MEDICAL ASSOCIATES OF WEST FLORIDA, LLP

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Medical Associates of West Florida, LLP deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine in not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature:_____ **Date:**_____

AUTHORIZATION AND ASSIGNMENT

I request that the payment of authorized Medicare/insurance benefits be made either to me or on my behalf for any services furnished by Medical Associates of West Florida, LLP. I authorize any holder of medical information about me to release to CMS/insurance carriers and its agents any information needed to determine these benefits or benefits related to services.

I hereby authorize Medical Associates of West Florida, LLP to furnish information to Medicare/insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier(s)/Medicare to make payment directly to Medical Associates of West Florida, LLP for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature:_____ **Date:**_____

DESIGNATED RELATIVE

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with the names listed below. Please list the family members or significant others, if any, whom we may inform about your medical condition, in case of an emergency:

Name:_____ Phone:( )_____

Name:_____ Phone:( )_____

Name:_____ Phone:( )_____

Signature:_____ **Date:**_____

Witness:_____

MEDICAL ASSOCIATES OF WEST FLORIDA, LLP

I authorize Medical Associates of West Florida, LLP to mail my billing statement and any other correspondence to my home address.

I authorize Medical Associates of West Florida, LLP to call my home phone/cell phone concerning appointments, test results or other health care information. I am fully aware that a telephone/cell phone is not a secure and private line.

I authorize Medical Associates of West Florida, LLP to leave confidential information on my telephone/cell phone answering service or voice mail.

I understand by signing I agree to all of the above.

Signature:_____ **Date:**_____

PRIVACY NOTICE

I have received a copy of Medical Associates of West Florida, LLP's HIPAA privacy notice. Please retain the last two pages for your records.

Signature:_____ **Date:**_____

MEDICAL ASSOCIATES OF WEST FLORIDA, LLP

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review it carefully.

WE SAFEGUARD INFORMATION ABOUT YOU HEALTH AND PERSON

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

TYPICAL USES AND DISCLOSURES OF MEDICAL INFORMATION

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians, as well as, insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for which you authorize disclosure such as other healthcare providers (doctors, nurses, and extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors.
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker's compensation
- Disaster relief

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

MEDICAL ASSOCIATES OF WEST FLORIDA, LLP

PATIENT PRIVACY RIGHTS

YOU HAVE THE RIGHT TO

- Inspect medical information from your chart. You may submit a written request to our office, pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last 5 (five) years, starting October 2005. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited, as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict consent at any time.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

OUR RESPONSIBILITIES UNDER HIPAA

We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that this notice has been changed and the effective date of the change, copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our Resource Officer at:
Medical Associates of West Florida, LLP, 7575 State Road 52, Bayonet Point, FL 34667 (727)861-9800

If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.