Chapel Podiatry and Associates, P.A.
Charles P. Chapel, D. P. M. FACFAOM

4191 Mariner Blvd. • Spring Hill, Florida 34609 • Phone (352) 684-1444 • Fax (352) 688-1282

PATIENT INFORMATION SHEET

PLEASE PRINT THE FOLLOWING INFORMATION CLEARLY

FULL NAME______________________ DATE______________

ADDRESS______________________ CITY__________ STATE______ ZIP __________

HOME PHONE (___)______________ BUSINESS PHONE (___)______________

FULL DATE OF BIRTH______________ AGE _______ RACE______________ SEX ☐ M ☐ F

PREFERRED LANGUAGE______________ETHNICITY______________

MARITAL STATUS (☐ S ☐ M ☐ D ☐ W ☐ SEP) SOCIAL SECURITY NO.______________

OCCUPATION (POSITION) ______________ DRIVER'S LICENSE NO. ______________

EMPLOYER______________________ TELEPHONE NO. ______________

EMPLOYER'S ADDRESS ______________________________

EMERGENCY CONTACT______________ RELATIONSHIP__________ PHONE NO. (______) ______

This portion of the form is for the Insurance Department and it is necessary that you complete this fully and accurately. This information is needed so we can process all claims quickly and accurately. **If you have coverage with more than one insurance carrier, please supply the information of both insurance carriers.**

IS YOUR VISIT TODAY A RESULT OF AN INJURY? ☐YES ☐NO

DATE OF INJURY ______________ ☐WORKERS COMP ☐AUTO INJURY ☐OTHER

A. WORKERS COMP CARRIER ______________________ CLAIM NO.______________

ADDRESS ______________________ POLICY NO. ______________

TELEPHONE NO. ______________ ADJUSTER ______________

B. AUTO INSURANCE CARRIER ______________________ CLAIM NO.______________

ADDRESS ______________________ POLICY NO.______________

TELEPHONE NO. ______________ ADJUSTER______________

C. PRIMARY INSURANCE ______________________ INSURANCE ID NO. ______________

SUBSCRIBER/INSURED NAME ______________ RELATIONSHIP ______________

D. SECONDARY INSURANCE ______________________ INSURANCE ID NO.______________

SUBSCRIBER/INSURED NAME ______________ RELATIONSHIP ______________

SUBSCRIBER SOCIAL SECURITY ______________ GROUP NO. __________ DOB ________

E. NO INSURANCE/SELF PAY - RESPONSIBLE PERSON ______________________

ADDRESS______________________ HOME PHONE (____) ______________

NOTE TO DIVORCED PARENTS: PARENT OR GUARDIAN WHO PRESENTS CHILD FOR TREATMENT WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

1 INSURANCE AGENT - DIRECT PAYMENT ASSIGNMENT & INFORMATION RELEASE

❖ I/We hereby name the Doctor(s) and/or Medical Practice given below, hereafter referred to as DOCTOR, as my/our assignee. I/We instruct my/our health care benefits plan provider (i.e.; insurance company, HMO, employer, union or government-run health plan), hereafter referred to as the PLAN, to pay the DOCTOR directly for all professional and medical services provided. Payment should be made by means of electronic funds transfer(s) (EFT) or check(s) made payable and mailed directly to the DOCTOR:

Charles P. Chapel, DPM
Chapel Podiatry Associates, P.A.
4191 Mariner Blvd.
Spring Hill, FL 34609

or im my current policy prohibits direct payment to doctors, then I/we hereby instruct and direct the PLAN to make out all checks payable to me/us and mail the payments to me/us in care of the DOCTOR as given directly above. **THIS IS A DIRECT ASSIGNMENT OF MY/OUR RIGHTS AND BENEFITS UNDER THIS POLICY.**

❖ I/We grant the DOCTOR a limited Power of Attorney to sign my/our name(s) in order to deposit and negotiate any payment received from the PLAN and apply the funds received toward my/our outstanding balance. These payments will not exceed my/our indebtedness to the above designated DOCTOR. I/WE agree to promptly pay any remaining balance due on all professional and medical service charges over and above the payment(s) from the PLAN. This assignment shall remain in effect until cancelled in writing by the DOCTOR.

❖ A photocopy of this agreement, or an electronic facsimile thereof shall be considered as effective as the original.

