CENTRAL FLORIDA
TOTAL HEALTH CARE

Today's Date: _____

PATIENT INFORMATION SHEET

Patient Name: _____ DOB _____
LAST FIRST MI

Patient Address: _____ City: _____ State: _____

ZipCode: _____ HomePhone: _____ CellPhone: _____ SS# _____

Age_____ Sex ___Male ___ Female Marital Status (Please Circle) Single Married Divorce Widowed

Driver's License # _____ E-mail _____

Place of Employment _____ Work Phone _____

Pharmacy Name _____ Pharmacy Address _____

Pharmacy Phone _____ Do you received mail pharmacy services ____Yes ___ No

If yes please indicate name and phone number _____

IN CASE OF AN EMERGENCY:

Contact Name _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

HEALTH INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID # _____ Group # _____

Secondary Insurance Name _____ Policy ID # _____ Group # _____

GUARANTOR (if is different from patient)

Name _____ SS# _____ DOB _____

Address _____ City _____ State _____

Zip Code _____ Phone Number _____ Relationship to patient _____

***PLEASE ANSWER IF YOU DON'T WANT TO GIVE ANY INFORMATION JUST CHECK ON REFUSED:**

Ethnicity ___Hispanic or Latino ___ Not Hispanic or Latino **Race:** _____

Nationality: _____ **Language(s)** _____ **Refused to tell** _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also, authorize Central Florida Total Healthcare or insurance company to release any information required to process my claim.

_____ _____

Patient/Guardian signature Date

CENTRAL FLORIDA
TOTAL HEALTH CARE

Patient History Form for Current Visit

Patient Name_____ Today's Date_____ Date of Birth_____

What medical concerns can we assist with today?

_____

_____

_____

Current Medications:

Medication	Dose (mg/mcg)	Number of times taken daily

Are you allergic to any medications? ☐ Yes ☐ No
If yes, to which medications? _____

Social History

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No
How many packs per day? _____
Do you drink alcohol, beer, or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No
How many drinks per week? _____
Do you currently drink coffee, pop, tea, or energy drinks? ☐ Yes ☐ No
Do you exercise daily/weekly? ☐ Yes ☐ No
Do you use seatbelts when driving? ☐ Yes ☐ No
Do you wear a helmet while riding a bike? ☐ Yes ☐ No

Have you have had any of these symptoms recently? (Please circle)

Cough	Change in Vision	Sinus pain	Leg cramps
Bloody nose	Swollen/painful joints	Allergy symptoms	Heartburn
Thoughts of suicide	Headache	Breathing problems	Diarrhea
Eye pain/runny eyes	Dizziness	Chest pain	Vomiting
Decreased hearing	Fainting	Palpitations	Rash
Abdominal pain	Hemorrhoids	Pain with urination	Urinating frequently
Back pain	Foot/ankle pain	Nerve pain	Trouble sleeping/snoring
Sore Throat	Swollen lymph nodes		

Females: Gynecological History

First day of your last menstrual period?_____

CENTRAL FLORIDA
TOTAL HEALTH CARE

Past Medical History Form

Patient Name_____ Today's Date_____ Date of Birth_____

Have you ever been hospitalized overnight? ☐ Yes ☐ No
Have you been tested or vaccinated for hepatitis A, B, or C? ☐ Yes ☐ No
Last TB screening _____
Last tetanus shot _____

Which of the following conditions are you currently being treated or have been treated for in the past? (please check the box)

- ☐ Heart disease/murmur/angina
- ☐ High cholesterol
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Heartburn/ reflux
- ☐ Anemia/blood or bleeding problems
- ☐ Swollen ankles/vein problems
- ☐ Diabetes
- ☐ Arthritis
- ☐ Thyroid Problem
- ☐ Corrective lenses/glasses
- ☐ Hernia
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Lung problems/cough
- ☐ Sinus problems
- ☐ Seasonal allergies
- ☐ Tonsillitis
- ☐ Ear Problems
- ☐ Kidney/bladder problem
- ☐ Cancer
- ☐ Sexually transmitted disease
- ☐ Hearing loss
- ☐ Kidney stones
- ☐ Eye disorder/glaucoma
- ☐ Seizures
- ☐ Stroke
- ☐ Headaches/migraine
- ☐ Neurological problems
- ☐ Depression/anxiety
- ☐ Psychiatric care
- ☐ Liver problem/hepatitis
- ☐ Ulcers/colitis
- ☐ Prostate problems
- ☐ Rheumatic fever
- ☐ Eating disorder

