ Mail_____

Please release the following information:

_____Problem List _____X-ray Reports _____Previous Release of Information
_____ Progress Notes _____EKG Reports _____Mental Health
_____History and Physical _____X-ray Films _____Medications
_____HIV/AIDS test results _____Lab Reports _____Outside Records
_____Drug/ Alcohol records _____Immunization _____Correspondence
_____ Other(please specify):_____

Release of records is necessary for:

_____Continuation of Care _____Personal Use _____Insurance _____Attorney/Legal _____Other(please specify)_____

1. I understand that I may revoke this authorization at any time, in writing except revocation will not apply to information already obtained, used or disclosed in response to this authorization; I may revoke this document by presenting my written revocation to Cinco Family Medicine. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 6months from the date of signature or upon occurrence of the following event:_____
2. I understand that the information authorized for use of disclosure may indicate the presence of a communicable or venereal disease which may include, but is not limited to, disease, such as hepatitis, syphilis, gonorrhea, Chlamydia, or HIV/AIDS. It may also contain information about drug and alcohol abuse as well as behavioral or mental health services.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.
4. I understand that the disclosure of this health information is voluntary and I can refuse to sign this authorization, I will still receive treatment id I do not sign this form. I also understand that I may inspect or request copies of the information to be used or disclosed. I f you I have any question \s related to disclosure, I can contact the office at 281-394-2390.
5. I understand that there may be a fee for preparing this information. Preparation fees, when applicable, are $25.00 for the first 20 pages and $0.50 per additional page. Copy of billing records $25.00
   With this knowledge, I give my authorization to the release of all information as listed above in my medical records, including any information concerning my identity, and release Cinco Family Medicine, its affiliates, agents and employees, form liability in connection with the release of the information contained therein.

   Patient Signature:_____Date:_____

   Witness Signature:_____Name:_____Relationship:_____

Complete the following if patient is a minor mentally incapacitated or deceased. Authorization must be given by patient legal representative, identified below:

Reason Patient Unable to Sign:_____ Signature:_____

Date:_____ Relationship:_____

Notice to Recipients of Copies of Alcohol and Drug Abuse Medical Records-PROHIBITION ON REDISCLOSURE: This information has been disclosed to you form records protected by the Federal Confidentially Rules(42 CFR Chap 1, Part 2, Subpart C, 2.32). The Federal Rules prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Chap 1, Part 2. A general authorization for the release of medical or information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute ant alcohol or drug abuse patient. Federal regulation state that any person who violates any provision of this law shall be fines not mere than $500 for the first offense and $5,000 in the case of subsequent offense

Cinco Family Medicine 24510 Kingsland Blvd. Katy, TX 77494 281-394-2390

Prescription Medication/ Refill Policy

Cinco Family Medicine is committed to providing you with quality, comprehensive medical care and patient safety is of the utmost importance. Due to large volumes of prescription refills, we have the following policy regarding medication refills. In addition, we ask your cooperation as part of your responsibility as a patient to remain vigilant of your medication and refrain from waiting until you are out of medication to contact out office for a refill.

• **We use an electronic medical record so all medication prescribed at your visit and refilled at your visit will be done electronically**

• **Please be sure to provide is with up to date preferred information here:**

○Preferred Pharmacy Name:_____

Address:_____

City/State/Zip:_____

Phone:_____ Fax:_____

Quantity of Medication Preferred(circle) 30days 60days 90days

Medication and Your Office Visit We ask that all patients bring their medication and supplements to all visits at our office for your doctor to review. I t is very important that we have an accurate record of ALL medications that you are taking.

•**What to do Prior to Your Office Visit** Prior to your office visit, please look over all of your medications. If refills are needed, please let your doctor know this AT THE TIME OF YOUR VISIT.

•**Chronic Medical Problems and Medications** Patients who take medications for chronic medical problems will require regular follow-up visits at our office. Your doctor will determine the time interval necessary for these visit. Again, this is for your safety, and many medications require monitoring of blood work and other tests to ensure that you are receiving the appropriate dosage of medication in a safe and effective manner. Please ensure you have enough medication to last until the next scheduled visit. If you are overdue for your visit bur need your medication, you will be supplied a MAXIMUM of 10 days pf medication and a full refill will be supplied only at the time of your visit.

