Patient Information

Date: _____________ Name: ___________________________________ Sex:__________
Date of Birth:_____________ Home# _________________ Cell#_____________________
Street Address: _______________________________ City: ____________Zip:__________
Social Security # ____________________Primary Language:_______________________
Ethnicity: Hispanic or Latino, Yes ___ No ___ Race: ______________________________
●**Parent/Guardian Email Address**: ____

Father's or Guardian's Name: ____
Relationship if not father: ____________________ Date of Birth: ___________________
Street Address: ___________________________ City: ________________ Zip: ________
Social Security# __________________________ Employer: _______________________
Phone# __________________________________ Work # _________________________

*Mother's or Guardian's Name:*____
Relationship if not mother:____________________Date of Birth: ___________________
Street Address:___________________________ City: ________________Zip:__________
Social Security# __________________________ Employer: _______________________
Phone# __________________________________ Work # _________________________

Primary Insurance: ___________________________ Policy ID:_____________________
Policy Holder's Name: __________________________ DOB: _______________________

Secondary Insurance: _________________________ Policy ID:_____________________
Policy Holder's Name: __________________________ DOB: _______________________

Emergency contact not living with you: _______________________________________
Relationship: ___________________________ Phone#: __________________________

Pharmacy Name: ________________________ Location: ________________________

●Will visits require special need services, such as services for the hearing impaired, during office visits? ________If yes, please explain:____

●**Person responsible for patient account:** ___________________________________

Parent/Guardian Signature: ____

Important Information Regarding Your Account

Statement of Financial Responsibility

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.

Notice of "Non-Covered" Services

I am aware that some services preformed by Plant City Pediatrics may be 'non-covered' by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

Waiver of "Usual, Customary and Reasonable" Clauses

(For patient is "UCR" coverage) I acknowledge that the fees charged by Plant City Pediatrics for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered 'usual, customary and reasonable', due to specialized services and staff. However, I agree to pay Plant City Pediatrics fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

Bill to/Payment Instructions

______ Commercial Insurance - Medicaid
(Initials)
I hereby authorize and request Plant City Pediatrics to bill my insurance company/Medicaid for services rendered to my child/children. I request payment of benefits to be made to Plant City Pediatrics for services rendered.

Office Policies

It is our policy that office visits, co-pays and deductibles to be paid in full at the time of service. I fully understand that if my account should need to be turned over to a collection agency for non-payment, that I will be charged an additional percentage of the amount to cover the agency's fees. I agree to pay any and all charges that exceed, or are not covered by my insurance.

____
Parent/Guardian Signature

Permission for Treatment

Permission is hereby granted for physicians, employees, or agents of Plant City pediatrics to render the patient named below such medical and surgical treatment as deemed necessary.

Permission to Release Medical Information

I authorize Plant City Pediatrics to release information form my medical record, or from the medical record, of the person for whom I am legally responsible, to my/their insurance company, other third-payors or their reviewing agencies. This information must be limited to that which is necessary to expedite claim processing. This authorization is valid for every visit to Plant City Pediatrics until written notice revoking is provided. I release Plant City Pediatrics of all responsibilities for loss of confidentiality through access and/or copies made of records released in compliance to this authorization. I have read all the above and understand/agree to all provisions therein regarding responsibility for payment, release of information, and permission for treatment.

Patient Name: ____
Parent/Guardian Signature: ______________________________
If Guardian/Relationship to Patient:_________________________

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, ____________________________, parent/guardian of ______________________ have received a copy of this office's Notice of Privacy Practices.

____
(Signature)

____
(Please print name and relationship)

____
(Date)

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign.

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify)

____
____
____
____

Employee Name: ________________________________

E-Prescribing Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **<u>Formulary and benefit transactions</u>** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **<u>Medication history transactions</u>** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **<u>Fill status notification</u>** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, or partially filled.

