IQ Health- Welcome To Your Secure Patient Portal

We are excited to offer you a new informational system through United Medical Physicians called IQHealth. This System allows web based interactions between patients and our office. You will be able to:

View your test results	**Update demographic information**
Request an appointment	**Send and receive messages**
Request medication refills	**Keep track of your health**

☐ I wish to participate ☐ I do NOT wish to participate

****If participating in IQ Health please make sure to provide your email on Page 1*

SATURDAY NO-SHOW FEE POLICY

(__________) **Please initial.** We make every effort to provide prompt medical care to all of our patients. Should you need to cancel your appt. this must be done 48 hours prior to your appointment this allows other patients who may be waiting to see the doctor to use the available appointment time. A NO SHOW is when a patient fails to keep a scheduled appointment. A NO SHOW will generate a **$50** fee and three no shows may require that you seek your medical care elsewhere. **If you receive one Saturday No Show you are no longer able to be scheduled on Saturdays.**

Patient Privacy Consent Form

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 that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as the quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

I understand that this organization has the right to change Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how private information is used or disclosed to carry our 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 abound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Assignment of Benefits: I hereby assign all medical and surgical benefits to which I am entitled to including Medicare,Medicaid,Private Insurance and any other health plans to Galicano F. Inguito JR.,MD. I authorize than any holder of medical information about me, to release to my insurance company and to my supplemental insurer and information needed to determine these benefits payable for medical and related services provided by Galicano F. Inguito JR.,MD.

Signature:_______________________________ Date:____________