Welcome To My Christian Doctor.

Thank you for allowing us the opportunity to assist you with your healthcare needs. We value all of our patients and are committed to providing you with high-quality healthcare services.

The New Patient Packet includes:

1. Patient Registration Form
2. Medical History Form
3. PHI Disclosure Consent
4. Telehealth Consent
5. Medicare Private Contract (for Medicare Beneficiaries only)
6. Financial Policy
7. Notice Of Private Practices

Please take a few moments to review and electronically complete the registration forms. If you sign the PHI Consent Form allowing the email of information, please return forms by email to admin@mychristiandoctor.com.

Thank you again for choosing My Christian Doctor. We look forward to assisting you with your healthcare needs.

God bless,

Simone Mater, M.D.
Family Physician.

MyChristianDoctor

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Date:

First Name: Middle Name: Last Name:

Birth Date: Age: Sex: Phone #:

Email: Occupation:

Address:

Marital Status: Name of Spouse: Weight: Height:

RESPONSIBLE PARTY (GUARANTOR) ☐ SAME AS PATIENT

Information below is required for treatment of a minor or a patient who does not have their own power of attorney.

First Name: Middle Name: Last Name:

Address:

Relationship: Phone Number:

PREFERRED PHARMACY

Name: Phone Number:

Address:

PHYSICIANS

Please list all active treating physicians (i.e. primary care physician, pulmonologist, oncologist, cardiologist).

Physician's Name: Specialty:

Physician's Name: Specialty:

Physician's Name: Specialty:

PAYMENT INFORMATION

Preferred Billing Method: ☐ Zelle ☐ Venmo ID: @

☐ Credit Card (An invoice from square up will be sent to your email).

GENERAL CONSENT FOR TREATMENT

I hereby consent to and authorize the performance of all treatments, and medical services deemed advisable by the physician of My Christian Doctor, LLC to me or to the above named patient of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all the above information is complete and accurate.

Signature: Date:

PATIENT FINANCIAL OBLIGATION AGREEMENT

I certify that I have read and agree to MCD's Financial Policy.

Signature: Date:

MEDICARE BENEFICIARIES ONLY

I understand MCD's provider has opted-out of Medicare. I accept full responsibility for payment of charges for all services provided.

Signature: Date:

NOTICE OF PRIVACY PRACTICES (Acknowledgement of Receipt)

I acknowledge that I was provided with a copy of the MCD's Notice of Privacy Practices (NOPP).

Signature: Date:

Name:	Date of Birth:

CURRENT MEDICAL CONDITIONS

1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

MEDICATIONS

Prescribed and over-the-counter:

Medication	Dose/Frequency	Medication	Dose/Frequency

ALLERGIES

Medication or Food (list reactions): ☐ No Allergies

Allergy	Reaction	Allergy	Reaction

SURGERIES

Type	Date

FAMILY HISTORY

☐ No known significant family history

1.		3.	
2.		4.	

SOCIAL HISTORY

Do you use tobacco, nicotine, marijuana, or recreational drugs? ☐ Yes ☐ No

If yes, please describe:

Do you consume caffeinated products? ☐ Yes ☐ No

If so, what and how much per day?

Do you drink alcohol? ☐ Yes ☐ No

If so, what type, how much and how often?

Do you excercise? ☐ Yes ☐ No If yes, how often?

Are you on a special diet? ☐ Yes ☐ No If so, what type?

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ (Print Name), hereby give my consent for My Christian Doctor, LLC (referred as MCD) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). MCD's Notice of Privacy Practices provided describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent MCD reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to admin@mychristiandoctor.com

With this consent, MCD may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, MCD may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential.

With this consent, MCD may email me any items that assist the practice in carrying out TPO which may include PHI, such as appointment reminder, forms, documents pertinent to clinical care and patient statements.

I have the right to request that MCD restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow MCD to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, MCD may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Signature: _____ Date: _____

Telehealth is healthcare provided by any means other than a face-to-face visit. In Telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow- up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e- health technologies, patient portals, and remote patient monitoring are all considered Telehealth services.

I _____ (Print Name) understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing emergency 911 services in my community.

I understand that Telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

I understand that I may opt out of the Telehealth visit at any time. This will not change my ability to receive future care at this office.

