Confidential Patient Information

PATIENT INFORMATION

FULL NAME ____ DATE OF BIRTH ____/____/_____ AGE ____ M ___ F ___

ADDRESS ____ APT # ____________ SSN ______ - _____ - _________

CITY ________________________________ STATE _________ ZIP CODE _______________ HOME PHONE ____________________________

BEST # TO CALL OR LEAVE MESSAGE ____ CELL PHONE ___________________________________

EMPLOYER'S NAME ____ OCCUPATION ____

WORK ADDRESS _____________________________ WORK PHONE ________________________ IS IT OK TO CALL WORK? YES ___ NO ___

PHARMACY YOU USE ____ PHARMACY PHONE NUMBER ______________________________

MARITAL STATUS: SINGLE ____ MARRIED ____ WIDOWED ____

EMERGENCY CONTACT ____ PHONE _______________________________________

CLAIM INFORMATION

IS YOUR CONDITION DUE TO: AN AUTO ACCIDENT _____ PERSONAL INJURY _____ WORK INJURY _____

TYPE OF CLAIM: CASH _____ HEALTH INSURANCE _____ MEDICARE _____

INSURANCE INFORMATION

RELATIONSHIP TO INSURED? SELF _____ SPOUSE _____ OTHER _____ CHILD _____ SPOUSE'S NAME ____________________________

INSURED DATE OF BIRTH ____/____/_____ INSURED SSN _______ - _____ - _________

PRIMARY INSURANCE COMPANY ____

ADDRESS ____ PHONE NUMBER _________________________________

POLICY NUMBER ____ GROUP NUMBER ____

SECONDARY INSURANCE ____

ADDRESS ____ PHONE NUMBER _________________________________

POLICY NUMBER ____ GROUP NUMBER ____

AUTHORIZATIONS: PLEASE READ CAREFULLY

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

PATIENT SIGNATURE ____ DATE ___________________________

GUARDIAN SIGNATURE ____ DATE ___________________________

THE MAGNOLIA MEDICAL GROUP

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Jacksonville, FL. 32256
Office: 904-737-6313 Fax: 904-739-1302

5851 Timuquana Rd. #201
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Office: 904-779-2220 Fax: 904-779-2227

HEALTH HISTORY FORM

Patient Name: ______________________________ Birth Date: ____________________

Health Habits:

Exercise ☐ None ☐ Mild (Climb stairs, walk 3 blocks, golf) ☐ Occasional Vigorous (work or recreation less than 4x a week for 30 min) ☐ Regular Vigorous (work or recreation 4x a week for 30 min)

Diet Are you dieting? ☐ Yes ☐ No If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

Caffeine ☐ None ☐ Coffee ☐ Tea ☐ Cola # of cups/cans per day? _________________

Alcohol Do you drink Alcohol? ☐ Yes ☐ No If yes, what kind? ___________________________
How many drinks per week? _____________ How long have you been drinking? (# of years) _____________

Tobacco Do you use tobacco? ☐ Yes ☐ No # of years _____________ Years quit? _____________
Cigarettes - pkgs/day ________ Pipe - #/day ________ Cigars - #/day ________ Chew - #/day ________

Family History: Has any blood relative ever had the following:

Breast Cancer	☐ no	☐ yes	High Blood Pressure....	☐ no	☐ yes	Kidney Disease.....	☐ no	☐ yes
Ovarian Cancer.....	☐ no	☐ yes	Heart Disease..............	☐ no	☐ yes	Depression...........	☐ no	☐ yes
Stroke...................	☐ no	☐ yes	Diabetes......................	☐ no	☐ yes	Melanoma............	☐ no	☐ yes

Other _____________________

Past Medical History: Have you ever had the following:

