Welcome to the West Coast Musculoskeletal Institute. We would like to thank you for allowing us to care for your orthopedic condition. Please help us service your needs by answering the questions below regarding your situation.

Is your injury/pain related to your **Employment**?	☐ Yes	☐ No
Is your injury/pain related to an **Accident**?	☐ Yes	☐ No
Is your injury/pain related to a **Law Suit**?	☐ Yes	☐ No
Is there an **Attorney** related to this injury/pain?	☐ Yes	☐ No

If yes, please list the name, address and phone number:

_____

_____

_____

NOTE: *If you have answered yes to any of the above questions, please see the receptionist (or call the scheduling department if forms were downloaded from the website) before completing the remaining paperwork.*

We recognize that your time is valuable and we try very hard to stick to the schedule as to avoid any delay in patient care. Here are some office policies that will help you negotiate prescription refills and paperwork requests. Since these require the physician or PA to review your account, they will be performed at the end of the business day so that our patient in the office do not have to wait unnecessarily.

We require a 72-hour notice to refill prescriptions. Please don't wait until you take your last dose to call and request a refill. Additionally, the practice does not accept checks or American Express, but we do offer other credit and debit transactions.

Paperwork requests are done in the order they are received. We require at least 72 hours to review the medical records and complete the paperwork. If you would like us to fax your paperwork directly from our office, please make sure it signed by you, if needed, before you leave.

Again, let us welcome you to the practice and thank you for helping us stay on course. We welcome any suggestions you may have that will help us become more efficient.

Signature of Patient/Parent of Minor/Legal Representative Date of Birth Date

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____

DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Marital Status: _____ Occupation: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Today's Date: _____ Date of Injury: _____ Are you: ☐ Right-handed ☐ Left-handed

Preferred Pharmacy (with cross streets): _____

INSURANCE INFORMATION:

Policy Holder's Name: _____ Date of Birth: _____

Insurance Company: _____ Phone Number: _____

Insurance Claims Address: _____

Group / Policy #: _____ Subscriber ID: _____

ONLY IF PATIENT IS A MINOR – RESPONSIBLE PARTY INFORMATION – *Please fill in ALL blanks.*

First Name: _____ MI: _____ Last Name: _____

Sex: ☐ M ☐ F DOB: _____ Phone: _____

Street Address: _____

Minor Pre-Authorization for Medical Care

I request and authorize West Coast Musculoskeletal Institute and its personnel to deliver medical care to my child listed above.

Guardian Name (Print): _____ Guardian's Signature: _____

Relationship to Patient (Print): _____ Date: _____

HISTORY OF PRESENT ILLNESS:

Height: _____ Weight: _____ lbs. Age: _____ Problem with: ☐ Right Extremity ☐ Left Extremity

Why are you here today? _____

SYMPTOMS:

Location: _____
(Where is the pain? Does it travel to other areas?)

Quality: _____
(Is the pain dull, throbbing, sharp? If a bump, is it warm, tender, red?)

Severity: _____
(How severe on a scale of 1 to 10, with 10 being the most severe?)

Duration: _____
(How long have you had this pain/problem? When did it start?)

Time: _____
(Does the pain/problem occur at a specific time? Is it rare, intermittent, constant?)

Context: _____
(What were you doing at the onset of the pain/problem?)

Associated signs/symptoms: _____
(Do you have numbness? Abnormal sounds like cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain?)

Modifying factors: _____
(What makes the problem worse or better? Example: Activities)

PAST HISTORY OF PRESENT ILLNESS:

Have you ever experienced any injury or symptoms regarding this body part? ☐ Yes ☐ No

If so, please provide details: _____

_____

Please list any hobbies/sports you enjoy:

_____

Which of the above activities are you unable to perform due to your pain?

_____

Have you seen any other physicians regarding THIS condition prior to coming to our office? ☐ Yes ☐ No

Doctor	When	Tests	Results	Treatment

PAST MEDICAL HISTORY:

☐ AIDS or HIV	☐ Cancer	☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Anemia	☐ Chicken Pox	☐ Hemorrhoids	☐ Mumps	☐ Tuberculosis
☐ Arthritis	☐ COPD	☐ Hepatitis	☐ Pneumonia	☐ Ulcer
☐ Asthma	☐ Dementia	☐ High Blood Pressure	☐ Polio	☐ Venereal Disease
☐ Back Trouble	☐ Diabetes	☐ Infectious Mono	☐ Rheumatic Fever	☐ Whooping Cough
☐ Bladder Infections	☐ Diphtheria	☐ Kidney Disease	☐ Scarlet Fever	☐ Other (Please List)
☐ Bleeding Tendency	☐ Epilepsy/Seizures	☐ Low Blood Pressure	☐ Sleep Apnea	☐ _____
☐ Blood Transfusions	☐ Fibromyalgia	☐ Measles	☐ Smallpox	☐ _____
☐ Bronchitis	☐ Glaucoma	☐ Migraine Headache	☐ Stroke	☐ _____

Please list **all medications** you are taking (Include non-prescription and herbal supplements):

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

Are you allergic to any medications?