Please describe any current or past medical treatment not listed above

_____

Please list your past surgeries

_____

_____

Family History

	Living	Age (or age at death)	List serious illnesses
Mother	☐ Yes ☐ No	_____	_____
Father	☐ Yes ☐ No	_____	_____
Sisters	☐ Yes ☐ No	_____	_____
	☐ Yes ☐ No	_____	_____
	☐ Yes ☐ No	_____	_____
Brothers	☐ Yes ☐ No	_____	_____
	☐ Yes ☐ No	_____	_____
	☐ Yes ☐ No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which family member?
Anemia or blood disease	
Cancer	
Diabetes	
Glaucoma	
Heart disease	
High blood pressure	
Mental Illness/depression	
Stroke	
Other serious illness	

Females: Gynecological History

How many times have you been pregnant? _____

Date of last Pap Smear _____

Have you had an abnormal Pap Smear? ☐ Yes ☐ No

Date of last mammogram? _____

Have you ever had a breast biopsy? ☐ Yes ☐ No

CENTRAL FLORIDA
TOTAL HEALTH CARE

PAYMENT POLICY FOR SERVICES RENDERED

- **If You Have Health Insurance:** Please **Initial** the Line Next Your Insurance in **Section 1, 2 Or 3.**
- **If You Do Not Have Health Insurance**: Please Read **Section 4.**
- **Everyone:** Please Sign at Bottom of Form and give your card (if applicable) to the Receptionist so we may make a copy for your file.

1. **IF YOU HAVE INSURANCE WITH ONE OF THE FOLLOWING INSURANCE COMPANIES,** please initial the appropriate line. We will bill these companies directly and will follow up on outstanding balances. You will be responsible for payment of your designated co-pay at each visit to the office BEFORE you see the doctor. You are responsible to present updated referral authorizations from your insurance carrier when required.

____ Medicare	____ Universal Health Care	___ PHCS	____ CIGNA
____ Medicaid	____ Multiplan	___ Humana	____ United Healthcare
____ AETNA	____PCP	___ Tricare	____ First Health
____ BCBS	____ Well Care	___ Provider Select	

2. **IF YOU HAVE BEEN INJURED ON THE JOB AND YOUR EMPLOYER HAS WORKERS COMPENSATION COVERAGE,** we must have information approving the claim from your employer and an accurate billing address to send the claim to for processing. Without this, we will consider payment for this visit to be your responsibility. Central Florida Total Health follows the South Carolina State Workers Compensation fee schedule and is not a member of any Worker's Comp PPO's.

Name of Insurance Company: _____ Contact Person: _____

Address: _____ Phone: _____

3. **IF YOU HAVE COVERAGE WITH INSURANCE COMPANY, NOT LISTED ABOVE.** If you provide us with a copy of your card, we will submit a claim directly to your insurance company for reimbursement as a courtesy. Please review the following procedure and sign.

"I understand that my services are being billed directly to my insurance carrier for me. The insurance company should send payment directly to me (the patient). If the payment is received at our office the payment will be forwarded to the patient. I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility."

Insurance Co Name: _____Signed: _____ Date: _____

4. **IF YOU DO NOT HAVE HEALTH INSURANCE,** you are responsible for payment of your bill at the time of your visit. We accept personal checks, credit cards, and cash. A payment of $50.00 is due before your visit. The balance will be due when your visit is complete. If your bill exceeds $200.00, a payment plan can be worked out at the time of the visit. Please ask for our payment agreement form.