❖ I/We understand that the personal information about me/us will be needed by the DOCTOR and the PLAN to determine and communicate what services or benefits are covered by the PLAN, and to submit or process a claim for payment on services rendered and for the DOCTOR to collect all fees owed for those services. Therefore, the purpose of obtaining payment for services rendered, I/we give to the DOCTOR, the PLAN, their agents, and/or any other holder of information about me/us, authorization to release and/or exchange medical, billing and collection information.

x____ ____/____/____
Signature of Policyholder **Date**

x____ ____/____/____
Signature of Patient (if other than Policyholder) **Date**

2 FINANCIAL AGREEMENT - AUTHORIZATION FOR TREATMENT & INFORMATION RELEASE

The Responsible Parties whose signatures appear below agree as follows:

❖ The Doctor(s), Associate Doctor(s), and staff of the Medical Practice named Dr. Chapel & Associate Doctor of Chapel Podiatry & Associates hereafter referred to as DOCTOR, are authorized to medically treat the patient named on this form.

❖ DOCTOR is authorized to collect, use and exchange *individually identifiable health information* (IIHI) consisting of the patient's past, present, future medical information and other personal information to treat the patient, communicate with the patient's other health care providers, seek payment and carry out necessary business functions. A patient may request to see IIHI pertaining to themselves, request copies, ask for corrections or amendments to the IIHI and request in writing restrictions on its' future use. DOCTOR is not obliged to honor all such requests.

❖ The Responsible Parties agree to pay for all fees and charges for supplies, services and treatment that are incurred by the patient per the terms of this agreement and authorize the DOCTOR or agents thereof to make credit investigations including employment verifications. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until the DOCTOR receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of majority.

❖ Not all services and/or fees are covered or paid by the Responsible Parties' health PLAN. Therefore, the Responsible Parties agree to pay for all deductibles co-payments, non-covered services, and any portion of covered services not paid in full by the PLAN and understand that such payments are due at the time of service or immediately upon presentation of the bill.

❖ All proceeds from the PLAN are assigned to DOCTOR where applicable. Payments to DOCTOR may not be withheld, delayed or excused for any reason; including the outcome of medical treatment, liens lawsuits, any coverage determination by the PLAN on their processing of claims, the financial insolvency of the PLAN and/or their contracted intermediaries & medical groups. Responsible Parties are strongly advised to monitor and communicate with the PLAN to ensure that DOCTOR's claims are paid promptly, since they, as Responsible Parties, are ultimately financially responsible for all amounts owed to DOCTOR.

❖ If any account balance is not paid in full within 60 days, the entire account of balance will be subject to a MONTHLY FINANCE CHARGE and a MONTHLY COST OF REBILLING / ACCOUNT MAINTENANCE CHARGE at the rates listed previously in Section 3 of the reverse side of this form. These rates and charges are subject to change upon written notice 30 days in advance of changes.

❖ If any account balance should remain unpaid for 60 days and DOCTOR refers the account to a collection agency or attorney for collection, Responsible Parties agree to pay the costs of collection and that such fees and costs may be added to the account balance. In a legal action between the parties any agreement to collect any unpaid balance due for medical services rendered, the prevailing party shall be entitled to recover reasonable attorney's fees and costs.

❖ The Responsible Parties acknowledge receipt of DOCTOR's Office Policy that includes the terms of this Financial Agreement, Authorization for Treatment & Information Release. This form together with DOCTOR's Office Policy contain the entire and only agreements between the parties. There are no other agreements, promises, representations or warranties, expressed or implied. The provisions of these agreements shall not be changed or modified except for an instrument in writing signed by the parties hereto.

Agreed to and accepted by the Responsible Parties:

x____ ____/____/____
Signature of Policyholder **Date**

x____ ____/____/____
Signature of Patient (if other than Policyholder) **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to either me or on my behalf to Chapel Podiatry & Associates, P.A. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

x____ ____/____/____
Beneficiary Signature Date

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Please print the following information clearly

FULL NAME______________________________ DATE ______________

AGE______________ HEIGHT______________ WEIGHT______________ SHOE SIZE ______________

WHO REFERRED YOU TO OUR OFFICE ______________________EMAIL______________________

PLEASE LIST YOUR MEDICAL/FAMILY DOCTOR'S NAME ______________________________

ADDRESS______________________PHONE______________________ DATE OF LAST VISIT ______________

ARE YOU CURRENTLY, OR HAVE YOU BEEN UNDER ANY OTHER DOCTOR'S CARE FOR ANY REASON IN THE PAST 2 YEARS? ☐ YES ☐ NO IF YES, EXPLAIN:______________________________

