CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name: ______________________________ Date of Birth: ____________________ Age: ________

Preferred Name: ______________________ Ethnicity: __________ Language: _____________ Gender: ☐Male ☐Female

Address: ____

E-mail address: ____ SS #: ___________________________

Home #: ___________________________ Cell #: ___________________________ Work #: ____________________

Occupation: ________________________ ☐Full-time ☐Part-time ☐Student ☐Retired ☐Other: ______________

Employer/School: ____

Address: ____

Emergency Contact: ____ Phone #: _____________________

Insurance Information – Please present current copy of Insurance card.

Insurance Company: ____

Name insured: _______________________________ Date of birth: ___________________________

Policy #: ____________________________________ Group #: ___________________________________

Secondary insurance: ____

Motor Vehicle Accident (MVA)

Date of MVA: ____________ State MVA occurred: ________ Claim submitted: ☐ Yes ☐ No --- Pip coverage: ☐ Yes ☐ No

Insurance company: ______________________________ Claim number: ______________________________

Adjuster name: __________________________________ Adjuster phone: _____________________________

Attorney name: __________________________________ Attorney phone: _____________________________

Primary Physician: ____ Phone: ____________________

For which condition(s) ____

Specialist: ____ Phone: ____________________

For which condition(s) ____

Pharmacy: ____ Phone: ____________________

Address: ____

Please be aware that e-mail is not secure communication and that discussion of medical care will become part of medical record.

What is the **best way** to communicate with you between office visits? ☐E-mail ☐Home ☐Work ☐Cell ☐Other: _____________

Is there any place you do **NOT** want me to leave a message? ____________________________________

May your doctor send you educational and promotional materials such as newsletters via e -mail? ☐Yes ☐No May your doctor discuss your private medical information with you via e-mail? ☐Yes ☐No

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of Patient____ **Today's Date**_________________

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: ______________________________ Date: ______________

CHIEF COMPLAINTS: Primary concern first.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

PAST MEDICAL HISTORY: Indicate whether you have had any of the following diseases.

☐ Cancer	☐ Diabetes	☐ Allergies	☐ Epilepsy
☐ High blood pressure	☐ Heart disease	☐ Asthma	☐ Stroke
☐ Anemia	☐ Kidney disease	☐ Tuberculosis	☐ Glaucoma
☐ Arthritis	☐ Liver disease	☐ Pneumonia	☐ Mental illness
☐ Back injury	☐ Diverticulitis	☐ COPD	☐ Alzheimer's disease

Any other diseases: Not listed above.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

FAMILY HEALTH HISTORY: Indicate whether a family member has **ANY** disease(s). See prompts above.

Relationship	Name	Age if living	Age at death	Disease(s)
Father				
Mother				
Brother(s)				
Sister(s)				
Paternal grandparents				
Maternal Grandparents				
Children				

Name: ______________________________ Date: ______________

ALLERGIES (drugs, food, or environmental substances)

Substance:	**Reaction:**

MEDICATION CURRENTLY TAKEN:	**MEDICATION PREVIOUSLY TAKEN:**

IMMUNIZATION HISTORY

SURGICAL HISTORY: List procedures and dates

HOSPITALIZATIONS, IMAGING & TEST HISTORY with DATES

SUPPLEMENTS (herbs, vitamins & OTC)