Medication	Reaction

Tape Allergy: ☐ Yes ☐ No

Latex Allergy: ☐ Yes ☐ No

Past Surgical/Hospitalization History:

Date	Surgery/Illness	Doctor	Hospital, City, State

Name: _____ DOB: _____

PATIENT SOCIAL HISTORY:

Marital Status	Use of Alcohol	Use of Tobacco	Living Situation
☐ Single	☐ Never	☐ Never	☐ With family
☐ Married	☐ Rarely	☐ Previously, but quit	☐ With friends
☐ Divorced	☐ Moderate	☐ Currently:	☐ Alone
☐ Widow	☐ Daily	_____ packs a day	☐ Other: _____

FAMILY MEDICAL HISTORY:

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

REVIEW OF SYSTEMS: Please indicate any personal history below:

Musculoskeletal

Joint pain	☐ No ☐ Yes
Joint stiffness or swelling	☐ No ☐ Yes
Weakness of muscles/joints	☐ No ☐ Yes
Muscle pain or cramps	☐ No ☐ Yes
Back pain	☐ No ☐ Yes
Cold extremities	☐ No ☐ Yes
Difficulty in walking	☐ No ☐ Yes

Constitutional Symptoms

Bad general health lately	☐ No ☐ Yes
Recent weight change	☐ No ☐ Yes
Fever	☐ No ☐ Yes
Fatigue	☐ No ☐ Yes
Headache	☐ No ☐ Yes

Ear/Nose/Mouth/Throat

Hearing loss or ringing	☐ No ☐ Yes
Earaches or drainage	☐ No ☐ Yes
Chronic sinus problems	☐ No ☐ Yes
Nose bleeds	☐ No ☐ Yes
Bleeding gums	☐ No ☐ Yes
Sore throat or voice change	☐ No ☐ Yes
Swollen glands in neck	☐ No ☐ Yes

Cardiovascular

Heart trouble	☐ No ☐ Yes
Chest pain or angina	☐ No ☐ Yes
Palpitations	☐ No ☐ Yes
Shortness of breath while walking	☐ No ☐ Yes
Swelling of feet, ankles or hands	☐ No ☐ Yes

Genitourinary

Frequent urination	☐ No ☐ Yes
Burning or painful urination	☐ No ☐ Yes
Blood in urine	☐ No ☐ Yes
Incontinence or dribbling	☐ No ☐ Yes
F-number of pregnancies	_____
F-number of deliveries	_____

Integumentary (skin, breast)

Rash or itching	☐ No ☐ Yes
Changes in skin color	☐ No ☐ Yes
Varicose veins	☐ No ☐ Yes
Breast pain	☐ No ☐ Yes
Breast lump	☐ No ☐ Yes

Neurological

Light headed or dizziness	☐ No ☐ Yes
Numbness/tingling sensations	☐ No ☐ Yes
Tremors	☐ No ☐ Yes
Paralysis	☐ No ☐ Yes

Hematologic/Lymphatic

Bleeding/bruising tendency	☐ No ☐ Yes
Anemia	☐ No ☐ Yes
Enlarged glands	☐ No ☐ Yes
Slow to heal after cuts	☐ No ☐ Yes

Endocrine

Excessive thirst or urination	☐ No ☐ Yes
Heat or cold intolerance	☐ No ☐ Yes
Dry Skin	☐ No ☐ Yes

Psychiatric

Memory loss or confusion	☐ No ☐ Yes
Nervousness/Anxiety	☐ No ☐ Yes
Depression	☐ No ☐ Yes
Insomnia	☐ No ☐ Yes

Gastrointestinal

Loss of appetite	☐ No ☐ Yes
Nausea or vomiting	☐ No ☐ Yes
Frequent diarrhea	☐ No ☐ Yes
Constipation	☐ No ☐ Yes
Rectal bleeding/blood in stool	☐ No ☐ Yes
Abdominal pain	☐ No ☐ Yes

Respiratory

Chronic or frequent coughs	☐ No ☐ Yes
Spitting up blood	☐ No ☐ Yes
Shortness of breath	☐ No ☐ Yes
Wheezing	☐ No ☐ Yes