GENERAL HEALTH (please check all that apply)

☐ ARTHRITIS (☐ RHEUMATOID ARTHRITIS ☐ OSTEOARTHRITIS)
☐ BLEEDING DISORDER______________________
☐ PACEMAKER
☐ EPILEPSY
☐ CANCER - TYPE ______________________
☐ COPD
☐ ANEMIA
☐ PERIPHERAL VASCULAR DISEASE
☐ KIDNEY DISEASE
☐ EMPHYSEMA
☐ CVA
☐ GLAUCOMA
☐ MALIGNANT HYPERTHERMIA
☐ ULCERATIVE COLITIS ______________________
☐ AIDS / HIV
☐ DEEP VEIN THROMBOPHLEBITIS
☐ METHEMEMOGLOBINEMIA
☐ THYROID DISEASE
☐ GOUT
☐ OSTEOPOROSIS
☐ TUBERCULOSIS
☐ ASTHMA
☐ REFLEX SYMPATIC DYSTROPHY
☐ HIGH BLOOD PRESSURE
☐ SCARLET OR RHEUMATIC FEVER
☐ COMPLEX REGIONAL PAIN SYNDROME
☐ VENEREAL DISEASE
☐ MYOCARDIAL INFARCTION
☐ NERVOUS PROBLEMS ______________________
☐ HEPATITIS
☐ STROKE
☐ LIVER DISEASE
☐ STENTS
☐ MITRAL STENOSIS
☐ CONGESTIVE HEART FAILURE
☐ SYSTEMIC LUPIS ERYTHEMATOSIS
☐ DIABETES (☐ INSULIN ☐ NON-INSULIN)
☐ OTHER MEDICAL CONDITIONS ______________________________

MEDICATIONS (WITH DOSAGES) - Are you presently taking any prescribed medications, over the counter medications or vitamins (please list)

______________________ ______________________
______________________ ______________________
______________________ ______________________

PHARMACY NAME______________________ PHONE NUMBER ______________________

ALLERGIES - Are you allergic to any of the following (please check)

☐ PENICILLIN ☐ IODINE ☐ SULFA ☐ ADHESIVE TAPE ☐ ASPIRIN
☐ CODEINE ☐ SHELLFISH ☐ LOCAL ANESTHESIA ☐ OTHER ______________

SURGERIES - Please list any surgeries you have had and list complications (Anesthesia, clotting, scar formation) ______________

____

HOSPITALIZATIONS - Other than surgeries listed ______________________________

____

FAMILY HISTORY - If any member of your immediate family has any of the following (please check)

☐ ARTHRITIS ☐ ASTHMA ☐ PERIPHERAL VASCULAR DISEASE
☐ DIABETES ☐ CANCER ☐ GOUT
☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ SICKLE CELL ANEMIA
☐ REACTION TO ANESTHESIA ☐ OTHER______________________________

SOCIAL HISTORY - HOBBIES / INTERESTS / ATHLETIC ACTIVITIES - Type and frequency (please list)

____

ALCOHOL USE? ☐ NO ☐ YES

DO YOU SMOKE? ☐ NO ☐ YES YEARS SMOKING______________________

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED _____ # CHILDREN

CURRENT WORK STATUS ______________ RETIRED ☐ YES ☐ NO

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee and hip complaints. Include signs, symptoms, durations, location, severity, onset) ______________________________