"I understand and agree that regardless of my insurance coverage, I am responsible for the balance of this account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and Central Florida Total Health incurs any collection charges, they will be my responsibility."

If the patient is a minor: **"By consenting to care at Central Florida Total Health, I am agreeing that I will take responsibility for the payment of the medical bills. I will provide the office with all information necessary and will communicate with the office regarding any changes in responsibility.**

Patient or Guardian Signature_____ **Date**_____

CENTRAL FLORIDA
TOTAL HEALTH CARE

30 Remington Road Suite 2 Oakland Florida 34787
Phone: (407) 392-1919 Fax: (407) 392-1917

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
SS#: _____ Patient's phone #: ( ) _____
Date of Request: _____ **Date Needed:** _____

OR

☐ I authorize Central Florida Total Healthcare **to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

☐ I authorize Central Florida Total Healthcare **to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)

☐ All medical records related to a specific illness or injury.

_____ _____
Specify illness/injury Date(s) of treatment

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

☐ Specific information (Select one or more, as applicable)

☐ Procedure report ☐ History & physical ☐ Physical Therapy ☐ Laboratory test results
☐ X-ray reports ☐ Other _____
(Please describe.)

☐ Entire copy of the record checked above.

AUTHORIZATION VALID FOR: (Check one.)

☐ This request only.

☐ One year from the date of this authorization **OR** _____ . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request **and** for medical records of any **future** treatment of the type described above until: _____
Insert Date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)*

CENTRAL FLORIDA
TOTAL HEALTH CARE

Authorization to Obtain Medication History

Patient Name: _____

DOB: _____ SS#_____

By signing this below, I hereby authorize Central Florida Total Health Care to obtain Medical Information related to the patient above, from Pharmacies and /or Providers for the purpose of continued treatment.

_____ _____

Patient/ Legal representative or Parent/Legal Guardian Signature Date

CENTRAL FLORIDA
TOTAL HEALTH CARE

PATIENT NO-SHOW/CANCELATION POLICY

In order for Central Florida Total Health Care to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive on time for such.

Effective July 1, 2012 if you miss an appointment or cancel with **LESS THAN 24 HOURS NOTICE, CENTRAL FLORIDA TOTAL HEALTH CARE** reserves the right to bill you $25.00 for each NO SHOW AND LATE CANCELATION. This fee will be **YOUR RESPONSIBILITY** and will not be billed to your insurance company.

We do realize that on a rare occasion emergencies may occur and we will address these situations with you at that time.

In addition to the $25.00 fee with each missed appointment, we will notify you of our policy if you have missed three (3) or more appointments without notification or validation. Additionally, we reserve the right to terminate our relationship with you (our patient) after 5 or more occurrences. Good health and a positive doctor-patient relationship are dependent upon consistent consultations and treatment. This cannot be accomplished with frequent missed appointments.

We thank you for working with us to ensure services are provided to you the best possible way.

CENTRAL FLORIDA
TOTAL HEALTH CARE

Consent to Use or Disclose Protected Health Information For Treatment, Payment and Health Care Operations

I consent to allow Central Florida Total Health Care to use or disclose my protected health information for treatment, payment and health care operations.

- ❑ Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.

- ❑ Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.

- ❑ Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of the practice.

I consent to allow Central Florida Total Health Care to disclose my protected health information for treatment activities of another health care provider.

I consent to allow Central Florida Total Health Care to disclose my protected health information to another physician or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Central Florida Total Health Care to disclose protected health information to another medical facility for health care operations activities, provided that the practice and the other entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations or for the purpose of health care fraud and abuse detection or compliance.

Patient Name: _____
(Please Print)

_____
(Signature of Person Authorizing Consent)

_____
(Print Name on Signature Line and List Relationship to patient)

Date : _____

CENTRAL FLORIDA
TOTAL HEALTH CARE

Dear Patient,

We understand that there are often legitimate reasons for having to cancel an appointment. We ask to show consideration by calling in advance if you are unable to keep an appointment as we would like to have the option to offer that appointment to another patient who needs to be seen.

