A C C E S S
HEALTH CARE PHYSICIANS®

# PATIENT REGISTRATION FORM

| | | | | |
|---|---|---|---|---|
| Today's date | | | ❑ Office ❑ Facility ❑Home | |
| **PATIENT INFORMATION** | | | | |
| Patient's Name<br>Last First MI | | | | Single / Mar /<br>Div / Sep / Wid |
| Date of Birth | Age | ❑ M ❑ F | Social Security # | Driver's License # |
| Street address | | | City, State, Zip | |
| Phone<br>(Home) | Phone<br>(Cell) | | Email address | |
| Referred By | Race | | Ethnicity | Primary Language |
| Pharmacy<br>Name | Pharmacy<br>Address | | | Pharmacy<br>Phone |
| **IN CASE OF EMERGENCY** | | | | |
| Emergency Contact | | | Relationship to patient | |
| Street address | | | City, State, Zip | |
| Phone (Home) | | | Phone (Cell) | |
| **INSURANCE INFORMATION** | | | | |
| ❑ **Medicare** ❑ **Medicaid** ❑ **HMO**<br>❑ **PPO** ❑ **POS** ❑ **PPC** | | | ❑ **Worker's Comp**<br>❑ **Auto Accident Date of Injury / /** | |
| **Primary Insurance Name** | | | **WC or Auto Insurance Company** | |
| Address | | | Address | |
| City, State, Zip | | | City, State, Zip | |
| Phone | Fax | | Employer at time of injury | |
| Policy Subscriber Name | | | Address | |
| Patient's relationship<br>to subscriber | | | City, State, Zip | |
| Subscriber ID# or<br>Social Security # | | | Phone | Fax |
| Plan Name | | | Claim # | |
| Policy # | Group # | | Claim Adjuster | |
| Primary Care Physician | | | Phone | Fax |
| Phone | Fax | | Case Manager | |
| **Secondary Insurance Name** | | | Phone | Fax |
| Address | | | Name of attorney | |
| City, State, Zip | | | Contact Person | |
| Policy # | Group # | | Phone | Fax |
| Phone | Fax | | Lawsuit pending? ❑ Yes ❑ No | |
| Policy Subscriber Name | | | Auto accident<br>deductible: $ | Met? ❑ Yes ❑ No |
| Patient's relationship to subscriber | | | LIEN? ❑ Yes ❑ No | LOP? ❑ Yes ❑ No |
| CO-PAY? $ | Self-pay? ❑ Yes ❑ No | | | |
| **EMPLOYMENT INFORMATION** | | | | |
| Employer | | | Occupation | |
| Street Address | | | City, State, Zip | |
| Phone | Fax | | Email | |

ACCESS HEALTH CARE PHYSICIANS

# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

**Patient Name:** *Last* *First* *MI*

**Today's Date:** **Reason for Visit:**

| **Previous or referring doctor:** | **Patient sex: M F** | **DOB:** |
|---|---|---|

## PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)

**Conditions you have had in the past (check all that apply):**

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV + | ☐ Cancer | ☐ Glaucoma | ☐ Liver Disease | ☐ Stroke |
| ☐ Anemia | ☐ Cataracts | ☐ Gout | ☐ Migraine Headache | ☐ Thyroid Problems |
| ☐ Anxiety | ☐ Chicken Pox | ☐ Heart Disease | ☐ Mononucleosis | ☐ TB |
| ☐ Arthritis | ☐ Depression | ☐ Hepatitis | ☐ Multiple Sclerosis | ☐ Ulcers |
| ☐ Asthma | ☐ Diabetes | ☐ Hernia | ☐ Pneumonia | LIST ANY OTHERS |
| ☐ Bleeding Disorders | ☐ Eating Disorder | ☐ High Cholesterol | ☐ Prostate Problem | ☐ |
| ☐ Breast Lump | ☐ Emphysema/COPD | ☐ Hypertension | ☐ Rheumatic Fever | ☐ |
| ☐ Bronchitis | ☐ Epilepsy | ☐ Kidney Disease | ☐ Sexually Transmitted Disease | |

**Surgeries**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

**Other hospitalizations**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

| **Have you ever had a blood transfusion?** | ☐ Yes | ☐ No |
|---|---|---|

**Do you know your blood type?** ☐ Yes ☐ No Type:

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

| **Drug Name** | **Strength** | **Frequency Taken** | **Drug Name** | **Strength** | **Frequency Taken** |
|---|---|---|---|---|---|
| 1 | | | 6 | | |
| 2 | | | 7 | | |
| 3 | | | 8 | | |
| 4 | | | 9 | | |
| 5 | | | 10 | | |