____

____

____

____

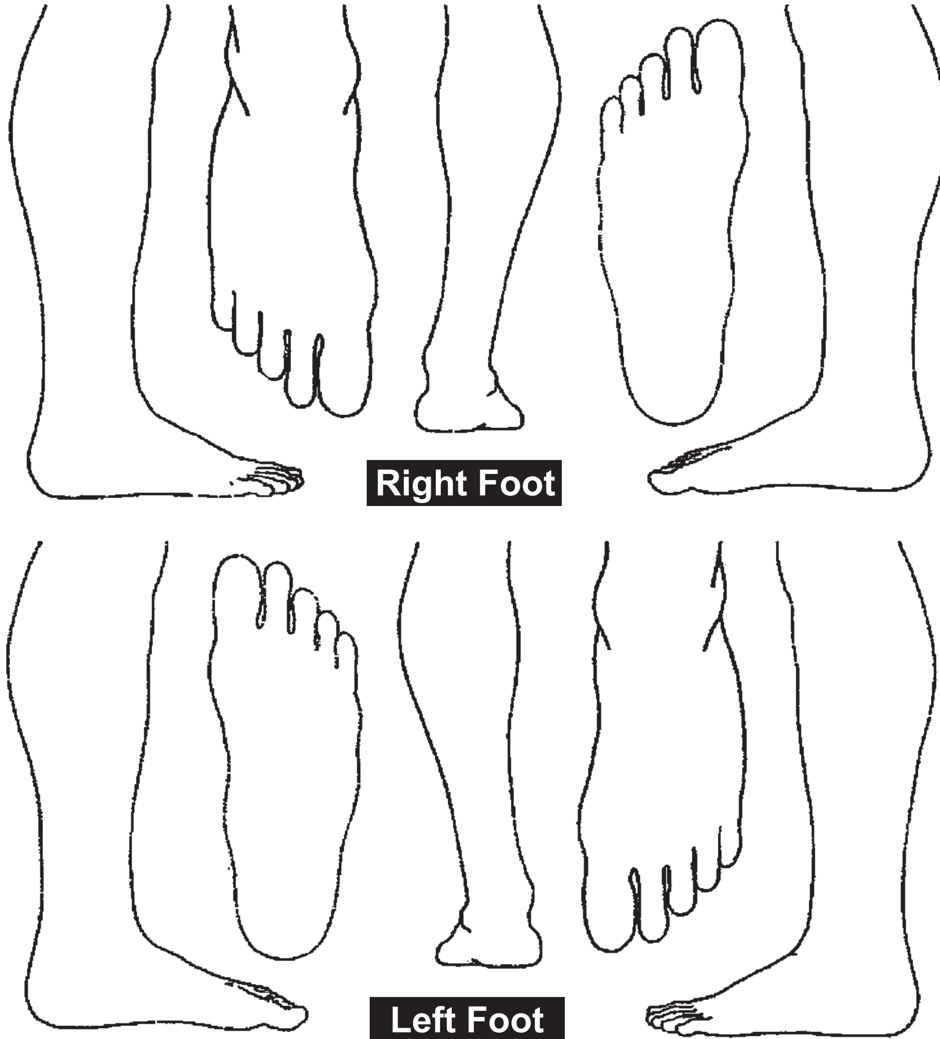
Have you been to a podiatrist before? ☐ Yes ☐ No

If yes, Name______________________ Last Visit ______________________

Please indicate the foot problems you now have or have had in the past:

☐ Ankle Pain
☐ Athlete's Foot
☐ Bunions
☐ Corns and Calluses
☐ Cramps in Feet or Legs
☐ Flat Feet
☐ Numb or Tingling in Feet/Legs
☐ Heel Pain
☐ Ingrown Toenails
☐ Plantar Warts
☐ Swelling in Ankles or Feet
☐ Tired Feet
☐ Varicose Veins
☐ Other ______________________

On the diagram below please mark the place(s) where you are experiencing pain in your feet:



CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

PATIENT'S SIGNATURE______________________ DATE ______________________

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Medical History and Patient Information

Patient's Name____ Date ______________

REVIEW OF SYSTEMS (ROS)
Please check each item that applies to you.

Allergic / Immunologic
- ☐ Arthritic flare-up
- ☐ Asthma attack recently
- ☐ Environmental allergies
- ☐ Eyes watering
- ☐ Hay fever
- ☐ Sensitivity to dust
- ☐ Weak immune system

Cardiovascular
- ☐ Ankle swelling
- ☐ Arm pain
- ☐ Blocked arteries
- ☐ Calf cramping
- ☐ Change in color of extremity
- ☐ Leg edema
- ☐ Cold feet
- ☐ Elevated BP
- ☐ Heart palpitations
- ☐ High cholesterol
- ☐ Leg pain at rest
- ☐ Murmur ______________
- ☐ Pain in left shoulder
- ☐ Varicosities
- ☐ Dizziness with change of position
- ☐ Change in temperature of extremity

Constitutional, General
- ☐ Appetite decrease
- ☐ Appetite increase
- ☐ Chills
- ☐ Dizziness
- ☐ Faintness
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise (General discomfort)
- ☐ Nausea and vomiting
- ☐ Night sweats
- ☐ Tiredness
- ☐ Weight gain
- ☐ Weight loss, unintentional
- ☐ Weight loss, intentional

Eyes, Ears, Nose, Mouth, Throat
- ☐ Bloody nasal discharge
- ☐ Dental problems
- ☐ Ear problems
- ☐ Headaches
- ☐ Sinus congestion
- ☐ Sore throat
- ☐ Abrupt visual loss
- ☐ Eye or vision problems
- ☐ Motion sickness
- ☐ Ringing in ears
- ☐ Glasses
- ☐ Neck pain, swelling, nodes