•**Special Medications** Certain medications called controlled substances, such as medications for ADD/ADHD, pain and anxiety require a special type of triplicate prescription. This medication must be picked up in person from the office. Since these types of medical problems require follow-up on a regular basis, refills will be given only through appropriate medication for the illness, We have open visits every day to accommodate this acute care for our patients.

•**Requiring Refills**

○**Please try to request refills from your doctor during your patients visit**. We will review the medication list in the computer with you at the time of your visit, and will send electronic refills during the visit.

○**Please request refills at least 3 days in advance** of when you will need the medication in the following manner.

- ▪Call your pharmacy and ask them to send an electronic refill request to our office
- ▪ Call the pharmacy and ask them to fax a refill request to your office

○ Urgent refills can be filled by calling the office, but please allow until the end of the business day for refill to be complete

Patient Signature:_____ Date:_____

Cinco Family Medicine

Ami C Foster, M.D.

24510 Kingsland Blvd.

Katy, TX 77494

281-394-2390

FAX 281-394-2395

LABS HAVE BEEN ORDERED FOR YOU

WHAT THIS MEANS TO YOU:

1.**This will be your only reminder/notification to get your labs drawn.**

Failure to get the labs done as recommended can be detrimental to your health. We will not be held responsible if you go against our recommendations and decide not to get your labs done.

YOU ARE RESPONSIBLE FOR NOTIFYING CINCO FMAILY MEDICINE IF YOU CHOOSE NOT TO COMPLEE THE LABS ORDERED.

2. You will receive your **NORMAL** results via the patient portal unless you opted-out of the patient portal on your consent forms. I you opted out of the portal you will receive normal written results via mail.

No phone calls will be made to report normal results. Normal results will not be mailed.

Should you need to print your results, please do so from the lab tab in the patient portal.

3. **ABNORMAL** results may require an office visit to discuss results, make medication changed and order important testing regarding your specific condition

For most cases, we will no longer report abnormal results via phone or patient portal messages or make changes to medication via phone or portal messages.

4. RESULTS CAN TAKE UP TO 2 WEEKS TO COME BACK DEPENDING ON THE TESTS THAT HAVE BEEN ORDERED.

Therefore, please do not call or request results before that time.

If you have not been notified of your results via portal, mail or via a phone call advising the need to schedule an appointment to discuss results within 2 weeks, please call the office.

5. CINCO FAMILY MEDICINE DOES NOT BILL FOR LABS ORDERED.

We have phlebotomist from Quest Diagnostics are a courtesy to our in-office patients. Labs can be sent to Quest and Labcorp as deemed by the insurance carrier

It is your responsibility to know if your insurance company has a requirement for a specific company and to notify Cinco Family Medicine before labs are drawn so they can be ordered accordingly.

IF YOU HAVE QUESTIONS ABOUT YOUR LAB BILL, YOU MUST CONTACT THE LAB CARRIER AS LISTED ON YOUR BILL OR EOB FROM YOUR INSURANCE COMPANY. WE DO NOT HANDLE BILLING ISSUES OR DISPUTES REGARDING LABS.

PATIENT SIGNATURE_____ DATE_____

Patient Portal is Here!

The patient portal is how you will obtain your results for lab work and imaging testing. Once we have received your results from the lab or imaging facility, Dr. Foster reviews them and makes comments, instructions and recommendations for you. The portal will also allow you to review and print your results any time, day or night! You can also request change and cancel appointments in the portal. Alerts will be sent to your email address telling you to log into your portal when there is something there for you to view.

