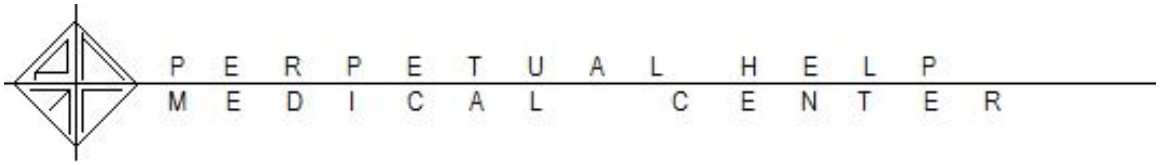

Date/Fetcha_____DOB/Fetcha de Nacimienta _____

Last Name/Dure Nombre_____First Name/Primero Nombre_____MI_____

Address/Domcilio_____

City/Ciudad_____State/Estado_____ZIP/Numero Postal_____

Home Phone/Telefono en casa_____Cell Phone/Telefono Celular_____

SSN/Seguro Social_____Sex/Sexo_____Email_____

Marital Status_____Employment Status_____

Spouse Name/Esposa Nombre_____DOB/Fetcha de Nacimiento_____

Party Responsible for Payment/Persona Responsible por to Cuenta_____

EMERGENCY CONTACT

Name of Relative or Friend (not living with you)/Nombre de Familiar o Amistad (que no vive con usted)_____

_____Relationship/Relacion_____

Address/Domicillo_____ Phone/Telefono_____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Mother/Madre_____Father/Padre_____

Employer/Empleador_____Ernployer/Empleador_____

Work Phone/Telefono_____Work Phone/Telefono_____

SSN/Seguro Social_____SSN/Seguro Social_____

Home Phone/Telefono_____Home Phone/Telefono_____

DOB/Fetcha de Nacimiento_____DOB/Fetcha de Nacimiento_____

Address/Domicilio_____Address/Domicilio_____

INSURANCE/SEGURANZA

Primary Insurance/Primaria_____

Address/Domicilio_____

ID#/Domicilio_____Group#/Numero de Grupo_____

Secondary Insurance/Secundaria_____

Address/Domcilio_____

ID#/Numero de Polica_____Group#/Numero de Grupo_____

☐ By checking this box, you agree to receive text messages from Perpetual Help Medical Center. You may reply stop to opt-out at any time. Reply help for assistance. Messages and data rates may apply. Message frequency will vary. Al marcar esta casilla, acepta recibir mensajes de texto de Perpetual Help Medical Center. Puede responder detener para darse de baja en cualquier momento. Responda ayuda para obtener ayuda. Pueden aplicarse tarifas de mensajes y datos. La frecuencia de los mensajes variará.

I authorize payment of medical benefits to Dr. Marie Claudette Grageda for services rendered. I understand that I am responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits.. Yo autorizo pagos de benficios medicos a la Dra. Marie Claudette Grageda para servicios rendidos. Yo entiendo que yo no soy fmancialmente responsible por todos los cargos si mi seguranza pago. Yo le doy permiso a la doctora que todo la informacion necesaria para asegure pago de beneficios.

X_____Date/Fetcha_____

Signature of Patient Parent or Guardian / Firma. de Paciente, Padre, o Guardiante

Marie Claudette Grageda, MD (Family and Anti-Aging Medicine)
930 Sunnyslope Rd STE C1, Hollister, CA 95023 **Tel:** 831-636-1571 **Fax:** 831-636-1706

PERPETUAL HELP
MEDICAL CENTER

HIPAA PRIVACY NOTICE / CONSENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment and to obtain payment from third party payers.

I have been informed by you of your Notice of Privacy Practices containing a more complete description, uses and disclosures of my health information. I have been given the right to review such notice, prior to signing the consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time at the address below this form to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you may restrict how your private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions. I understand I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I authorize you to disclose (release) my medical information to: _____

Relationship (husband, wife, sister, brother…) _____

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient if Minor: _____

Email Address: _____

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PERPETUAL HELP
MEDICAL CENTER

Office Policy

_____**Be on time for your appointments** and courteous to other patients. Because it only takes one patient to drag down the whole schedule and cause a long wait and big delay for everyone. If you'll be late, kindly give us a call to re-accommodate you on the schedule. (10 minute window max)

_____**Follow up/nurse visits** results require a consultation with the doctor to go over all results.

_____**No Prescriptions** will be refilled without being seen within 6 months. Controlled medication will only be filled with appointment. Please be sure to bring all medications and ask for your refills during your appointment. Please do not wait until the last minute.

_____**Telephone Calls** on most medical questions and concerns can be handled by our medical assistants. Inquiries for Dr. Grageda will be returned as soon as she will be available. Generally this is at the end of the workday due to their patient schedule.

_____**Cancellation** of an appointment requires 24 hour notice, so we have time to schedule another patient in need of care. Otherwise, a $50 charge will be billed towards your account.

_____**No food or drinks** are allowed in the office.

_____**Cleanliness and Order** should be observed at all times inside the office by returning all the magazines to its proper places and supervising your children not to bother other patients and cause any damages that will be charged towards your account.

