Sanitas Medical Center

PATIENT INFORMATION

If not the patient, the individual completing this form is _____, the

☐ Parent ☐ Legal Guardian ☐ Legal Representative (each a "Personal Representative") of the patient.

Patient Name ("Patient"): First Name:_____Middle Initial: _____Last Name:_____

Date of Birth: ____(MM) ____(DD) _____(YYYY)

Address: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersexual ☐ Choose not to disclose

Current Gender Identity: ☐ Female ☐ Male ☐ Transgender: Male to Female ☐ Transgender: Female to Male ☐ Neither exclusive female or male ☐ Choose not to disclose ☐ Something else, please specify: _____

Sexual Orientation: ☐ Heterosexual ☐ Homosexual (Gay/Lesbian) ☐ Bisexual ☐ Other _____ ☐ Do not know ☐ Choose not to disclose

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

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

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

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

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

Employer Name: _____ Work Phone: ----------_____

Emergency Contact: _____Emergency Contact Phone: ----------_____

Relationships to patient: _____

Consent to disclose medical information to Emergency Contact: ☐ Yes ☐ No

DISCLOSURE TO FRIENDS AND/OR FAMILY MEMBERS

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

Name	Relationship	Phone Number

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

Legal Guardian/Proxy or Caregiver: _____ Contact Phone: _____

Pharmacy Name: _____**Pharmacy Phone Number**: _____-_____-_____

INSURANCE INFORMATION

Primary Insurance: _____ Phone Number: _____

Insurance Address: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

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

Responsible Party Name (Last): _____ (First): _____ (MI): _____

Guarantor Date of Birth: ____(MM) ____(DD) _____(YYYY)

Address: _____ Primary Phone: _____

Secondary Insurance: _____ Phone Number: _____

Insurance Address: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

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

Responsible Party Name (Last): _____ (First): _____ (MI): _____

Guarantor Date of Birth: ____(MM) ____(DD) _____(YYYY)

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

Patient or Patient's Personal Representative: _____ **Date**: _____

FINANCIAL POLICY

_____**(Initials)** The doctors and the healthcare providers of Sanitas charge fees for the care provided to you. The fees may not be the same as the estimate given. This includes any deductibles and coinsurances. Copays are due at the time of service. You are also responsible for any deductibles and coinsurances on your insurance plan. All payments for services must be made in full prior to receiving care, including copayments and any outstanding balances.

If your health insurance company does not pay the full amount of fees charged by Sanitas, you (the patient or responsible party) will pay Sanitas for the cost of care not paid by the health insurance company. This also applies for patients within their grace period.

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

health insurance, then you will have to pay the fees for the medical services rendered to you.

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

_____**(Initials)** Sanitas can bill my health insurance company for my care. Payments will be made to Sanitas on my behalf.

Patient or Patient's Personal Representative: _____ **Date**: _____

CONSENT TO TREATMENT

___**(Initials)** I am a patient of Sanitas. By signing below, I give my consent to be treated by Sanitas healthcare providers. I understand treatment and services may include: lab tests, routine exams, screening tests (tests that can find an illness early, before a person shows signs of having the disease), diagnostic tests (tests that show if a person has a certain illness or health problem). I understand that no promises have been made to me about the results of any treatment or services. I understand that I have the right to refuse any treatment or procedure and have the right to discuss all medical treatments with my provider. I acknowledge that I have read and understood each

of the above provisions appearing in this section. I have also had the opportunity to ask any questions, and by my signature, I consent and agree to such provisions individually and collectively. A copy may be used in lieu of the original.

_____**(Initials)** I acknowledge that during my appointment, Sanitas may record the conversation between me and my provider for the purpose of improving the accuracy and efficiency of clinical documentation.

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

Patient or Patient's Personal Representative: _____ **Date**: _____

PATIENT HIPAA ACKNOWLEDEMENT and NOTICE OF ELECTRONIC DISCLOSURE OF PROTECTED HEALTH NFORMATION

____ **(Initials)** Notice of Privacy Practices. I acknowledge receipt of the *Notice of Privacy Practices* (https://www.mysanitas.com/en/legal/notice-privacy-practices) which describes my rights and Sanitas' duties with respect to my protected health information (my "PHI"), and specifies that Sanitas is permitted to use, disclose, receive and exchange my PHI for (i) treatment, payment and healthcare operations purposes; (ii) as I may authorize in writing; and (iii) as otherwise allowed pursuant to the regulations of the Health Insurance Portability & Accountability Act ("HIPAA") and relevant state laws (collectively, the "Permitted Uses"). I understand that I may contact the Privacy Officer (patientprivacy@mysanitas.com) with any questions or complaints. To the extent permitted by law, I voluntarily consent to the use, disclosure, receipt and exchange of my PHI for the purposes described in the *Notice of Privacy Practices*.

___**(Initials)** Medical Students. Sanitas is proud to be an Academic Center for Health Care Students. With your consent, as part of the program, a student may be invited to speak to you about your visit and/or overall health before you are seen by your physician. Critical to the experience is the awareness and education of the importance of patient's privacy and confidentiality. As a result, all students participating in this program will have completed HIPAA compliance training, signed an agreement to adhere to the Sanitas *Code of Conduct,* and will have signed an agreement of confidentiality, prior to commencing, as to ensure that your patient rights are protected.