**Allergies to medications**

| **Drug Name** | **Reaction You Had** | **Drug Name** | **Reaction You Had** |
|---|---|---|---|
| 1 | | 3 | |
| 2 | | 4 | |

**Vaccines**

| **Vaccine name** | **Date Received** | **Vaccine Name** | **Date Received** |
|---|---|---|---|
| 1 | | | |
| 2 | | | |

| PATIENT NAME: | | | | DOB: | |
|---|---|---|---|---|---|
| **HEALTH HABITS AND PERSONAL SAFETY (SOCIAL HISTORY)**<br>ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. | | | | | |
| **Exercise** | ☐ Sedentary (No exercise) ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | |
| | ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | |
| | ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | |
| **Diet** | Are you dieting? | | | ☐ Yes | ☐ No |
| | If yes, are you on a physician-prescribed medical diet? | | | ☐ Yes | ☐ No |
| | # of meals you eat in an average day? | | | | |
| **Caffeine** | ☐ None | ☐ Coffee | ☐ Tea | ☐ Cola | |
| | # of cups/cans per day? | | | | |
| **Alcohol** | Do you drink alcohol? | | | ☐ Yes | ☐ No |
| | If yes, what kind? | | | | |
| | How many drinks per week? | | | | |
| **Tobacco** | Do you use tobacco? | | | ☐ Yes | ☐ No |
| | ☐ Cigarettes – packs/day | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day | |
| | ☐ # of years: _____ | ☐ Or year quit: _____ | | | |
| **Drugs** | Do you currently use recreational or street drugs? | | | ☐ Yes | ☐ No |
| | Have you ever given yourself street drugs with a needle? | | | ☐ Yes | ☐ No |
| **Personal Safety** | Do you live alone? | | | ☐ Yes | ☐ No |
| | Do you have frequent falls? | | | ☐ Yes | ☐ No |
| | Do you have vision or hearing loss? | | | ☐ Yes | ☐ No |
| | Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your doctor or his staff? | | | ☐ Yes | ☐ No |

| **FAMILY HEALTH HISTORY** | | | |
|---|---|---|---|
| **Relation** | **AGE** | **AGE AT DEATH** | **SIGNIFICANT HEALTH PROBLEMS** |
| **Father** | | | |
| **Mother** | | | |
| **Brothers** | | | |
| | | | |
| **Sisters** | | | |
| | | | |

| **MENTAL HEALTH** | | |
|---|---|---|
| Is stress a major problem for you? | ☐ Yes | ☐ No |
| Do you feel depressed? | ☐ Yes | ☐ No |
| Do you panic when stressed? | ☐ Yes | ☐ No |
| Do you have problems with eating or your appetite? | ☐ Yes | ☐ No |
| Do you cry frequently? | ☐ Yes | ☐ No |
| Have you ever seriously thought about hurting yourself? | ☐ Yes | ☐ No |
| Do you have trouble sleeping? | ☐ Yes | ☐ No |
| Have you ever been to a counselor? | ☐ Yes | ☐ No |
| Have you ever attempted suicide? | ☐ Yes | ☐ No |

| **SCREENINGS** (please indicate most recent date) | |
|---|---|
| Last Colonoscopy: / / ☐ Normal ☐ Abnormal | Cholesterol Screening: / / ☐ Normal ☐ Abnormal |
| Test for blood in stools: / / ☐ Normal ☐ Abnormal | Electrocardiogram: / / ☐ Normal ☐ Abnormal |

**PATIENT NAME:** **DOB:**

**Review Of Systems (check all that apply to you)**

**CONSTITUTIONAL**
- ☐ Wt. loss or gain
- ☐ Fever
- ☐ Fatigue
- ☐ Chills

**EYES**
- ☐ Blurry vision
- ☐ Double vision
- ☐ Vision changes
- ☐ Cataracts
- ☐ Glaucoma

**ENT/MOUTH**
- ☐ Sinus problems
- ☐ Runny nose
- ☐ Tooth pain
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ Gum pain
- ☐ Gum bleeding
- ☐ Swallowing difficulties
- ☐ Ear pain
- ☐ Ear discharge