_____**Co-payment** must be paid at the time of service. NOTE: Please remember this is part of your insurance plan and you are responsible for the amount that must be paid and any changes due to insurance.

_____**Outstanding balance** over 90 days past due, will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

_____**Billing questions** are handled by Terry Cook's Medical Billing. They can be reached at 831-682-5633.

_____**Form completion** for DMV, School, Physical and WIC will only be filled out with appointment. All Disability forms require an appointment and will have a $50 fee. (Fee is due at time of pick up). Time frame to picked up of one week. (Office will call when forms are ready.) Printing of records for personal use is $25 fee. *Please remember to bring all forms at the day of the visit that need to be filled out.

_____**Rest/Nursing home and elderly patients** who require assistance need somebody to accompany them during the consult.

_____**Communicable disease management protocol** strictly enforce all patients who are exposed or positive to contagious disease such as but not limited to Covid-19, SARS, Flu etc. should refrain from coming out in public and self quarantine to prevent exposing others safety. Dr. Grageda can still see the patient over the phone or telemedicine.

_____**Call-in/Walk-in/sick visit patients** should be specific and kept to one medical complaint per visit. Please understand we're squeezing you in a busy schedule. Kindly be considerate for an extended wait.

_____**Patient discontinuance from practice due to**: being rude to our staff, abusive language, aggressive behavior, non-compliance with medical advice and office policy, "doctor or drug shopping", accusations or threats regarding competency, threats to see an attorney, filing of a medical malpractice suit, an account being sent to full collection, any behavior that would lead a reasonable person to conclude that there is a lack of trust or respect, etc.
We strive to provide a pleasant working relationship that is cheerful, healthy, comfortable and free from intimidation, hostility or other offenses, which might interfere with work performance. We realize and understand that our practice style and scheduling format is not for everyone. In addition selection of a medical care provider is a two-way relationship. Not only should we be acceptable to the patient, but also the patient should fit with our practice style.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____
Signature of patient or responsible party **Date**

Marie Claudette Grageda, MD (Family and Anti-Aging Medicine)
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Health Information Exchange (HIE) Consent Form

Patient Consent for Health Information Exchange (HIE)

Purpose: This consent form allows your health information to be shared securely through the Health Information Exchange (HIE) system. The HIE helps healthcare providers such as hospitals, specialists, and labs access your medical records more quickly and coordinate your care better.

Benefits of Participating in HIE

- **Faster Access to Medical Records**: Your healthcare providers can quickly access your medical history, including test results, prescriptions, and diagnoses, improving treatment decisions.
- **Better Care Coordination**: Specialists, hospitals, and other providers involved in your care can see a complete picture of your health, ensuring more coordinated care.
- **Reduced Duplication of Tests**: Sharing information through HIE helps avoid unnecessary repeat tests and procedures, saving time and reducing healthcare costs.

Risks and Privacy Concerns

- **Privacy and Security**: Your information is shared securely under federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA). The HIE system uses encryption and other security measures to protect your data.
- **Potential Concerns**: Although we take strict measures to protect your privacy, there is a small risk that unauthorized individuals could access your information. However, every effort is made to prevent this from happening.
- **You Can Change Your Mind**: If you decide at any time that you no longer want your information shared, you can opt out by contacting our office.

Patient Decision

Please choose one of the following options:

- **I Consent**: I give permission for my health information to be shared through the Health Information Exchange (HIE) with other healthcare providers for the purpose of my care.

  Signature: _____ Date: _____

- **I Do Not Consent**: I do not want my health information to be shared through the Health Information Exchange (HIE). I understand this may impact the speed and coordination of my care.

  Signature: _____ Date: _____

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Your Rights and Protections

- **HIPAA Protection**: Your health information is protected by HIPAA and will only be shared with authorized individuals for your healthcare.
- **Right to Revoke**: You can change your decision about HIE at any time by notifying us in writing.
- **Access to Information**: You can request a copy of your health records or the list of providers who accessed your information through the HIE.

If you have questions about this form or the Health Information Exchange (HIE), please contact our office at 831-636-1507] or DrG.PHMC@gmail.com

For Office Use Only

Patient Name: _____ Date: _____
Consent Status: ☐ Consented ☐ Opted Out
Staff Initials: _____

Patient Information Sheet: Health Information Exchange (HIE)

What is HIE?
The Health Information Exchange (HIE) is a secure system that allows healthcare providers to access and share your medical records to provide better care.

Why Should I Participate?

- Improves communication between doctors, specialists, and hospitals.
- Helps your doctors make quicker, more informed decisions.
- Reduces the need for repeat tests and treatments.

How is My Information Protected?
Your health information is protected under HIPAA and other privacy laws. Only authorized healthcare providers can access your information. The HIE uses encryption and other advanced security measures to keep your information safe.

Can I Change My Mind?
Yes. You can change your decision at any time by contacting our office. If you decide to opt out, your health information will no longer be shared through the HIE.

Questions?
If you have any concerns or need more information, please contact Perpetual Help Medical Center at 831-636-1507] or DrG.PHMC@gmail.com

These forms aim to ensure that patients are fully informed about the benefits and risks of HIE, while respecting their privacy and consent choices.