Please follow the link to the patient portal from your email or from our website:
www.Cincofamilymedicine.com

(click on the red Patient Portal button at the bottom of our home page)

Your username and password are: in your email see attached sheet

Once you log in, you will be prompted to change your password and create some security questions. If you have any trouble logging in, please call us at:

281-394-2390

As a reminder, please do not submit urgent request, questions, concerns or time sensitive items on the patient portal. We will respond to all messages in the portal within 24-48 hours and on Monday if messages left over the weekend. This is not meant to substitute communication with the office. Unlike the patient end of the portal, we do not receive instant notification that a message has been left in the portal. The messages are only retrieved if we logged into out electronic medical records system. We cannot be held liable for messages submitted that do not comply with the process. Thank you for understanding and complying with our process for the portal.

I have read the above information and understand that is how Dr. Foster (and staff) will communicate my results to me. I know that this is the only way I will receive my results unless I opt-out below. I understand that I am responsible for obtaining these results from the patient portal when notified via the e-mail address I provided. I also understand that I am responsible for notifying Dr. Foster (and staff) if I have not received results within 2-3 weeks after testing. I also understand that I must notify Cinco Family Medicine if my e-mail information changes.

X_____ Date_____

Patient signature

X_____ Date_____

Witness

☐ I have chosen to opt-out of the patient portal x_____

Cinco Family Medicine Physician/Patient

Memorandum of Understanding

Thank you for choosing Cinco Family Medicine for your medical care. We appreciate the trust and confidence you have placed in us. Our goal is to provide YOU with high quality, personal medical care, which is responsive to your individual needs and values. In order for this goal to be achievable, it is important that we (the Physician and the Patient and/or the Patient's caregiver) each commit to satisfying certain responsibilities as follows:

Physician Responsibilities

•I will listen effectively, provided YOU with explanations as to health care matters, and otherwise encourage a way of life of open, full and honest communication between us.

•I will provide YOU with information regarding the different treatment plan for YOUR acute or chronic condition to enable YOU to select the plan appreciate for YOU.

•I will provide convenient options (telephone, voice mail and email) for non-urgent communication between YOU and my practice team for scheduling office visits and follow-up visits and for obtaining test results and referrals.

•I will provide YOU telephone availability for urgent communication, 24 hours per day \, and 7 days per week by myself or one of the other physicians in the office.

•As technology develops, every effort will be made to provide convenient options (e-consultations, secure email) for non-urgent communications between YOU and I and/or my team, including post-hospital support, follow-up visits and consultations.

•I will coordinate a multidisciplinary approach to YOUR health care by referring YOU to other clinicians and health care institutions when appreciate.

• I will coordinate and integrate care provided by other health care professionals, other clinicians and health care institutions effectively so as to avoid duplication, delay and error.

• I will provide flexible and expanded office hours, schedule YOUR appointments within a reasonable time, and see YOU as closely as reasonable possible to YOUR scheduled appointment time.

•I will furnish YOU with test and treatment results promptly and correctly.

•I will provide YOU with information and recommendations regarding preventive care, maintaining wellness, self-management directions and counseling.

• I will keep clinical information in a system that allows for ready search, retrieval and information transfer while protecting privacy and confidentiality, including participating in development and maintenance of standardized electronic health records and patient registries.

•My practice team will be trained in the responsibilities described above.

Your Responsibilities

•Communicate openly, fully, freely, and proactively with my Physician's staff.

•Be an active participant in the development with my Physician of a treatment plan for my or the parties acute or chronic condition, and follow agreed-upon treatment plan.

• Provide Physician with feedback regarding my or the patients treatment plan.

•Appear on time for appointments, procedures and other medical tests at my Physician's office, and timely submit materials, samples and information as requested by Physician.

•Schedule and attend follow up appointments at intervals suggested by my Physician.

•Follow my Physician's and other health care professionals' recommendation with respect to maintenance or improvement of my or the Patient's health and wellness.

•Participate in developing and maintaining a comprehensive Patient health record by authorizing delivery and circulation of my or the patients clinical information to and from clinicians and health care institutions.

Please take the time to carefully read and understand each of our respective responsibilities. To show that you accept and agree with them sign your name below. Thank you once again.

_____ _____

Patient Signature **Date**

_____ _____

Signature of Care Giver or Guardian **Date**