___**(Initials)** Notice of Electronic Disclosure and Authorization. I understand that my PHI is subject to electronic disclosure. In accordance with HIPAA and Texas law, Sanitas is permitted to electronically disclose my PHI without my authorization to another covered entity for the purpose of treatment, payment, health care operations, performing certain insurance functions, or as may otherwise authorized or required by state or federal law. In all other cases, Sanitas will not electronically disclose my PHI to any other person without a separate authorization from me or my legally authorized representative for each disclosure. When a separate authorization is required, such authorization may be in written or electronic form or orally given if documented in writing by Sanitas. (Tex. Health & Safety Code §§ 181.154(b),(c), §241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

___**(Initials)** Health Information Exchange. Sanitas participates in one or more health information exchanges (HIEs), including the Health Information Exchange Texas Emergency Encounter Notification Services ("HIETexas"). An HIE is an organization that oversees and governs the electronic exchange of health-related information among organizations according to nationally recognized standards. HIEs are designed to provide my healthcare providers with quick access to my medical records to make treatment more effective and efficient.

HIETexas is the state-level HIE network operated by the Texas Health Services Authority as part of the Texas Legislative mandate to establish statewide health information exchange capabilities. HIETexas can notify my Sanitas care team when I am admitted to, discharged from, or transferred between hospitals or other facilities so they can coordinate my care and follow up after my visit.

I authorize Sanitas to include me in the patient panels for the HIEs in which Sanitas participates. However, my treatment and care at Sanitas is not conditioned on HIE participation. If at any time I do not want Sanitas to electronically share, request and/or access my PHI through HIEs I may opt-out of future electronic release of my PHI through HIEs by completing a HEALTH INFORMATION EXCHANGE OPT-OUT FORM obtained from a Sanitas Medical Center location or the Sanitas website (https://www.mysanitas.com/en/resources).

I have read, understand and agree to the initialed sections above:

Patient or Patient's Personal Representative: _____ **Date**: _____

CONSENT FOR COMMUNICATIONS

___**(Initials)** By providing my phone number below, I voluntarily and expressly authorize Sanitas, or third parties acting on behalf of Sanitas (including Business Associates and subject to patient confidentiality restrictions), to contact me at this phone number with information related to my treatment and care or marketing purposes for health-related programs, products and services recommended by Sanitas which may be beneficial to me, including through the use of automated technologies, SMS/MMS messages, AI generative voice, and prerecorded and/or artificial voice messages. I understand that such communications may not be encrypted or secure. Sanitas will use appropriate safeguards to protect my PHI in accordance with HIPAA and relevant laws. Message and data rates may apply.

___**(Initials)** I acknowledge that **I have the right to opt out** of receiving future Sanitas communications **at any time** by using the opt-out method provided in the communication. By opting out of Sanitas communications, I will no longer receive general communications such as appointment reminders, wellness updates or promotional messages. However, I will still receive direct communications from my healthcare provider or care team regarding important matters related to my treatment or care, which may include calls for pre-visit planning, lab results, or other important information necessary for my health and wellbeing. I understand that **I may revoke this consent for communications at any time**, either by completing a new patient registration form or reasonably notifying Sanitas. I also understand that **I am not required to sign this consent for communications as a condition to receive treatment or services from Sanitas** and that **opting out of Sanitas communications will not affect my treatment or the services available to me**. I confirm that I own or control the phone number provided below and agree to notify Sanitas in writing within 30 days if I change my phone number.

___**(Initials)** I acknowledge and agree to receive health-related communications from Sanitas (or third parties acting on behalf of Sanitas, including Business Associates), which may (i) occur more than once per day or three times per week, including outside the hours of 8:00AM to 8:00PM, as deemed necessary; and (ii) exceed one minute in duration for phone calls or 120 characters for text messages. I understand that these communications may exceed the limitations set forth under applicable law.

___**(Initials)** By providing my email address below, I authorize Sanitas, or third parties acting on behalf of Sanitas (including Business Associates and subject to patient confidentiality restrictions), to contact me at this email address with information related to my treatment and care or marketing purposes for health-related programs, products and services recommended by Sanitas.

Patient or Patient's Personal Representative: _____ **Date**: _____

Patient Name: _____

Phone Number: _____ **Email Address**: _____

SELF-MANAGED WELLNESS PROGRAMS

A patient self-managed wellness program ("SMWP") empowers individuals by involving them in their health and wellness through education, self-monitoring, and personal responsibility. At times, Sanitas may offer a SMWP to eligible patients to afford tools, resources, and support for managing chronic conditions, preventing illness, and enhancing overall well-being. Sanitas may collaborate with third parties ("Wellness Vendor") to offer patients a SMWP using digital technology (i.e., mobile applications, wearables). SMWPs are not equivalent to medical advice, are not monitored by your provider, and may potentially yield inaccuracies. If offered, you will have the opportunity to ask questions. If you participate, Sanitas may need to share certain personal information about you with the Wellness Vendor in connection with your enrollment. Participation is not mandatory and will not affect your ability to receive care at Sanitas.

Patient or Patient's Personal Representative: _____ **Date**: _____

PHOTO IDENTIFICATION (*if applicable*)

For the benefit of its patients, Sanitas has implemented a process to use photographs of patients for identification and authentication purposes to enhance patient safety and security. I voluntarily and expressly authorize Sanitas to take a photograph of me (or the person for whom I am a Personal Representative) to be used for patient identification/authentication purposes during patient registration/check-in and throughout the duration of my visit. I understand that my photograph will only be used for this purpose, stored in my electronic medical record in accordance with HIPAA and relevant laws, and will not be shared with third parties without my consent except as required by applicable law. I understand that using my photograph for identification/authentication purposes is voluntary, and I have the right to revoke my authorization and opt-out of participating at any time by notifying Sanitas in writing. My refusal to participate will not affect my treatment or the services available to me at Sanitas. If I prefer not to be photographed, I will be asked to provide photographic identification at each visit.

Patient or Patient's Personal Representative: _____ **Date**: _____

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