This letter is to notify you that failure to provide a 24 hour notice of cancellation will rest in $25.00 cancelation fee for appointments. This will be billed to you directly and cannot be filled to your insurance.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTOOD THE ABOVE NOTICE, AND THAT I HAVE RECEIVED A COPY AND FULL EXPLINATION REGARDING THE PROVIDED INFORMATION.

Signature of Patient: _____ Date: _____

Print Name: _____

*IF PATIENT IS UNDER AGE 18 OR UNABLE TO AUTHORIZE CONSENT:

Signature of Parent or Legal Guardian: _____ Date: _____

Print Name: _____

CENTRAL FLORIDA
TOTAL HEALTH CARE

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.

1. Introduction

Central Florida Total Health Care is required by law to maintain the privacy and security of your health information and provide individuals with notice of its legal duties and privacy practices with respect to health information. Central Florida Total Health Care is required to abide by the terms of the Notice currently in effect. Central Florida Total Health Care reserves the right to change the terms of this Notice at any time and to make new Notice provisions effective for all health information that it maintains. Upon your request, we will provide you with a current copy of this Notice.

This Notice of Privacy Practices outlines our practices and legal duties to maintain the confidentiality of your protected health information ("PHI") under the privacy and security regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").

PHI includes demographic information that can be used to identify you such as your name, address, and telephone number; information concerning your past, present, or future physical or mental health condition; information concerning the provision of health care to you; and information concerning the past, present, or future payment for health care. Your PHI may be maintained by us electronically and/or on paper.

This Notice describes uses and disclosures of PHI to which you have consented, that you may be asked to authorize in the future, and that are permitted or required by state or federal law. Also, it advises you of your rights to access and control your PHI.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with Central Florida Total Health Care.

If you have any questions about Central Florida Total Health Care's Notice of Privacy Practices, please contact the Jessica A. at 407-392-1919.

2. Safeguarding Your PHI

We have in place appropriate administrative, technical, and physical safeguards to protect and secure the privacy and security of your PHI. We train our employees on the regulations and policies that are in place to protect the privacy and security of your PHI. Medical records are maintained in secure areas within our practice and electronic medical record systems are monitored and updated to address security risks in compliance with the HIPAA Security Rule. Only employees who have a legitimate "need to know" are permitted access to your medical records and PHI. Our employees understand their legal and ethical obligations to protect your PHI and that a violation of this Notice of Privacy Practices may result in disciplinary action.

3. Uses and Disclosures of PHI

As part of our registration materials, we will request your written consent for our practice to use and disclose your PHI for the following types of activities:

- **Treatment.** Treatment means the provision, coordination, or management of your health care and related services by Central Florida Total Health Care and health care providers involved in your care. It includes the coordination or management of health care by a provider with a third party insurance carrier, communication with lab or imaging providers for test results, consultation between our clinical staff and other health care providers relating to your care, or our referral of you to a specialist physician or facility.
- **Payment.** Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims management, and collection activities. Payment also may include your insurance carrier's efforts in determining eligibility, claims processing, assessing medical necessity, and utilization review. Payment may also include activities carried out on our behalf by one or more of our collection agencies or agents in order to secure payment on delinquent bills.
- **Health Care Operations.** Health care operations means the legitimate business activities of our practice. These activities may include quality assessment and improvement activities; fraud and abuse compliance; business planning and development; and business management and general administrative activities. These can also include our telephoning you to remind you of appointments, or using a translation service if we need to communicate with you in person, or on the telephone, in a language other than English.

  When we involve third parties in our business activities, we will have them sign a Business Associate Agreement obligating them to safeguard your PHI according to the same legal standards we follow.

4. Electronic Exchange of PHI

We may transfer your PHI to other treating health care providers electronically. We may also transmit your information to your insurance carrier electronically.

5. Uses and Disclosures of PHI Requiring Your Written Authorization

Uses and disclosures of your PHI made for purposes of psychotherapy, marketing and disclosures that constitute a sale of PHI will be made only with your written authorization.