**ALLERGY/IMMUNO**
- ☐ Rashes/hives/welts
- ☐ Itchiness
- ☐ Allergic asthma/bronchitis

**NEURO**
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Headache
- ☐ Lack of coordination
- ☐ Balance problems
- ☐ Seizures
- ☐ Numbness

**PSYCH**
- ☐ Depression
- ☐ Mood swings
- ☐ Memory problems
- ☐ Anxiety

**ENDO**
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Nail changes
- ☐ Night sweats
- ☐ Hot flashes

**SKIN**
- ☐ Skin rashes
- ☐ Bruising
- ☐ Changes in skin lesions
- ☐ Wounds
- ☐ Ulcers

**GENITOURINARY**
- ☐ Burning urination
- ☐ Excessive urination
- ☐ Incontinence of urine
- ☐ Blood in urine
- ☐ Frequent bladder/kidney infections
- ☐ History of sexually transmitted disease

**GASTROINTESTINAL**
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Incontinence of bowels
- ☐ Blood in stools
- ☐ Bloating
- ☐ Poor appetite
- ☐ Hemorrhoids
- ☐ Nausea

**HEM/LYMPH**
- ☐ Bruising
- ☐ Nosebleeds
- ☐ Lack of energy

**RESPIRATORY**
- ☐ Frequent lung infections
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Wheezing
- ☐ Sleeping problems
- ☐ Persistent cough
- ☐ Asthma

**CARDIOVASCULAR**
- ☐ History of Rheumatic fever
- ☐ Palpitations
- ☐ Chest pain
- ☐ Swelling hands
- ☐ Swelling feet
- ☐ Irregular heart beat
- ☐ High or low blood pressure

**MUSC/SKELETAL**
- ☐ Difficulty walking
- ☐ Joint stiffness
- ☐ Muscle pains
- ☐ Back pain
- ☐ Pain during walking

**WOMEN ONLY**

| | |
|---|---|
| Age at menstruation: | Date of last PAP smear: / / ☐ Normal ☐ Abnormal |
| Number of pregnancies _____ Number of live births _____ | Date of or age at last menstruation: / / |
| Last Mammogram: / / ☐ Normal ☐ Abnormal | Bone Density Screening: / / ☐ Normal ☐ Abnormal |

| | | |
|---|---|---|
| Experienced any recent breast tenderness, lumps, or nipple discharge? | ☐ Yes | ☐ No |
| Date of last rectal exam? / / ☐ Normal ☐ Abnormal | | |

**MEN ONLY**

| | | |
|---|---|---|
| Do you usually get up to urinate during the night? | ☐ Yes | ☐ No |
| If yes, # of times _____ | | |
| Do you feel burning discharge from penis? | ☐ Yes | ☐ No |
| Has the force of your urination decreased? | ☐ Yes | ☐ No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | ☐ Yes | ☐ No |
| Do you have any problems emptying your bladder completely? | ☐ Yes | ☐ No |
| Any difficulty with erection or ejaculation? | ☐ Yes | ☐ No |
| Any testicle pain or swelling? | ☐ Yes | ☐ No |
| Date of last prostate and rectal exam? / / ☐ Normal ☐ Abnormal | | |
| Date of last PSA test (if any): / / ☐ Normal ☐ Abnormal | | |

**Is there anything else you would like to discuss with the doctor?** _____

_____

_____ _____

*Patient signature* *Date*

_____ _____

*Provider signature* *Date*

ACCESS HEALTH CARE PHYSICIANS

## PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

- Declaration to Decline Life-Prolonging Procedures (Living Will)

  ☐ I have ☐ I have NOT made a Living Will

- Health Care Surrogate

  ☐ I have ☐ I have NOT designated a Health Care Surrogate

- Durable Power of Attorney

  ☐ I have ☐ I have NOT appointed a Durable Power of Attorney for Health Care Decisions

If you have signed an advance directive outlining your wishes, we will gladly make a copy and place it in your chart. If you have not created an advance directive, we will gladly provide you with a packet of information and forms.

## PATIENT PRIVACY QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may <u>verbally</u> inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Name: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship: _____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

- Name: _____ Phone #: _____
- Name: _____ Phone #: _____

III. ☐ I understand that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL"

IV. Confidential messages (i.e., appointment reminders) ☐ May ☐ May **<u>not</u>** be left on answering machine or voicemail.

V. Please print the phone number where you want to receive calls about your appointments: _____

☐ I am fully aware that a cell phone is not a secure and private line.

