Mango Medical

* * * * PLEASE PRINT * * * *

Patient Legal Name: ___________________________________

Home Number: ___________________________________

Cell Number: ___________________________________

EMAIL Address: ___________________________________

Date Of Birth: ___________________________________

Physical Address: ___________________________________

(Needed for prescriptions per State & Federal regulations)

Mailing Address: ___________________________________

Emergency Contact: __________________#________________

(Relationship) (Phone Number)

Must present a current I.D. and Insurance Cards for the Appointment
(Kaiser Permanente NOT accepted)

Primary Insurance: ________________#___________________

Secondary Insurance: ________________#___________________

Please provide us with accurate Primary and Secondary Insurance Information
Failure to do so may result in a bill to you the patient

_ _ _ _ _ _ _ _ _ _ _ _ New Patients Only _ _ _ _ _ _ _ _ _ _ _ _

➡️ SIGN - Authorization for Release of Medical Information - Designation?

➡️ SIGN - Patient Expectations & Standards of Conduct

➡️ SIGN - HIPPA Agreement

➡️ PCP - Did I tell my Insurance Carrier to change to my NEW PCP

I hereby certify that all of the information provided by me in this intake form (or any other accompanying or required documents) is correct, accurate and complete to the best of my knowledge. I understand that the falsification, misrepresentation or omission of any information in said documents will cause denial of medical services, termination from the practice and all co-payments required by insurance are to be paid at the time of service. Any charges not covered by insurance are the sole responsibility of the patient.

Confirmation of Primary Care Provider Choice

Thank you for choosing my practice for your health care needs. I'll work with you to provide the best medical care and keep you as healthy as possible.

This notice confirms that:

1. You selected me as your primary care provider (PCP) for routine health and well-being care and to arrange care from specialists when needed.
2. If you're a member of HMSA's health maintenance organization (HMO), HMSA QUEST Integration, Essential Advantage HMO, or HMSA Akamai Advantage® PPO plans, my practice will let HMSA know that you chose me as your PCP. You should receive a new HMSA membership card with my or my practice's name within 10 days after HMSA receives the information.
3. As an HMSA member, you can choose any PCP from HMSA's network and you may change your PCP at any time.

My practice has sent the following information to HMSA to designate or confirm that I'm your PCP:

Patient's full name: ______________________________

Patient's DOB: ______________________________

Patient's HMSA plan: ______________________________

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HMSA subscriber name: ______________________________

HMSA subscriber ID no.: ______________________________

Patient's address: ______________________________

Patient's phone no.: ______________________________

PCP's full name: ______________________________

HMO Health Center (if applicable): ______________________________

Date/Sign Here: ______________________________

If you'd like to change your PCP and you're enrolled in an HMSA HMO, HMSA QUEST Integration, Essential Advantage HMO, or HMSA Akamai Advantage PPO plan, you can call HMSA at the phone number on the back of your HMSA membership card.

If you're enrolled in an HMSA Preferred Provider Organization (PPO) plan or in HMSA Federal Plan 87, you don't need to notify HMSA if you change your PCP. However, you may call HMSA at the phone number on the back of your HMSA membership card if you need help finding a doctor.

Permitted Communication Form

A. Family and Friends. It is the policy of Mango Medical to not release confidential medical information regarding your treatment to family members or friends, except for
   (i) parents and/or legal guardian.
   (ii) other persons authorized by the patient.
   (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the individual is entitled to receive information regarding your treatment), in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

B. If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member or friend, please check (✓) the line next to the "no" response.

By signing below, you authorize the following people to receive information regarding your treatment or care. You can update this list at any time by speaking to our patient service representatives.

_______ No, do not discuss my health and information with anyone other than myself.

I Authorize This Person(s) to Be Able to Discuss My Health & Information with Mango Medical:

Name:	Relationship to Patient:	Phone Number:

Printed Name: ____

Patient Signature: ____

Relationship to Patient (if other than self): _________________________

Date: _____________________

INSURANCE DISCLAIMER

FOR MANGO MEDICAL PATIENTS

INCLUDING (BUT NOT LIMITED TO) INSURANCE COMPANIES BELOW

HMSA (PPO, HMO, QUEST, MEDICARE SUPPLEMENT)
ALOHACARE (QUEST, MEDICARE SUPPLEMENT)
OHANA (QUEST, MEDICARE SUPPLEMENT)
UNITED HEALTHCARE (UHC, QUEST, MEDICARE, HMO)
UNITED HEALTH ALLIANCE (UHA)
MEDICARE
HMWG
PSWA
AETNA
BLUE CROSS BLUE SHIELD ANTHEM
VA (TRIWEST, FOR LIFE, SELECT)-Call VA Community Care at 877-881-7618 to verify referral coverage for your appointment date **each time**.