Endocrine
- ☐ Bone loss
- ☐ Cold intolerance
- ☐ Cuts take longer to heal
- ☐ Dry hair
- ☐ Dry skin
- ☐ Extreme thirst
- ☐ Heat intolerance
- ☐ Polyuria
- ☐ Weight change
- ☐ Hyperglycemia (High Glucose levels)
- ☐ Hypoglycemia (Low Glucose Levels)

Gastrointestinal
- ☐ Abdomen Pain
- ☐ Abdominal cramps
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diverticulosis
- ☐ Esophageal ulcer
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Pain after eating fatty foods
- ☐ Ulcer duodenal
- ☐ Yellowing skin
- ☐ Paralysis of stomach muscles
- ☐ Fecal incontinence

(Over ⟶)

Genitourinary

- ☐ Bladder infections
- ☐ Blood in urine
- ☐ Burning with urination
- ☐ Current need for kidney dialysis
- ☐ Urinary frequent at night
- ☐ Urinary incontinence
- ☐ Impotence
- ☐ Discharge
- ☐ Sexual Dysfunction
- ☐ Currently pregnant or trying to get pregnant? ☐ Yes ☐ No
- ☐ Do you take oral contraceptives? ☐ Yes ☐ No

Hematologic, Lymphatic

- ☐ Bleeding problems
- ☐ Bleeding tendency
- ☐ Bruise easily
- ☐ Frequent nose bleeds
- ☐ Increased time to stop bleeding
- ☐ Recent sickle cell crisis
- ☐ Leg swelling
- ☐ Swollen groin lymph nodes
- ☐ Fluid retention
- ☐ Swollen nodes under arms

Integumentary

- ☐ Burning of skin
- ☐ Dermatitis
- ☐ Discoloration
- ☐ Dry, scaly skin
- ☐ Excessive scar tissue
- ☐ Non-healing wound
- ☐ Pruritus (Itching)
- ☐ Rash, petechiae
- ☐ Skin cancer
- ☐ History of foot/leg ulcerations (when, where) ____

Musculoskeletal

- ☐ Arthralgia (Pain in joints)
- ☐ Back pain
- ☐ Episodic weakness
- ☐ Hip pain
- ☐ Muscle pain
- ☐ Muscle tenderness
- ☐ Muscle weakness
- ☐ Stiffness in AM
- ☐ Joint swelling

Neurological

- ☐ Change in memory
- ☐ Change in sensation
- ☐ Confusion
- ☐ Forgetfulness
- ☐ Hyperesthesia (Sensitivity to touch)
- ☐ Hypersensitivity
- ☐ Nervous problems
- ☐ Neurological symptoms or problems
- ☐ Numbness
- ☐ Trouble with balance
- ☐ Uncontrolled movements
- ☐ Paralysis
- ☐ Tremors

Psychiatric

- ☐ Agitation
- ☐ Anxious feelings
- ☐ Depression
- ☐ Libido decrease
- ☐ Panic attacks
- ☐ Suicidal thoughts
- ☐ Psychiatric or emotional difficulties
- ☐ Irritability

Respiratory

- ☐ Breathing difficulties, respiratory symptoms
- ☐ Chest pain with inspiration
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Difficulty in breathing
- ☐ Coughing up excess sputum
- ☐ Wheezing
- ☐ Need to be upright to breath (unable to lay down)

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

I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

______________________	__________	______________________	__________
Patient Signature	Date	Reviewed By	Date

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I ___________________________ request that the office of Chapel Podiatry & Associates will be able to release pertinent medical information to the following family/friends.

1.______________________________
2.______________________________
3.______________________________
4.______________________________
5.______________________________
6.______________________________

____________________________________ ________________
Patients signature Date

____________________________________ ________________
Witness signature Date

Our office will provide you with a 4-6 digit number. The names listed above will be asked this number when calling the office. Please make sure that they have this number available or the information that they are requesting will not be given. Please keep in mind that this is for your protection only.
Thank you for your understanding.