_____ _____

**PLEASE *PRINT* PATIENT NAME** **DATE OF BIRTH**

_____ _____

**LEGAL REPRESENTATIVE** **RELATIONSHIP TO PATIENT**

_____ _____, 20_____

**SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE** **TODAY'S DATE**

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## CONSENT TO TREAT

**I, the undersigned voluntarily give consent to my Access Health Care Physicians, LLC. and its affiliates to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.**

_____ **Date:** _____ **DOB:** _____
**Patient Printed Name**

_____ **Relationship to Patient:** _____
**Signature of Patient/Legal Representative**

. . . . . .

## RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

**I, have received/reviewed a copy of the Access Health Care Physicians, LLC. and its affiliates, Notice of Privacy Practices and the Florida Patient Bill of Rights.**

_____ **Date:** _____
**Signature of Patient/Legal Representative**

. . . . . .

**OFFICE USE ONLY**

**I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:**

| Date | Initials | Reason |
|---|---|---|
| | | |

## AUTHORIZATION AND ASSIGNMENT

**I hereby authorize my Access Health Care Physicians, LLC. and its affiliates practice location to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Access Health Care Physicians, LLC. and its affiliates for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.**

_____ **Date:** _____
**Signature of Patient/Legal Representative**

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# CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) and Access Health Care Physicians, LLC, and its Affiliates, prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care with Access Health Care Physicians, LLC, and its Affiliates, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be storedas medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then betransferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Access Health Care Physicians, LLC, and its Affiliates, to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Date of Birth

# Consent to Text Message Updates

I _____, date of birth_____,
*(Patient Name)*
consent to have Access Health Care Physicians LLC. and / or its affiliates, contact me by text message for the purpose of health updates and appointment reminders.

☐ I allow text messages for health updates / appointment reminders

☐ I do not allow text messages

I acknowledge the appointment reminders by text are an additional service, and the responsibility of attending or canceling an appointment is still my responsibility.

I agree to advise the practice if my mobile number changes or if it is no longer in my possession. I can cancel these text reminders at any time.

Texts messages are generated using a secure facility. I understand that they are transmitting over a public network on to a personal device that may not be secure. SMS data rates may apply.

Patient Signature: _____

Date: _____ Mobile Phone Number: _____

# Social Determinants of Health Assessment

Patient Name: _____ Date of Birth: _____

| | | |
|---|---|---|
| **Food** | | |
| Within the past 12 months, did you worry that your food would run out before you got to buy more? | ☐Yes | ☐No |
| Within the past 12 months, did the food you bought just not last, and you did not have the money to buy more? | ☐Yes | ☐No |
| **Housing / Utilities** | | |
| Do you have housing? | ☐Yes | ☐No |
| Within the past 12 months, have you stayed outside? | ☐Yes | ☐No |
| Within the past 12 months, have you stayed in a car? | ☐Yes | ☐No |
| Within the past 12 months, have you stayed in a tent? | ☐Yes | ☐No |
| Within the past 12 months, have you stayed in an overnight shelter? | ☐Yes | ☐No |
| Within the past 12 months, have you temporarily stayed in someone else's home? | ☐Yes | ☐No |
| Are you worried about losing your housing? | ☐Yes | ☐No |
| In the last 12 months, have you been unable to get utilities (heat, electricity) when it was really needed? | ☐Yes | ☐No |
| **Transportation** | | |
| Within the past 12 months, has a lack of transportation kept you from medical appointments? | ☐Yes | ☐No |
| Within the past 12 months, has a lack of transportation kept you from doing things needed for daily living? | ☐Yes | ☐No |
| **Education** | | |
| Do you want help with school (i.e. getting a high school diploma, GED, or equivalent)? | ☐Yes | ☐No |
| Do you want help with training (i.e. starting or completing job training)? | ☐Yes | ☐No |
| Do you speak a language other than English at home? | ☐Yes | ☐No |
| **Interpersonal Safety** | | |
| Do you feel physically or emotionally safe where you currently live? | ☐Yes | ☐No |
| Within the past 12 months, have you been humiliated or emotionally abused by anyone? | ☐Yes | ☐No |
| Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by anyone? | ☐Yes | ☐No |
| **Healthcare** | | |
| In the past month, did physical health keep you from doing your usual activities (work, school, or hobbies)? | ☐Yes | ☐No |
| In the past month, did mental health keep you from doing your usual activities (work, school, or hobbies)? | ☐Yes | ☐No |
| In the past 12 months, was there a time that you needed to see a doctor, but could not because it cost too much? | ☐Yes | ☐No |
| **Employment** | | |
| Do you have a job or any other source of income? | ☐Yes | ☐No |
| **Immediate Need** | | |
| Do you have food tonight? | ☐Yes | ☐No |
| Do you have a place to sleep tonight? | ☐Yes | ☐No |
| Are you afraid you will get hurt if you go home tonight? | ☐Yes | ☐No |
| Would you like help with any of the needs identified? | ☐Yes | ☐No |

