WELCOME TO SAINT MOSCATI COMMUNITY HEALTH CARE

Date: _____

Existing Patient: Revise all information that has changed since your last visit

Confidential
Registration Information - Please Print

Patient Information:

Last Name_____ First Name_____ MI___

Home Address: _____ City: _____ Zip: _____

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

Gender: Male___ Female___ SSN: _____ - _____- _____ Birthdate ____/____/_____

Circle One: Married - Single - Partnered – Widowed Name of Partner/Spouse/Significant Other _____

Employer: _____ Occupation: _____

Business Address_____ Phone: _____

Spouse/Responsible Party (if patient is minor) Information:

Last Name_____ First Name_____ MI___ Phone: _____

Address (if different): _____ City: _____ Zip: _____

Employer: _____ Occupation: _____

Business Address_____ Phone: _____

Spouse/Responsible Party SSN: _____-_____-_____ Birthdate: _____

Insurance Information:

Name of Primary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ Relation: _____ *Birthdate: ____/____/____

Insurance Address _____

Name of Secondary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ Relation: _____ *Birthdate: ____/____/____

Insurance Address _____

*This information is required by HIPAA

Emergency Contact:

Name: _____ Relationship _____ Phone: _____

Preferred Pharmacy: _____ How did you hear about us? _____

Advance Directive Completed? Yes No POLST Completed? Yes No Organ Donor: Yes No

_____ _____
Signature of Patient or Parent/Guardian of Minor Child Date

WELCOME TO SAINT MOSCATI COMMUNITY HEALTH CARE

Additional Patient Information:

Patient Name: _____ **Date of Birth** _____

***Patient's Race:** ❑ American Indian / Alaska Native ❑ Black / African American ❑ Other
❑ Native Hawaiian/Pacific Islander ❑ White ❑ Asian ❑ Declined

***Patient's Ethnicity:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined

***Patient's Preferred Language:** ❑ English ❑ Spanish ❑ Other _____

**The collection of this information is legal and authorized under Title VI of the Civil Rights Act of 1964. The purpose of gathering this information is to improve the overall quality of healthcare offered. The information gathered is helpful in measuring trends, identifying disparity gaps in healthcare, and implementing targeted intervention toward specific populations that may be at a higher risk for certain illnesses. This information will never be used to profile patients or discriminate against patients in any way.*

Request for Confidential Communications Regarding Medical Information:

I request that Saint Moscati communicate with me confidentially about medical matters in the following manner:

Patient's Preferred Method of Contact: ❑ Phone ❑ Email**

Would you like the clinic to leave medical information for you in a voicemail? ❑ Yes ❑ No

Would you like to be enrolled in the Patient Portal to access your health file? ❑ Yes ❑ No

Would you like to receive Text notifications for appointment reminders? ❑ Yes ❑ No

Saint Moscati may disclose my protected health information (PHI) to the following person(s)
(Please note: If you want to allow us to disclose PHI to your spouse/child/etc, his/her name MUST be listed below):

_____ _____
_____ _____

Consent to Obtain Medication History from Pharmacies through e-Prescribing:

I hereby give my consent to Saint Moscati, including its licensed practitioners and employees, to access, use and disclose my protected health information to any pharmacies I currently use or will use in the future for the purpose of transmitting prescriptions to them for my treatment. I consent to the disclosure of my prescription medication information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health program to Saint Moscati and pharmacies for the purpose of my treatment. My consent includes the re-disclosure of protected health information maintained by a drug or alcohol treatment program.

_____ _____ _____
Signature of Patient or Legal Representative ***Date*** ***Relationship to Patient***

WELCOME TO SAINT MOSCATI COMMUNITY HEALTH CARE

Assignment of Insurance Benefits/Release of Information

I authorize Saint Moscati to release any information including the records of any treatment or examination rendered during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly Saint Moscati benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf for myself of my dependents. I authorize the use of my signature on all my insurance submissions.

_____ _____

Signature of Patient or Parent/Guardian of Minor Child Date

Medicare Authorization

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to Juan Luis Castillo, FNP-C/Saint Moscati for any services furnished to me by SM. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the health care provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services, Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Beneficiary Date

Patient Acknowledgment of Receipt of Notice of Privacy Practices, Patient Rights & Responsibilities Office Policies and Financial Policy

Your name and signature below indicate that you have received a copy of the Saint Moscati Notice of Privacy Practices and Patient Rights & Responsibilities on the date indicated. If you have any questions regarding the information in Saint Moscati's Notice of Privacy Practices, please do not hesitate to contact the Practice Administrator as indicated on the notice. Your signature also indicates that you have received a copy of the Saint Moscati's Financial Policy. By my signature I agree to the terms outlined in the financial policies. Please contact Clinic Manager if you have any questions.

Patient Name (Printed): _____ Date: _____

_____ _____

Signature of Patient or Parent/Guardian of Minor Child Relationship to (if not patient)

WELCOME TO SAINT MOSCATI COMMUNITY HEALTH CARE

No-Call, No-Show Cancelation Policy

We value your time and strive to provide the best possible care to all our patients. To ensure we can accommodate everyone efficiently, we have the following policy regarding missed appointments:

- A **$25 fee** will be charged for any **missed appointment** if you do not give at least **a 24-hour notice** prior to cancellation of your appointment.
- Each patient is allowed **up to 4 missed appointments** within a **12-month period.**
  - **– 1st Missed Appointment**: $25 fee applied.
  - **– 2nd Missed Appointment**: $25 fee applied.
  - **– 3rd Missed Appointment:** $25 fee + written warning.
  - **– 4th Missed Appointment:** Discharge from the practice.

Please note:

- Cancellations must be made **at least 24 hours in advance** to avoid the fee.
- Missed appointments will be reviewed on a case-by-case basis.

_____ _____

Signature of Patient or Parent/Guardian of Minor Child Date

Consent for Treatment

I (or my legal guardian/parent) authorize Saint Moscati to provide medical care reasonable by current best practice guidelines and standards.

_____ _____

Signature of Patient or Parent/Guardian of Minor Child Date

Patient Social Media Policy

At Saint Moscati Community Health Care, we prioritize patient privacy and respect for our staff. By engaging with our clinic on social media, you agree to the following:

- **Privacy:** Do not share confidential medical information about yourself or others. Do not take photos, videos, or recordings without permission.
- **Respect:** Offensive, false, or threatening comments about the clinic, staff, or patients will not be tolerated.
- **Reviews:** You may leave honest reviews, but do not disclose specific medical details or post misleading information.
- **Use of Branding:** Unauthorized use of the clinic's name, logo, or images is prohibited.
- **Consequences:** Violations may result in service restrictions or legal action.

_____ _____

Signature of Patient or Parent/Guardian of Minor Child Date

WELCOME TO SAINT MOSCATI COMMUNITY HEALTH CARE

Narcotic (Opioid) Prescription Policy – Patient Acknowledgment

Saint Moscati is committed to safe and responsible pain management. As part of our dedication to fighting the opioid crisis and preventing addiction, we have adopted the following prescribing policy:

We only prescribe narcotic (opioid) medications for **short-term use in the following cases:**

- Pain experienced after a **severe, acute injury**.

These prescriptions will be **limited in dose and duration** to support safe recovery. We **do not** prescribe opioids for chronic pain or long-term use**.** We will work with you to manage pain using safer alternatives such as non-narcotic medications, therapy, and specialist referrals when appropriate. If you have any questions, we encourage you to discuss them with your provider.

Patient Acknowledgment: I have read and understand Saint Moscati's narcotic prescription policy.

_____ _____

Signature of Patient or Parent/Guardian of Minor Child Date