By signing this consent form you are agreeing that Plant City Pediatrics can request, and use, your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I understand all of the above, and I hereby provide informed consent to Plant City Pediatrics to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

____________________________________ ____________________

Print Patient Name | Patient Date of Birth

____________________________________ ____________________

Signature of Parent/Guardian | Date

____

Relationship to Patient

Plant City Pediatrics
PRACTICE GUIDELINES AND POLICIES

Patient Name: ______________________ DOB: ___________
Initial:

______**No-Shows**: We require 24 hour notice of cancellation as a courtesy to other patients seeking services. NO-SHOW APPOINTMENTS WILL RESULT IN DISCHARGE FROM THE PRACTICE.

______**Appointments**: Our office will schedule appointments as a courtesy for patients and in consideration of your time. We do not accept walk-in's. Minors must be accompanied by a parent or guardian. ***Only 2 adults may accompany the child during the exam.**

______**Emergencies:** Our providers will make every effort to receive your calls and respond promptly to urgent issues. If you do not receive an immediate response, you will call 911, receive paramedic intervention, or seek the nearest emergency room. **The answering service will not** schedule or cancel appointments or refill medications. Please be available to answer your phone after paging a provider if you have an urgent need.

_______**Prescription Refills:** It is our office policy that you should be responsible to know when your medications must be refilled, at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy or by notifying our office 5 days in advance. We can not take weekend, walk-in or after hours refill request.

______**Antibiotics and Phone Encounters:** Our providers do not treat new patients or illnesses over the telephone. Prescriptions are not called in after office hours. Antibiotics are not called in without an office visit to support the necessity.

______**Vaccine Policy:** We require that all new patients follow the Advisory Committee on Immunization Practice (ACIP) Vaccine Schedule. This schedule will not be altered in any way.

______**Information:** You agree to provide the correct name, correct address, cell or other phone number, email address, insurance information, Social Security number, driver's license or picture identification at the time of registration or as requested by the practice.

______**Financial Responsibility:** By these initials and your signature below, you accept financial responsibility for all charges for services rendered. If a minor, or under guardianship, the parent or guardian accompanying the patient assumes this responsibility.

______**Payment Methods:** We accept cash, check, and major credit cards.

______**Well-Visits:** Are required at 1 week of age, 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, and annually after 3 years of age. Non-compliance with well visits will result in discharge from the practice.

______**Form Fees:** Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice: $25 fee for forms and letters (FMLA, letters, disability forms, etc.).

______**Blue and Gold Forms:** Our office will provide blue and gold forms, as requested at well visits, free of charge. If forms are requested at another time, there is a $5.00 fee.

______**Medical Records:** The medical chart is **the property of the practice.** However, copies of your pertinent medical information are available upon request. The practice charges a fee for a copy of the record according to those published annually by the State of Florida Comptroller's Office. This fee is available upon request. Records to other providers are provided free of charge.

______**Insurance Copayments, Deductibles and Coinsurance:** Payment is expected at time of service. Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All co-payments, deductibles and coinsurance are to be paid at the time of service.

______**Statement Policy:** Patient statements are sent each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company we are required to bill them for services rendered. The sending of a statement may be delayed until your insurance responds to a claim. You understand that such a delay does not alter our policy or patient financial responsibility and you will be liable for all service fees.

______**Collection and Bank Fees:** Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense. The banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees.

______**Cell Phones: We require that cell phones be silenced when you enter the office area** and when your child is being examined. If the parent/guardian is on the phone, the provider will return when you are able to give them your attention during your child's visit.

______**ADHD Patients:** We will refill ADHD medications after an initial visit by Neurology. Patients must be rechecked 1 month after a medication change and every 3 months to continue receiving refills. **We do not write prescriptions for psychiatric medications/antidepressants.**

______**Patient Discharge:** The practice reserves the right to discharge a patient for any reason. Because of quality care considerations, the practice may discharge you for failure to comply with treatment plans. In addition, **we will discharge patients due to continued no-show appointments, disorderly conduct in the office, on the phone and with out staff.**

______Visit Charges: You may be seen for both a well visit and a problem/sick visit on the same day because you satisfy the requirements for both types of visits during one appointment. **PLEASE BE ADVISED** that your insurance company may apply some charges to patient responsibility. If you prefer to return for the problem visit on another day please advise the provider.