Mango Medical is NOT responsible for making sure that you are covered under medical insurance or covered under any referral with limited dates. As a courtesy, we will attempt to verify insurance coverage, request prior authorizations if applicable and bill insurances for services directly. If we are unable to verify coverage, or if there is a gap in your coverage (a period of time you have a lapse in coverage), you understand and agree to pay the full costs associated with the appointment(s). Any co-payments or payments for uncovered services will be due within 90 days of service or be subject to collections. This includes loss of insurance for any reason or change in referral status for the provided dates of service.

All non-insured persons, non-verifiable coverage or insurance coverage that we do not file will be considered FFS (Fee for Service) and will be due and payable in full at the time of service.

________________________________ ______________________

Patient Signature Date

____

Printed Name of Patient

Form updated: 08/15/2023

Patient Expectations & Standards of Conduct

Patient-Provider Partnership Agreement:

Welcome and thank you for choosing Mango Medical! Your primary care provider is committed to providing you with the best healthcare based on your personalized health needs. Our goal is to form a partnership to keep your whole self as healthy as possible, no matter your current state of health. We ask for you to make a commitment to yourself in this partnership and become an active participant in your care.

Mango Medical is a patient-centered medical home that will provide you with an expanded type of care. Your primary care provider will work with you and your other healthcare providers as a team to take care of you. As your care team we will involve you in the decisions about your health and thus be able to develop a stronger relationship with you.

Standards of Conduct:

At Mango Medical we practice the golden rule: Treat others as we would like to be treated. Please take note that we maintain an expectation of patients to also follow this rule to the best of their ability. Abusive, disruptive and otherwise non-compliant patient behavior is not tolerated. Examples of inappropriate behavior may be, but are not limited to swearing, hitting, threatening, yelling, habitually no-showing, falsifying information, purposeful misuse of medication, lying or being otherwise deceitful. This type of behavior towards any staff, property or patients at Mango Medical Is not tolerated and is cause for dismissal from care.

Financial Responsibility & Expectations:

Mango Medical accepts all insurance plans and participates with many popular carriers. It is your financial responsibility to understand your health insurance coverage. Please call the customer service department of your insurance for more information about your plan.

We will ask you when you check-in at an appointment to verify or update your personal information and expect that you will notify us of any changes to your insurance, address or phone number. Upon check in you will also be

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Patient Signature | Patient Name | Date

HIPAA AGREEMENT PLEASE SIGN THE LAST PAGE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice **of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment. payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access** and control your protected health information. "Protected health in**formation is information about** you, including **demographic information, that may identify you and that relates to your past, presen**t or future physical or mental health or c**ondition and related health care services.**

We are required to abide by the terms of this Notice of Pri**vacy Practices. We may change the terms of our notice at any time. The new not**ice will b**e effective f**or all protected health information that we maintain at that time. Upon your **request**, we will provide you **with any revised Not**ice of Privacy P**ractices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.**

1. Uses and Disclosures of Protected Health information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Followin**g arc examples of the types of uses and disclosures o**f your protected health information that your physician's o**ffice is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.**

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the nece**ssary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (4.8., a specialist or**

laboratory) who, at the request of your physician. becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed. as needed. To obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity. and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities. training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party business associates that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information. as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: Wc may disclose your private health insurance for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law. to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law. such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system. government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your prolected health information to a public health authority **that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.**

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety. or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations. to track products: to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, **so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law. (2) limited information requests for identification and location purposes. (3) pertaining to victims of a crime. (4) suspicion that death has occurred as a result of criminal conduct.(5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.**

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organs, eye or tissue donation purposes.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities: (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for t**he provision of protective services to the President or others legally authorized.**

Workers' Compensation: We may disclose your protected health inform**ation as authorized to comply with workers' compensation laws and other similar legally-established programs.**

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing you the Opportunity to Agree or Object:

We may use and disclose your protected health information in the followi**ng instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician. may, using professional judgment, determine whether the disclosure is in your best interest.**

Facility Directories: Unless you object, w**e will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable) and your religious affiliation. All of this information. except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation** will be onl**y given to a member of the clergy, such as a priest or rabbi.**

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify your protected health information that directly **relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may usc or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.**

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain thc protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in civil. criminal, or administrative action or proceeding: and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means *y*ou may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice **of Privacy Practices. Your request must state the specific restriction requested and to whom *y*ou want the restriction to apply.**

Your p**hysician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction. we may not use or disclose your protected health information in violation of**

that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure. for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, **to law enforcement (as provided in the privacy rule) or correctional facilities. as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions. restrictions and limitations.**

You have the right to obtain a paper copy of this notice from us. upon request. even if you have agreed to accept this notice electronically.

Patient Signature ____

Printed Name ____

Date ______/_______20______