Other uses and disclosures of your PHI will be made only with your specific written authorization. This allows you to request that Central Florida Total Health Care disclose limited PHI to specified individuals or companies for a defined purpose and timeframe. For example, you may wish to authorize disclosures to individuals who are not involved in treatment, payment, or health care operations, such as a family member or a school physical education program. If you wish us to make disclosures in these situations, we will ask you to sign an authorization allowing us to disclose this PHI to the designated parties.

If Central Florida Total Health Care intends to engage in fundraising, you have the right to opt out of receiving such communications. If you authorize us to use or disclose your PHI for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose your PHI for the reasons contained within your authorization. However, we cannot take back disclosures already made with your permission.

6. Uses and Disclosures of PHI Permitted or Required by Law

In some circumstances, we may be legally permitted or required to use or disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization in certain situations, including, but not limited to:

- **Emergencies.** If you are incapacitated and require emergency medical treatment, we will use and disclose your PHI to ensure you receive the necessary medical services. We will attempt to obtain your consent as soon as practical following your treatment.
- **Others Involved in Your Healthcare:** Upon your verbal authorization, we may disclose to a family member, close friend or other person you designate only that PHI that directly relates to that individual's involvement in your health care and treatment. We may also need to use PHI to notify a family member, personal representative or someone else responsible for your care of your location and general condition.
- **Communication Barriers.** If we try but cannot obtain your consent to use or disclose your PHI because of substantial communication barriers and your physician, using his or her professional judgment, infers that you consent to such use or disclosure, or the physician determines that a limited disclosure is in your best interests, we may permit such use or disclosure.
- **Required by Law:** We may disclose your PHI to the extent that its use or disclosure is required by law. This disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Public Health/Regulatory Activities:** We may disclose your PHI to an authorized public health authority to prevent or control disease, injury, or disability or to comply with state

child or adult abuse or neglect law. We are obligated to report suspicion of abuse and neglect to appropriate regulatory agencies.

- **Food and Drug Administration:** We may disclose your PHI to a person or company as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations as well as to track product usage, enable product recalls, make repairs or replacements or to conduct post-marketing surveillance.
- **Health Oversight Activities.** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, and other activities necessary for the appropriate oversight of the health care system and government benefit programs such as Medicare and Medicaid.
- **Judicial and Administrative Proceedings.** We may only disclose your PHI in the course of any judicial or administrative proceeding in response to a court order expressly directing disclosure, or in accordance with specific statutory obligations compelling us to do so, or with your permission.
- **Law Enforcement Activities.** We may disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, or missing person, or complying with a court order or other law enforcement purpose. Under some limited circumstances we will request your authorization prior to permitting disclosure.
- **Coroners and Medical Examiners,** We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other lawful purpose.
- **Funeral Directors and Organ Donation Organizations**. We may disclose your PHI to enable a funeral director to carry out his or her lawful duties. PHI may also be disclosed to organ banks for cadaveric organ, eye, bone, tissue and other donation purposes.
- **Research.** We may disclose your PHI for certain medical or scientific research where approved by an institutional review board and where the researchers have a protocol to ensure the privacy and security of your PHI.
- **Serious Threats to Health or Safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military and National Security Activities.** We may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military authorities to assure proper execution of military missions. We also may disclose your PHI to certain federal officials for lawful intelligence and other national security activities.
- **Worker's Compensation:** We may disclose your PHI as authorized to comply with worker's compensation laws.
- **Inmates of a Correctional Facility:** We may use or disclose PHI if you are an inmate of a correctional facility and our practice created or received your PHI in the course of providing care to you while in custody.
- **US Department of Health and Human Services:** We must disclose your PHI to you upon request and to the Secretary of the United States Department of Health and Human Services to investigate or determine our compliance with privacy and security laws.
- **Disaster Relief Activities:** We may disclose your PHI to local, state or federal agencies engaged in disaster relief and to private disaster relief assistance organizations (such as the Red Cross if authorized to assist in disaster relief efforts).