Patient/Guardian Signature:________________________________Date:__________

VACCINE POLICY

Plant City Pediatrics follows the immunization guidelines recommended by the Advisory Committee on the Immunizations Practice (ACIP). Our practice believes that children should receive the recommended vaccines according to the guidelines provided by the ACIP. Vaccines are safe and effective in preventing diseases and health complications in children and young adults. Regular vaccinations help children ward off infections, and are administered as one of the safest and best methods of disease prevention. We require all NEW PATIENTS to follow the recommended vaccine schedule and do not allow alternative schedules.

Patient Name: ____

Date of Birth: ______________________

I, the parent/guardian, have received a copy of the Vaccine Schedule, and agree to follow it. I understand that if I choose not to follow the recommended schedule, my child/children will be discharged from Plant City Pediatrics.

Parent/Guardian: ____
Relationship: ______________________
Date: ____________________________

Plant City Pediatrics
Privacy Agreement

Date: ___________________

Patient's Name: _______________________ D.O.B. _______________

I, the parent/guardian of the above patient, give consent for the following individual(s) (18 years or older) to receive medical information, pick-up prescriptions, referrals, etc., and when necessary, bring my child to their doctor's visit and make medical decisions. I give my full consent for Plant City Pediatrics to provide medical care and release all medical information pertaining to my child to this individual:

1) _______________________________ Relationship:________________

2) _______________________________ Relationship:________________

3) _______________________________ Relationship:________________

4) _______________________________ Relationship:________________

5) _______________________________ Relationship:________________

6) _______________________________ Relationship:________________

I, the parent/guardian of the above patient, give consent for Plant City Pediatrics to leave detailed phone messages and medical information regarding this child on my answering machine if I am not available. ___________Yes __________No

____
Signature of Parent/Guardian

____
Please Print name of Parent/Guardian

Pediatric Medical History Form

Your answers on this form will help your provider understand your child's medical history.

Date: ____________________

Child's Name: ____________________________ Date of Birth: __________________

Person Completing Form/Relationship ____

Medications:

Medication Dose How many times daily

____
____
____

Allergies: □ Yes □ No

If yes, to what? ____

Immunization History:

To the best of my knowledge, my child is up to date on his/her immunizations □ Yes □ No

If no, why?____

Birth History:

Please indicate any medical problems during pregnancy ___________________________________

Please list any medications taken during pregnancy ______________________________________

Any drug or alcohol use during the pregnancy □ No □ Yes _______________________________

Delivered by □ Elective C-Section □ Emergent C-Section □ Forceps □Vacuum extraction

□ Normal Vaginal Delivery

Number weeks of gestation _____________ Birth Weight __________ Discharge Weight __________

Did the baby receive the Hepatitis B Vaccine □ Yes □ No If yes, date given _________________

Did the baby receive the Vitamin K shot □ Yes □ No If yes, date given __________________

Please indicate any medical problems during the newborn period ___________________________

Name of hospital or place where child was born ____

Newborn Hearing Screening Passed □ Yes □ No If yes, date passed __________________

Personal Medical History:

Please check if your child has had an of the following medical problems:

□ ADD/ADHD	□ Chicken Pox	□ Headaches	□ Liver disease/Hepatitis
□ Allergies	□ Concussion	□ Hearing Problems	□ Recurrent ear infection
□ Anemia	□ Diabetes	□ Heart Problems	□ Seizures
□ Asthma	□ Eczema	□ Congenital heart disease	□ Urinary tract infections
□ Bleeding disorder	□ Fracture	□ High blood pressure	□ Vesicoureteral reflux
□ Bronchiolitis	□ Handicaps/Disabilities	□ Kidney disease	□ Vision problems

Hospitalizations:

Has your child ever stayed overnight night in a hospital? □ No □ Yes

If yes, when and why? ____

Surgical History:

Please indicate any surgeries or procedures your child has had. Please include the year and surgery/procedure was performed. ____
____
____

Patient GYN History if applicable:

Age of first period ________ years   First day of last period _________Has not had menses yet ______