Heart Disease............	☐ no	☐ yes	Diabetes.................	☐ no	☐ yes	Chronic Fatigue..........	☐ no	☐ yes
Chest Pain.................	☐ no	☐ yes	Cancer....................	☐ no	☐ yes	Stomach Ulcer............	☐ no	☐ yes
Blood Clots...............	☐ no	☐ yes	Glaucoma...............	☐ no	☐ yes	Kidney Disease...........	☐ no	☐ yes
Arthritis	☐ no	☐ yes	Asthma...................	☐ no	☐ yes	Thyroid Disease	☐ no	☐ yes
Tuberculosis	☐ no	☐ yes	AIDS or HIV	☐ no	☐ yes	Bleeding Tendency......	☐ no	☐ yes
Rheumatic Fever........	☐ no	☐ yes	Stroke.....................	☐ no	☐ yes	Mitral Valve Prolapse.....	☐ no	☐ yes
Anemia	☐ no	☐ yes	Hepatitis.................	☐ no	☐ yes	High Blood Pressure.......	☐ no	☐ yes
Heart Attack	☐ no	☐ yes	Lung Problems........	☐ no	☐ yes	Emphysema/COPD	☐ no	☐ yes
Kidney Stones...........	☐ no	☐ yes	STD History...........	☐ no	☐ yes	Gout...........................	☐ no	☐ yes
Osteoporosis	☐ no	☐ yes	Palpitations	☐ no	☐ yes	Fainting/Dizzy Spells	☐ no	☐ yes
Heartburn..................	☐ no	☐ yes	Sinus trouble	☐ no	☐ yes	Allergies	☐ no	☐ yes
Leg Blood Clots.........	☐ no	☐ yes	Swollen Ankles.......	☐ no	☐ yes	Constipation	☐ no	☐ yes
Bloody/Tarry Stool....	☐ no	☐ yes	Diverticulitis	☐ no	☐ yes	Abdominal Pain...........	☐ no	☐ yes
Hemorrhoids.............	☐ no	☐ yes	Back Pain...............	☐ no	☐ yes	Shoulder Pain	☐ no	☐ yes
Knee Pain	☐ no	☐ yes	Foot Pain................	☐ no	☐ yes	Gallbladder.................	☐ no	☐ yes
Seizures	☐ no	☐ yes	Hearing Problems ...	☐ no	☐ yes	Headaches	☐ no	☐ yes
Vision Problems	☐ no	☐ yes	Depression	☐ no	☐ yes	Sleep Problems............	☐ no	☐ yes

High Cholesterol........ ☐ no ☐ yes Ulcer .... ☐ no ☐ yes Liver Disease .... ☐ no ☐ yes
Urinary Disorders ...... ☐ no ☐ yes Eye Disease .... ☐ no ☐ yes Drug Addictions .... ☐ no ☐ yes
Gastric Reflux........... ☐ no ☐ yes - if yes are you on medication for this? (name) ________________________

Women Only: Birth Control Pills ☐ no ☐ yes

Number of children: _______________________ Last menstrual period _____________________

Date of last mammogram ___________________ Breast lump or discharge __________________

Date of last pap ___________________________

Current Medications (including over the counter drugs, aspirin, and nose sprays)

Drug Name	Dosage	Times per day

Medication Allergies	Type of Reaction

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RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled Substance medications (i.e., narcotics, tranquilizers, and barbiturates) are very useful in relieving pain, thus improving function and/or ability to work. They have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions:

1. I understand that the risks associated with controlled medications include dependence, addiction, tolerance and constipation, sleep changes, potential for increased pain, risk to unborn children, withdrawal, and changes in appetite, coordination, sexual desire and sexual preference.
2. I will not share, sell or trade my medication with anyone. I will not alter my prescriptions under any circumstance.
3. **I WILL NOT OBTAIN PAIN MEDICATION FROM ANY OTHER PHYSICIANS. DOING THIS WILL CONSTITUTE A BREACH OF THIS CONTRACT AND WILL IMMEDIATELY END ANY AND ALL RESPONSIBILITY ON BEHALF OF MY PHYSICIAN FOR FURTHER CARE.**
4. I understand that if I break any portion of this agreement, my doctor will stop prescribing these pain-control medicines and may elect to discharge me from the office.

I agree to follow these guidelines which have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be provided to me upon request.

Patient signature: ____ Date: __________________

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REQUEST FOR MEDICAL RECORDS
DR VINCENT GALIANO, MD

Date: ______________________

To: __________________________________

Phone: ___________________

Fax: _____________________

Patients
Name: _______________________________

DOB: ________________

SS#: __________________

I hereby request the following records to be released to:

Name: _______________________________

Phone: ____________________

Fax: ______________________

Patient signature: ____

Date: _______________________

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AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby grant **Vincent Galiano, M.D. P.A.** or its designated representative(s) the authority to seek, receive, and release any and all information pertaining to me as may be necessary to process my insurance claim(s) and to bill and receive payment from my insurance company for any and all services rendered to me by **Vincent Galiano M.D. P.A**. or its designees.

I hereby agree to pay **Vincent Galiano M.D. P.A**.in a timely fashion, for any and all services rendered which may or may not be covered by my insurance. This includes all co-payments and/or insurance payments which I may receive as a result of services rendered by **Vincent Galiano M.D. P.A.** I further agree that if collection becomes necessary, I will pay all costs of collection of my balance including reasonable attorney fees.

CONSENT FORM FOR DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURE.