Eyes

Eye disease or injury	☐ No ☐ Yes
Wear glasses/contacts	☐ No ☐ Yes
Blurred or double vision	☐ No ☐ Yes

Allergic/Immunologic

List food/environmental allergies:

_____
_____
_____
_____

Patients 65 or older: **Spiritual/Cultural Preference?** _____

Healthcare Proxy? ☐ **Yes** ☐ **No** **Name:** _____

Power of Attorney for Healthcare? ☐ **Yes** ☐ **No** **Name:** _____

Copy of POA? ☐ **Yes** ☐ **No** **Do Not Resuscitate?** ☐ **Yes** ☐ **No**

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____
Patient Printed Name DOB

_____ _____
Signature of Patient/Parent of Minor/Legal Representative Date

Financial Policy

Welcome to our Office

At West Coast Musculoskeletal Institute and Access Health Care Physicians, we are committed to providing you with the highest level of service and quality care, and we regard your understanding of our financial policies and those of your insurance as an essential element of your care and treatment. If you have any question regarding your account, charges, insurance, or payments, please ask to speak with one of our billing representatives.

Payment Policy

Payment in full is expected at the time service is rendered. For your convenience, we accept cash, credit or debit cards at your appointment. We do not accept checks.

Insurance Plans

If you are insured, we will bill those insurance plans with which we have an agreement. **It is ultimately your responsibility to be aware of the details of your insurance plan.** If you are not familiar with the allowable benefits of your insurance, we recommend that you contact your insurance company prior to your visit so you understand what services are or are not covered. **Please note that if your insurance requires a co-pay, co-insurance, or deductible, it will be collected at the time of your visit.** In the event that your insurance determines that a service is "non-covered," we will bill you and payment will be due upon receipt of that statement.

Self-Pay Accounts

If you do not have a valid insurance plan to cover the cost of services, you will be required to make full payment at the time services are rendered, unless other arrangements have been made in advance with our office.

Outstanding Balances

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify the billing department immediately and we will gladly work out a payment plan with you. Please note that in the event of non-payment, the account may be turned over to an outside collection agency and the expenses will be added to your account balance. Any payment made by check for an outstanding balance that is returned for insufficient funds or due to a "stop payment" will result in a $25.00 fee.

Referrals

If your insurance plan requires a referral, we prefer that the referral is provided before making an appointment with our office. We do our best to obtain referrals from your primary care doctor, but in the event that we do not receive it, your appointment, if one is made, will need to be rescheduled until the necessary paperwork is obtained.

I understand that WCMI agrees to bill my insurance as a courtesy, and that I must submit information as needed to ensure payment for services. I further understand that I am ultimately responsible for all payment of services.

AUTHORIZATION AND ASSIGNMENT

I hereby authorize West Coast Musculoskeletal Institute and Access Health Care Physicians 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 West Coast Musculoskeletal Institute (or named physicians or affiliates) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to crossover 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.

Name of Patient (Please Print)	Date of Birth
Signature of Patient or Responsible Party	Date

PATIENT PRIVACY QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may 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: _____

2. 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 #: _____

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

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

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.

CONSENT TO TREAT
and
RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, the undersigned, voluntarily give consent to my West Coast Musculoskeletal Institute and Access Health Care Physicians medical professional 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. Also, I have received/reviewed a copy of the West Coast Musculoskeletal Institute/Access Health Care Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ _____

Signature of Patient/Legal Representative Date

_____ _____

Please *print* Patient Name Date of Birth

_____ _____

Legal Representative Relationship to Patient

OFFICE USE ONLY

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

Date	Initials	Reason

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

WEST COAST MUSCULOSKELETAL INSTITUTE

INSURANCE CARRIER: _____ POLICY NUMBER: _____ DATE OF LOSS: _____

For and in consideration of WEST COAST MUSCULOSKELETAL INSTITUTE agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to WEST COAST MUSCULOSKELETAL INSTITUTE for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize WEST COAST MUSCULOSKELETAL INSTITUTE to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to WEST COAST MUSCULOSKELETAL INSTITUTE against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by WEST COAST MUSCULOSKELETAL INSTITUTE as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with WEST COAST MUSCULOSKELETAL INSTITUTE and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to WEST COAST MUSCULOSKELETAL INSTITUTE including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for WEST COAST MUSCULOSKELETAL INSTITUTE and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, WEST COAST MUSCULOSKELETAL INSTITUTE will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to WEST COAST MUSCULOSKELETAL INSTITUTE at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to WEST COAST MUSCULOSKELETAL INSTITUTE at the address on the bill. INSERT NAME OF PROVIDER's medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by INSERT NAME OF PROVIDER. I further instruct my insurance company to make payment for charges submitted by WEST COAST MUSCULOSKELETAL INSTITUTE in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give WEST COAST MUSCULOSKELETAL INSTITUTE limited power of attorney to endorse and sign my name on any draft for payment to either WEST COAST MUSCULOSKELETAL INSTITUTE or myself if said draft represents payment for charges related to services rendered by INSERT NAME OF PROVIDER.