**If positive SDOH findings are noted, please schedule the patient for an SDOH assessment visit with their provider.**

Patient Signature: _____ Date: _____

Physicians Signature: _____ Date: _____

# HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES

**Effective Date: March 24, 2017**

**Your Information. Your Rights. Our Responsibilities.**

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.**

## YOUR RIGHTS

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

| | |
|---|---|
| **Get an electronic or paper copy of your medical record** | • You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.<br>• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. |
| **Ask us to correct your medical record** | • You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.<br>• We may say "no" to your request, but we'll tell you why in writing within 60 days. |
| **Request confidential communications** | • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.<br>• We will say "yes" to all reasonable requests. |
| **Ask us to limit what we use or share** | • You can ask us not to use or share certain health information for treatment, payment, or our operations.<br>✧ We are not required to agree to your request, and we may say "no" if it would affect your care.<br>• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.<br>✧ We will say "yes" unless a law requires us to share that information. |

| | |
|---|---|
| **Get a list of those with whom we've shared information** | • You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.<br>• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. |
| **Get a copy of this privacy notice** | • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |
| **Choose someone to act for you** | • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.<br>• We will make sure the person has this authority and can act for you before we take any action. |

## YOUR CHOICES

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

| | |
|---|---|
| **In these cases, you have both the right and choice to tell us to:** | • Share information with your family, close friends, or others involved in your care.<br>• Share information in a disaster relief situation.<br>• Include your information in a hospital directory.<br>• Contact you for fundraising efforts.<br>• *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* |
| **In these cases we *never* share your information unless you give us written permission:** | • Marketing purposes<br>• Sale of your information<br>• Most sharing of psychotherapy notes |
| **In the case of fundraising:** | • We may contact you for fundraising efforts, but you can tell us not to contact you again. |

## OUR USES AND DISCLOSURES

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

| | | |
|---|---|---|
| **Treat you** | • We can use your health information and share it with other professionals who are treating you. | ***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.* |
| **Run our organization** | • We can use and share your health information to run our practice, improve your care, and contact you when necessary. | ***Example:*** *We use health information about you to manage your treatment and services.* |
| **Bill for your services** | • We can use and share your health information to bill and get payment from health plans or other entities. | ***Example:*** *We give information about you to your health insurance plan so it will pay for your services.* |

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

| | |
|---|---|
| **Help with public health and safety issues** | • We can share health information about you for certain situations such as:<br>✧ Preventing disease.<br>✧ Helping with product recalls.<br>✧ Reporting adverse reactions to medications.<br>✧ Reporting suspected abuse, neglect, or domestic violence.<br>✧ Preventing or reducing a serious threat to anyone's health or safety. |
| **Do research** | • We can use or share your information for health research. |
| **Comply with the law** | • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. |
| **Respond to organ and tissue donation requests** | • We can share health information about you with organ procurement organizations. |
| **Work with a medical examiner or funeral director** | • We can share health information with a coroner, medical examiner, or funeral director when an individual dies. |

*Our Uses and Disclosures (continued)*

| | |
|---|---|
| **Address workers' compensation, law enforcement, and other government requests** | • We can use or share health information about you:<br>✧ For workers' compensation claims.<br>✧ For law enforcement purposes or with a law enforcement official.<br>✧ With health oversight agencies for activities authorized by law.<br>✧ For special government functions such as military, national security, and presidential protective services. |
| **Respond to lawsuits and legal actions** | • We can share health information about you in response to a court or administrative order, or in response to a subpoena. |

## OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**Changes to the Terms of This Notice**
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

## COMPLAINTS

If you believe your privacy rights have been violated, you may submit a comment or complaint about our privacy practices by:

1) Mail to Corporate Privacy Officer, Access Health Care Physicians LLC., 14690 Spring Hill Drive, Suite 201, Spring Hill, Florida 34609;

2) Email to youmatter@aurosmgmt.com;

3) Phone (877) 379-4568;

4) Written communication to the facility following the process outlined in our Company's Patient Rights documentation; and/or

5) Written communication to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

**You will not be penalized for filing a complaint.**

## Florida Patient's Bill of Rights and Responsibilities
## Florida Statutes Chapter 381(026)

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

# FINANCIAL POLICY

The information listed below was designed to provide our patients with a detailed explanation of our financial policies. We realize this information may not always address your specific situation and encourage you to speak with a member of our billing department whenever you have any questions or concerns regarding your account.