I understand that Telehealth services can only be provided to patients, including myself, who are residents of or physically located in the state of Florida at the time of this service.

I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of Telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand.

These risks include but are not limited to:

- It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

I agree that information exchanged during my Telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

I understand that medical information, including medical records, are governed by federal and state laws that apply to Telehealth. This includes my right to access my own medical records (and copies of medical records).

I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I agree that I have verified to my healthcare provider my identity and current location in connection with the Telehealth services. I acknowledge that failure to comply with these procedures may terminate the Telehealth visit.

I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via Telehealth and to confirm that he or she is a licensed healthcare provider.

Signature: _____ Date: _____

I, Simone Mater, M.D., have not been excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act.

I, _____ (Medicare beneficiary's first and last names), or _____ my legal representative accept full responsibility for payment of charges for all services furnished by Simone Mater, M.D..

I (Medicare beneficiary) or my legal representative understand that Medicare limits do not apply to what Simone Mater, M.D. may charge for items or services furnished.

I (Medicare beneficiary) or my legal representative agree not to submit a claim to Medicare or to ask Simone Mater, M.D. to submit a claim to Medicare.

I (Medicare beneficiary) or my legal representative understand that Medicare payment will not be made for any items or services furnished by Simone Mater, M.D. that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I (Medicare beneficiary) or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The expected or known effective date and expected or known expiration date of the opt-out period is January 07, 2022 (effective date) and January 07, 2024 (expiration date).

I (Medicare beneficiary) or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

This contract cannot be entered into by me (Medicare beneficiary) or by my legal representative during a time when I (Medicare beneficiary) require emergency care services or urgent care services. However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual.

I (Medicare beneficiary) or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract before items or services are furnished to me under the terms of this contract.

I, Simone Mater, M.D., will retain the original contract (original signatures of both parties required) for the duration of the opt-out period and will supply CMS with a copy of this contract upon request.

I, Simone mater, M.D., understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

Provider's Signature:		Date:	
Provider's NPI: 1659552305			
Patient's Signature:		Date:	
Legal Representative Signature:		Date:	

Thank you for choosing My Christian Doctor (MCD) as your healthcare provider. We are committed to providing you with the highest quality of care at the lowest cost possible. This Financial Policy is an agreement between MCD and you, the patient (or responsible party). Patients are required to read and agree with our financial policy prior to any services being rendered. A copy of this policy will be provided to you upon request.

Health Insurance

My Christian Doctor does not participate in any insurance plan and does not bill your insurance company. MCD charges you a transparent reasonable flat fee for services rendered. After each visit, a copy of your medical receipt is available for you upon request.

Medicare

MCD's provider does not participate and has opted-out of Medicare. Our provider can still provide services to Medicare Beneficiaries, however, a private contract is required. If you are a Medicare Beneficiary, you will be required to enter into a contract with our provider by signing a Medicare Private Contract prior to any services being rendered.

Payment

Payment is due at the day of service. We will send you an invoice within a few hours after your visit via your preferred method of payment (Venmo, Zelle, or credit card). If you haven't received an invoice within 24 hours after your visit please look for it in your Venmo/Zelle app or spam email (Square Invoice).

Missed Appointments

If you need to cancel your appointment, we respectfully request at least 4 hours notice. Any cancellation/ reschedule made less than 4 hours or no shows will result in a cancellation fee equivalent to 50% of your appointment fee. In the event of an emergency, your cancellation fee may be applied to future services.

If you have any questions regarding our financial policies, please contact us at (941) 315-4875 or email us at admin@mychristiandoctor.com.

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

"This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully."

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

My Christian Doctor by phone at (941) 315-4873 or email at admin@mychristiandoctor.com.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. People who work for our practice – including, but not limited to, doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Optional Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Optional Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Optional Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Optional Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Optional Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Optional Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Optional Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to admin@mychristiandoctor.com specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing.

Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to admin@mychristiandoctor.com in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to admin@mychristiandoctor.com. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to admin@-mychristiandoctor.com. Our practice will notify you of the costs involved with your requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact us at My Christian Doctor by phone at (941)315-4873 or email at admin@mychristiandoctor.com.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact us at My Christian Doctor by phone at (941)315-4873 or email at admin@mychristiandoctor.com. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact us at My Christian Doctor by phone at (941)315-4873 or email at admin@mychristiandoctor.com.