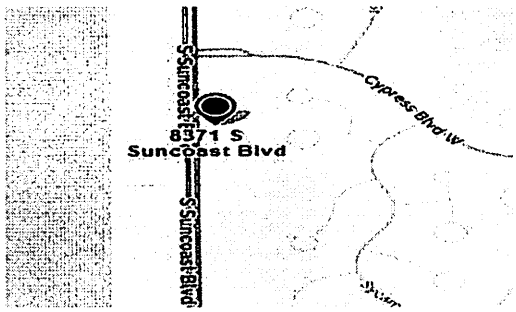
I further direct my insurance carrier or responsible other entity to provide information to WEST COAST MUSCULOSKELETAL INSTITUTE which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of INSERT NAME OF PROVIDER. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient Name	Date of Birth	Patient Signature	Date
Parent/Guardian Name	Patient/Guardian Signature	Date	

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

Office Locations

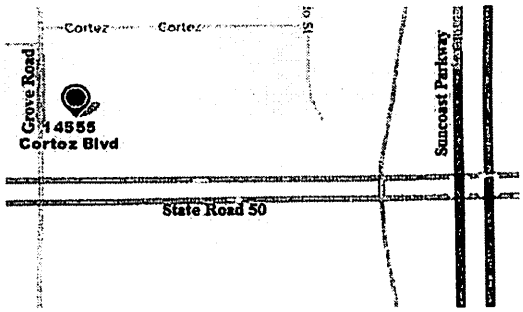
Citrus County



8371 South Suncoast Blvd.
Homosassa, FL 34446

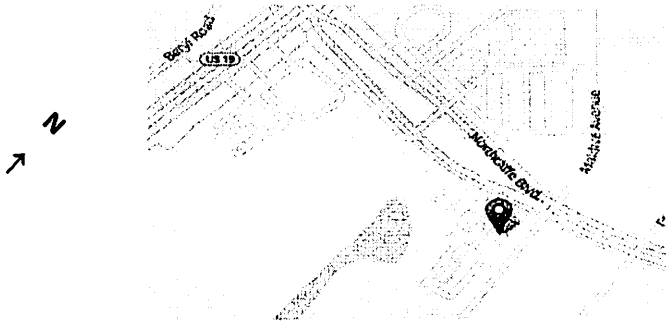
South of Cypress Blvd at Sugar Mills Woods Entrance

Hernando County



14555 Cortez Blvd.
Brooksville, FL 34613

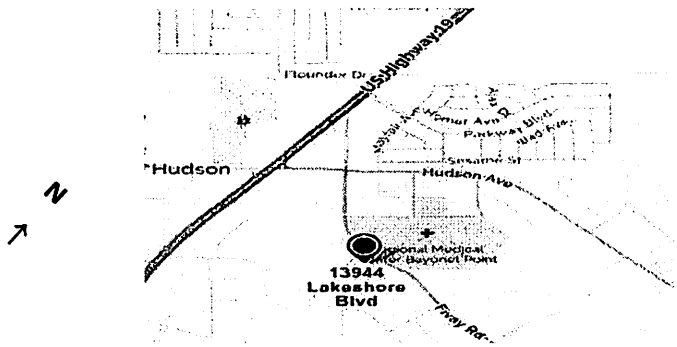
On the corner of Cortez Blvd and Grove Rd.



8468 Northcliffe Blvd.
Spring Hill, FL 34606

3rd Right after turning off Commercial Way

Pasco County



13944 Lakeshore Blvd, Suite C
Hudson, FL 34667

Take Hudson Avenue to Fivay Road.
The office is across the street from Bayonet Point Hospital.

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. • 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. • 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. • 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. ✧ We are not required to agree to your request, and we may say "no" if it would affect your care. • 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. ✧ We will say "yes" unless a law requires us to share that information.

Your Rights (continued)

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. • 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. • 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. • Share information in a disaster relief situation. • Include your information in a hospital directory. • Contact you for fundraising efforts. • *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 • Sale of your information • 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: ✧ Preventing disease. ✧ Helping with product recalls. ✧ Reporting adverse reactions to medications. ✧ Reporting suspected abuse, neglect, or domestic violence. ✧ 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: ✧ For workers' compensation claims. ✧ For law enforcement purposes or with a law enforcement official. ✧ With health oversight agencies for activities authorized by law. ✧ 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.