## Registration

Information gathered provides us with contact information as well as ensures your claims will be filed to the correct insurance company.

Upon arrival for your appointment, you will be asked for basic information:

- Current patient information: name, address, telephone number, employer, date of birth, social security number, and emergency contact.
- Current Insurance Card.

Please arrive at least ten (10) minutes prior to your appointment time. Having information readily available will assist us in making the check-in process easier for you. Information obtained in the registration process is kept in your confidential medical record.

You will be asked to make co-payments at the time of service. For your convenience, we can also handle your payments on your account at the Registration Desk. We accept cash, check, debit cards and major credit cards (MasterCard, Visa, and Discover).

## Co-payments

Co-payments will be collected at the time of your visit. Please check with your insurance company for the requirements and provisions of your policy to determine the dollar amount of your co-payment prior to your appointment.

## NSF Checks

Any negotiable items returned because of Non-Sufficient Funds (NSF) will be sent a 15-day statutory notice letter via certified mail. Receipt of the letter provides the presenter of the NSF item seven (7) days to pay the face amount of the negotiable item, plus a service charge, in the following amounts:

Amount of Check $50.00 or Less..... Fee = $25.00 per Check

Amount of Check $50.01 - $300.00..... Fee = $30.00 per Check

Amount of Check $300.01 or More..... Fee = $40.00 per Check

Or an amount equal to 5% on the face Value of the Check, whichever is greater.

## Liabilities

It is the obligation of the responsible party to settle any outstanding liability charges. We cannot act as administrator to resolve financial arrangements. The balance for services rendered is considered due in full at the time of the services.

## Participation with Insurance Companies

We reserve the right to determine which insurance companies or programs we participate with on an annual basis.

## General Insurance Policy

As a convenience to you, our Insurance Staff will file a claim on your behalf provided we have your current insurance policy information available. However, it is impossible for our staff to determine your coverage and payment levels, since each insurance company offers many options as part of their health care coverage package.

Our staff cannot guarantee that your insurance carrier will pay all or even part of your claim. Your insurance policy is a contract between you and your insurance carrier. Ultimately, the patient is responsible for their charges. Patients should resolve disputed coverage issues directly with their insurer or employer. It is the patient's responsibility to know the details of their insurance contract and if whether your provider is a network provider for their particular plan.

When your insurance company processes your claim, they will provide you with an Explanation of Benefits (EOB). This EOB will explain what the insurance company has agreed to pay. Most insurance companies agree to pay only a percentage of the charges with the remaining balance being the responsibility of the patient. The EOB may use the term "Usual, Customary and Reasonable" (UCR). Insurance companies develop UCRs independently of one another. Therefore, because of policy deductibles, co-payments, non-covered services and UCRs, you may have a balance due after the insurance pays. No UCR adjustments will be honored unless the clinic has a signed contract in effect with that specific insurance carrier.

## Medicare Policy

Federal law requires all physicians to file claims to Medicare.

We accept Medicare assignment. This means we agree to accept Medicare's allowance on services provided to you. You will still be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare.

If you carry a supplemental plan to Medicare, please ensure we have your policy information so that a claim can be filed for you.

## Medicaid

All Medicaid patients must present a valid stamped card prior to being seen. If the patient wishes to be seen without their validated card, they will be required to make payment at time of service or asked to reschedule.

## General Credit Policies

All accounts are payable upon receipt of your first statement. Credit is extended as a courtesy, and arrangements will be based on demonstrated needs.

If you are not covered by a medical insurance plan, payment is expected at the time services are provided.

## Hardship

Patients who are having financial difficulties may qualify for a reduction in a repayment plan or a financial adjustment on their account. They will be required to complete a financial form and include the necessary information to process their application.

## Questions Regarding Your Account

If you have questions regarding your account or wish to make a payment using MasterCard, Visa, Discover or Debit Card, please contact our Billing Department during the hours of 8:00 am and 5:00 pm, Monday through Friday, at 352-593-4101.

*Thank you for your cooperation in helping us serve you with the highest quality, accessible and cost effective health care services.*