Family History:

Please indicate if your child has a family history (***parents, siblings, grandparents, to the child)*** of any of the following:

Diagnosis	Family Member	Diagnosis	Family Member
□ ADD/ADHD	________________	□ Hearing disability	__________________
□ Alcohol/Drug use	________________	□ High cholesterol	__________________
□ Allergies	________________	□ High blood pressure	__________________
□ Birth defects	________________	□ HIV/AIDS	__________________
□ Blood disorders	________________	□ Learning disability	__________________
□ Cancer, type	________________	□ Mental illness	__________________
□ Heart disease (heart attack, bypass, stents)	________________	□ Migraines	__________________
□ Deafness/Hearing problem	________________	□ Scoliosis	__________________
□ Depression	________________	□ Seizure disorder	__________________
□ Developmental delay	________________	□ Speech problems	__________________
□ Diabetes	________________	□ TB/Lung disease	__________________
□ Genetic disorder	________________	□ Stroke	__________________
□ Hepatitis/Liver disease	________________	□ Thyroid disease	__________________
		□ Other	__________________

Social History:

Who lives at home?

Name   Relationship   DOB

____
____
____
____
____
____

Is the child cared for by any one other than the parents? □ No □ Yes

If yes, by whom and how frequently? ____

Does anyone in your home smoke? □ No □ Yes

____

Physician/Physician Assistant Signature: ________________________________

Plant City Pediatrics
2370 Walden Woods Drive Suite A
Plant City, Florida 33563
Phone: 813-659-9800 Fax: 813-659-9807

Medical Record Request

Patient Name: DOB: Social Security Number:

Address: Telephone Number: (____)________________

I hereby authorize: ____

____

To release information from the medical record of the above mentioned patient.

To:____

____

For the following purpose or treatment: ____

____

If more than 20 pages, please <u>MAIL</u> records!

Type of Access Requested: _____ Copies of Record _____Inspection of Record

This authorization expires 90 days from the date signed below and covers only treatment for the dates or diagnosis specified above.

______H&P ___Immunization Record ____Other
______Progress notes ___Consultation Reports ____Current Information
______Labs ___**All Records, Changing Primary Physician**

__________ I acknowledge, and hereby consent to such, that the release of information may contain Alcohol, drug abuse, psychiatric, HIV testing, HIV results, and AIDS information.
Initials

_______I, the undersigned, have read the above and authorized the staff of Plant City Pediatrics to disclose such information as herin contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information". Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the authorization except if the authorization is for (1) conducting research-related treatment, (2) obtaining information in connection with the eligibility for enrollment in a health plan, (3) determining an entity's obligation to pay a claim, or (4) creating health information to provide to a third party.

Date: ____
Parent or Guardian's Signature:____
Printed Name: ____
Witness Signature: ____

FOR OFFICE USE ONLY:
Date Received:________________________Processed By:____________________

Date:________________ Patient Name: ______________________________________
Date of Birth:______________ Age:_______________

Lead Poisoning Risk Assessment

Does your child live in or regularly visit (once a week or more) any house built before 1978? Y N U

Does your child live or regularly visit any house or building that has vinyl mini-blinds, lead pipes, pipes with lead solder joints, or had metal pipes replaced or repaired within the last 5 years? Y N U

Does your child have a mother, sibling or play mate, who has, or did have, lead poisoning? Y N U

Does your child frequently come into contact with an adult whose job or hobby involves exposure to lead? Some examples are employment in building renovation, an auto battery factory, auto or radiator repair shop, highway bridge sandblasting or painting, welding metal structures, wire cable cutting or hobbies such as refinishing furniture, casting bullets, making stained glass, toy soldiers, dive weights or fishing weights? Y N U

Does your child eat food that has been stored in metal cans, from leaded crystal, ceramic or pewter dishes, or have contact with cosmetics, candies, spices, and home or fold remedies not made or sold in the United States? Have you ever seen your child eat dirt? Y N U

Does your child play in loose soil, near a busy road or near any industrial sites such as a battery recycling plant, junk yard or lead smelter? Y N U

Has your child lived in a foster care home or in a country other than the U.S.? Y N U

**Indicate response by circling "Y" for yes, "N" for no, or "U" for unknown. Sign name and relationship at the bottom of the page. A yes or unknown response to any question indicates the child is at risk for lead poisoning. The child should receive blood lead testing and appropriate follow-up. See Risk Assessment, Screening, and Follow-up of Children for Elevated Blood Lead Levels.