7. Your Rights Regarding PHI

- **Right to Request Restrictions for Certain of Uses and Disclosures.** You have the right to request that we not use or disclose your PHI unless such a use or disclosure is required by law. Such a request must be made in writing and include the specific PHI you wish restricted as well as the individual(s) who should not receive the restricted PHI. If we agree to your request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. However, we not required to agree to your requested restriction except in the case of restricting disclosure of PHI to a health plan as described below.

  If you request a restriction on certain uses and disclosures of your PHI to a health plan for a particular health care item or service where said health care item or service is paid for out of pocket and in full, we will abide by your request. Such a request must made be made in writing to the practice Privacy Officer. Your request must describe in a clear and concise fashion the health care item or service you wish restricted.
- **Right to Access.** You have the right to inspect and obtain a copy of your PHI. You may request copies of your PHI in either paper or electronic form. In very limited circumstances, we may deny access to your PHI. To request access to your PHI, please submit a request in writing to the practice Privacy Officer including whether you want your copy in electronic or paper form. We will respond to your request as soon as possible, but no later than 30 days from the date of your request. If access is denied you will receive a denial letter within 30 days. If access is denied, an appeals process may be available in certain cases. We have the right to charge a reasonable fee for providing copies of your PHI (and for electronic media, if applicable). Furthermore, you may request that a copy of your PHI be transmitted directly to a third party provided such request is made in writing, signed by you and clearly identifies the designated third party and location to send your PHI.
- **Right to Confidential Communications.** You have the right to request to receive communication of PHI by alternative means or at alternative locations. For example, you may wish your bill to be sent to an address other than your home. Such requests must be made in writing to the practice Privacy Officer. We will not require an explanation of your reasons for the request, and will accommodate reasonable requests.
- **Right to Amend.** You have the right to request that we amend your PHI. Your request must be made in writing. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for amendment, you have the right to submit a written statement disagreeing with the denial. Central Florida Total Health Care has the right to submit a rebuttal statement. A record of any disagreement regarding amendments will become part of your medical record and may be included in subsequent disclosures of your PHI.
- **Right to an Accounting of Disclosures.** Subject to certain limitations, you have the right to a written accounting of disclosures by us of your PHI for not more than 6 years prior to the date of your request. Your right to an accounting applies to disclosures other than those made for purposes of treatment, payment, or health care operations. Please make your request in writing to the practice Privacy Officer. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. We will provide you with one accounting every 12 months free of charge. We will charge a reasonable fee based upon our costs for any subsequent accounting requests.

- **Right to a Copy of our Notice of Privacy Practices.** We will ask you to sign a written acknowledgement of receipt for our Notice of Privacy Practices. We may update this Notice of Privacy Practices at any time. Upon your request, we will provide you with a current copy of this Notice.
- **Right to Notice of Breach.** You have a right to receive notice if there has been a breach of your unsecured PHI.

8. Complaint Procedure

- **Within our Practice:** If you have a complaint about the denial of any of the specific rights listed above, about our Notice of Privacy Practices, or about our compliance with state and federal privacy laws you may receive more information about the complaint process by contacting the practice Privacy Officer at 407-392-1919
- **Outside our Practice:** If you believe that Central Florida Total Health Care is not complying with its legal obligations to protect the privacy of your PHI, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights.
- We will not retaliate against you for filing a complaint.

9. Effective Date. This Notice is effective as of September 23, 2013.

reviewed and modified as necessary to ensure that it accurately reflects your organization's privacy practices. Document and form approval should follow your standard operating procedures including, as applicable, consultation with your legal counsel.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Central Florida Total Health Care's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Central Florida Total Health Care may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Central Florida Total Health Care's *Notice of Privacy Practices* by submitting a request in writing for a current copy of Central Florida Total Health Care's *Notice of Privacy Practices.*

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

For Central Florida Total Health Care Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Central Florida Total Health Care made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

☐ Patient or patient's personal representative refused to sign

☐ Patient or patient's personal representative unable to sign

☐ Other_____

_____

Employee Name (printed)

_____ _____

Employee Signature Date