____
Your personal protection number.

11/07

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: ______________________________
(please print)

Date of Birth: ____________________

I request that all communications to me (by telephone, mail or otherwise) by ____________________ [insert name of Practice] and/or its staff be handles in the following manner:

- For written communications: Address to: ____________________
  ____
  ____
  ____
- For oral communications: Call: ____________________
  (telephone number)
  May we leave a message?
  Yes ☐ No ☐

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

____
____
____

____
Patient Signature

____
Date

For Practice Use Only

Practice: ☐ Accepts ☐ Denies

Privacy Officer Signature: ____________________

Date: ____________________

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FINANCIAL POLICY

This Financial Policy/Agreement was created and put into effect to assist our practice to keep medical costs down while still providing quality care to our patients. In order to do this we have set-up a few guidelines that must be enforced. Please be sure to read each of these guidelines carefully. Our staff will be happy to answer any questions you may have.

Due to the many increases in the cost of providing quality care to our patients, we have chosen to become less lenient in our payment arrangements. These policies have been put into effect in an effort to keep your costs down by eliminating those patients accounts that choose to disregard payment for services rendered. The number has become so considerable that many practices are being forced to do the same. We apologize for any offence that may be taken by these policies.

All accepted insurances are filed as a courtesy. Our billing department will submit your claim to your primary insurance carrier. It is up to you to provide us with all the necessary information to submit your claim **correctly. Please acknowledge that all services rendered by this practice is ultimately the responsibility of the patient, regardless of your insurance status or whether or not we participate in your plan.** You may be asked to sign a "waiver" for any services performed that may not be covered by your insurance company. This waiver indicates your financial acceptance to have a service performed that may or may not be a "covered service" by your insurance carrier.

Secondary claims are submitted for you ONLY if your primary insurance carrier is Medicare. If your primary carrier is not Medicare, you will be billed for any remaining balance and be held responsible for payment, regardless of your coverage with a secondary payor.

Should you be covered by another HMO, you must pay for your visit, in full, at the time the service is rendered. Any possible payment by your HMO will be negotiated between you and your insurance carrier. A proper receipt can be sent to you, if needed, to assist you in submitting this claim.

If you are responsible for a co-payment, this must be paid prior to seeing the doctor. Any previous outstanding balance must be paid prior to seeing the doctor. Our billing company sends out monthly statements, for your convenience.

Should you not show for a scheduled appointment, you will be billed a $25.00 fee. This can be avoided by canceling a scheduled appointment within 24 hours of that appointment. Our practice will not re-schedule an appointment for you unless this "no show" fee is paid.

Any outstanding patient balance not paid in a timely manner can and will be forwarded to our collection agency. All fees incurred for this action will be your responsibility. Once you are sent to collections, you will be considered discharged from our practice and it will become your responsibility to locate another physician. It is your responsibility to keep our practice updated of any change of insurance or change of address.

My signature below indicates I have read, understand and agree to abide to the conditions set forth in this financial policy.

____
Patient's printed name

______________________________ ____________
Patient's Signature Date

______________________________ ____________
Employee/Witness Date

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ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

______________________________ __________________
Patient Name (please print) Date

____
Patient, Guardian or Patient's legal representative

____
Signature

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NOTICE OF PRIVACY PRACTICES

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

Effective April 14, 2003
The privacy of your medical information is important to us. You may be aware that U.S. government regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Use and disclosure of protected information.
Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. For example, if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent Florida laws, such as restriction on disclosure of information concerning HIV/AIDS).

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. For example, under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered.

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. For example, our accountants may see your name, dates of treatment and procedure codes during audits of our books or we may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer. We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. **required by law;**
2. **required for public health purposes;**
3. **required by law to report child abuse;**
4. **where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct**
5. **required by law in judicial or administrative proceedings;**
6. **required for law enforcement purposes by a law enforcement official;**
7. **required by a coroner or medical examiner;**
8. **permitted by law to a funeral director;**
9. **permitted by law for organ donation purposes;**
10. **permitted by law to avert a serious threat to health or safety;**
11. **permitted by law and required by military authorities if you are a member of the U.S. armed forces**

Florida law provides additional protection for information regarding HIV / AIDS. We will continue to follow Florida State law with respect to such information.
We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner.
Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have.
You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.
You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR § 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law or for public health purposes after being de-identified or limited to remove personally identifiable information] or disclosures made before April 14, 2003.

You have the right to obtain a paper copy of this notice from our office.

Obligations that we have.
We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.
We are required to abide by the terms of this notice as long as it is currently in effect.
We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to our privacy officer.

The Office Supervisor, is our privacy officer. You can contact the Office Supervisor at 352-684-1444 if you desire further information, or have any questions or concerns.
No retaliatory action will be taken against you for any complaint you may make.