Thereby consent to and authorize **Vincent Galiano M.D. P.A.** and other health professionals, as designated, to perform a physical examination and routine diagnostic procedures upon me. I also consent to and authorize **Vincent Galiano M.D. P.A.** to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) ordered by **Vincent Galiano M.D. P.A.** to be performed on me despite the risk involved and complications that might be involved which were explained to me at the time they were considered.

CONSENT FOR REFERRALS TO SPECIALISTS OR DIAGNOSTIC TESTING

If I am referred out to another doctor or for any testing needed, I authorize **Vincent Galiano M.D. P.A.** to send the necessary information needed to be treated or for a test to be done. The information sent may include office notes, any testing, personal information to contact the patient, and billing information.

PLEASE PRINT AND SIGN NAME

Print Name: ____ Date: _____________________

Patient Signature: ____________________________________ Date: ____________________

Witnesses: _________________________________ _________________________________

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OFFICE POLICY FOR PAYMENT OF SERVICES AND SUPPLIES

PAYMENT(S) for services rendered is the responsibility of the patient. If we are a participating provider, we will process and file your insurance claim. Upon receipt of insurance payment your statement balance will be mailed to you. **Balances must be paid within 15 days of billing**. There is a twenty dollar fee for all Returned Checks.

APPOINTMENT CANCELLATION

Our office must be given notice that you intend to cancel your appointment at least 24 hours in advance. Failure to give notice of cancellation will result in a twenty-five dollar charge.

Thank you for your understanding and consideration.

Signature: ______________________________ Date: ________________

Relationship if other than patient: ______________________________

Patient's name: ______________________________
(Please Print)

PAYMENT POLICY

Thank you for choosing Dr. Vincent Galiano as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan that we can't verify coverage, payment is due in full until coverage can be verified. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit.
3. **Non-covered services.** Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family member may be discharged from this practice. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** Our policy is to charge for missed appointments not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to service you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

______________________________	______________________________
Signature of patient or responsible party	**Date**

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Giving Consent

Name: ____

DOB: ______________________

TO THE PATIENT: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.
Purpose of Consent: By signing this form, you will consent to our use and disclosure on your protected health information to carry out treatment, payment activities and healthcare operation.
Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, and the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.
Right to Revoke: you will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted in our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. Understand that we may decline to treat you or to continue to treat you if you revoke this Consent.
Signature:
I, _____________________ (PRINT), have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my PHI (protected health information) to carry out treatment, payment activities and healthcare operations. **I also authorize my Healthcare provider to discuss or release my Healthcare information to anyone listed below.**

____ Name and relationship

____ Name and relationship

____ Name and relationship

____ Name and relationship

Signature: ______________________________________ Date: _________________________

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintain the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practice that we have in effect at the time.
We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your individual rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practices. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
THE HIPAA PRIVACY OFFICER AT (904) 737-6313

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or discloser your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to

certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that maybe responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

OPTIONAL:

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

OPTIONAL:

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL:

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. **Disclosure Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for purpose of:

- maintaining vital records, such as births and deaths;
- reporting child abuse or neglect;
- preventing or controlling disease, injury or disability;
- notifying a person regarding potential exposure to a communicable disease;
- notifying a person regarding a potential risk for spreading or contracting a disease or condition;
- reporting reactions to drugs or problems with products or devices;
- notifying individuals if a product or device they may be using has been recalled; or
- notifying appropriate government agency(ies) and authority(ies) regarding potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal

procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
- Concerning a death we believe has resulted from criminal conduct;
- Regarding criminal conduct at our offices;
- In response to a warrant, summons, court order, subpoena or similar legal process;
- To identify/locate a suspect, material witness, fugitive or missing person; or
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator).

OPTIONAL

5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or corner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL

6. **Organ and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL

7. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for a research study; (ii) the use or disclosure of your IIHI is being used only for research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.
8. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military.** Our practice may disclose your IIHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National Security.** Our practice may disclose IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the

safety and security of the institution and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:
1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must have a written request to the **HIPAA PRIVACY OFFICER AT (904) 737-6313** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the **HIPAA PRIVACY OFFICER AT (904) 737-6313**. Your request must describe in a clear and concise fashion:
(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the **HIPAA PRIVACY OFFICER AT (904) 737-6313** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the **HIPAA PRIVACY OFFICER AT (904) 737-6313**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares your information with the nurse or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the **HIPAA PRIVACY OFFICER AT (904) 737-6313**. All requests for an "accounting of disclosures" must

state a time period, which may not be longer than six (6) years from the date of disclosure. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 2-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the **HIPAA PRIVACY OFFICER AT (904) 737-6313**.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the **HIPAA PRIVACY OFFICER AT (904) 737-6313**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies; please contact the **HIPAA PRIVACY OFFICER AT (904) 737-6313**.