Tuberculosis Risk Assessment Questionnaire

Has your child had contact with a parent, relative or other caretaker with either active tuberculosis, abnormal chest x-ray suggestive of tuberculosis, or history of a positive PPD skin test? Y N U

Are any parents, relatives or caretakers of your child from a region with high incidence of tuberculosis (i.e., Latin America, Asia, Africa and Eastern Europe)? Y N U

Has your child been exposed to any adult who is HIV positive, homeless, a drug user, a migrant worker, indigent, resident from a nursing home, prisoner or other institution? Y N U

Has your child ever been institutionalized? (i.e., imprisoned, detention home, foster care, mental hospital or orphanage). Y N U

Does your child have cancer, diabetes, renal failure, malnutrition or an immunosuppressive condition? Y N U

Parent/Guardian Signature:____
Relationship to Patient:____

Physician/Provider Signature:_______________________________________

Domestic Violence (DV) Screening

Patient Name: ________________________________DOB:_______________

Parent/Guardian Completing _______________________Date:_____________

This information is part of your health care record. Your responses will not be released to anyone without your written consent, except as otherwise provided by law. If you do not feel comfortable talking today, you can call a hotline number anytime at:

NYS Adult Domestic Violence Telephone#
1-800-942-6906
TTY for the Hearing Impaired – English
1-800-818-0656
En Espanol Voice Telephone #
1-800-942-6908
TTY for the Hearing Impaired – Spanish
1-800-780-7660

NYC Bilingual Domestic Violence Hotline
Call 311 or 1-800-621-4673
Hearing Impaired
1-800-810-7444

Violence Intervention Program
(212) 410-9080

Please answer the following questions:

1. Do you feel safe at home? □ Yes □ No
2. We all have disagreements – when you and your partner or a family member argue, have you ever been physically hurt or threatened? □ Yes □ No
3. Do you feel your partner or family member controls (or tries to control) your behavior too much? □ Yes □ No
4. Does he or she threaten you? □ Yes □ No
5. Has your partner (or other family member) ever hit, pushed, shoved, punched or kicked you? □ Yes □ No
6. Have you ever felt forced to engage in unwanted sexual acts/contact with your partner or other family member? □ Yes □ No

Physician use only
DV Screen

□ DV – (Negative)
□ DV+ (Positive)
□ DV? (Suspected)

Provider Signature_____________________________

HIPPA NOTICE OF PRIVACY PRACTICES

Effective Date: March 26, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

This notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will pride you with information about our denial and how you can disagree with denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 813-659-9800.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

● We may provide your Health Information to other health care professionals – including doctors, nurses and technicians – for purposes of providing you with care.

● Our billing department may access your information – and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

● We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

● Notify and/or communicate with your family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

● As Required By Law.

● For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

● In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed in the course of any civil administrative or judicial proceeding.

● To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

● For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

● For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances. We may only use or disclose your Health Information after you have signed an authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

● Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice.

● Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes. Disclosures that constitute a sale of PHI will require a separate written authorization.

● Use of Disclosure of Psychotherapy Notes. *Written* authorization is required if our practice intends to use or disclose psychotherapy notes.

●Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised That We May Also Use or Disclose Your Health Information for the Following Purposes:

● Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

● Change of Ownership. In the event that our business is sold or merged with another organization, your Health Information/Record will become the property of the new owner.

VI. Our Duties.

We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and make the new Notice provisions applicable to all your Health Information – even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.

You may make complaints to our HIPAA Privacy Officer or the Security of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

VII. Contact Information. You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: **MARY KIFER** at **813-659-9800.** You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, Telephone: 202-619-0257 Toll Free: 1-877-696-6775.