Name: ______________________ Date: ______________

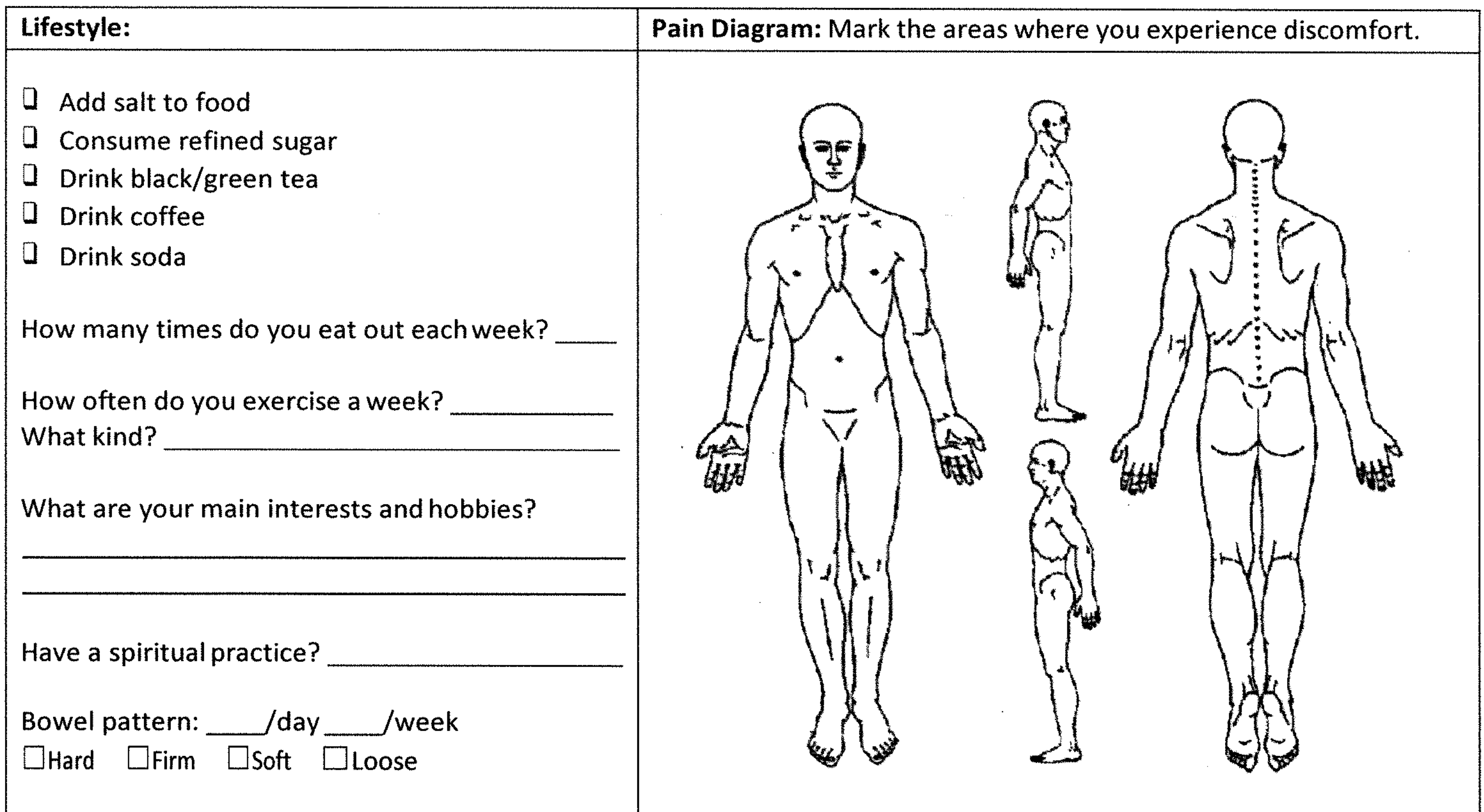
SOCIAL HISTORY

Marital status: ______________________
Have a supportive relationship: ______________________
Living arrangements: ______________________

Number of children: ______________________
Number of adults in household: ______________________
Sexually active: ______________________
Birth control method: ______________________
Employment: ______________________
Enjoy your work: ______________________
Education level: ______________________

Alcohol history: ______________________
Frequency of drinks: ______________________
Number of years drinking alcohol: ______________________

Tobacco history: ______________________
Number of cigarettes/day: ______________________
Number of years using tobacco: ______________________
Have you ever used illegal drugs: ______________________
Have you ever used cocaine: ______________________
Have you ever used marijuana: ______________________
Number of years using drugs: ______________________



Lifestyle:

- ❑ Add salt to food
- ❑ Consume refined sugar
- ❑ Drink black/green tea
- ❑ Drink coffee
- ❑ Drink soda

How many times do you eat out each week? _____

How often do you exercise a week? ___________
What kind? ______________________

What are your main interests and hobbies?
____
____

Have a spiritual practice? ______________________

Bowel pattern: ____/day ____/week
☐Hard ☐Firm ☐Soft ☐Loose

Pain Diagram: Mark the areas where you experience discomfort.

FEMALE ONLY

Menstrual History

Last menstrual period: ______________________
Age at menarche (first period): ______________________
Birth control method: ______________________
Duration of menstrual cycle: ______________________
Duration of menstruation: ______________________
Menstrual pain: ______________________
Menopausal symptoms: ______________________
Last mammogram: ______________________
Last pap-smear: ______________________
Last dexa scan: ______________________

Pregnancy History

Sum of all pregnancies (Gravida): ______________________
Number of deliveries after 37 weeks: ______________________
Number of deliveries > 19 weeks and < 37 weeks: ________
Number of abortions induced (TAB): ______________________
Number of abortions spontaneous (miscarriages): ________
Number of multiple births: ______________________
Ectopics: ______________________
Number of living children at birth: ______________________
Delivery dates: ______________________
Type of delivery: ______________________

Review of Systems

Mark any of the following you have or have had in the past 6 months.

BREAST
- ❑ Breast implants
- ❑ Breast mass
- ❑ Breast pain
- ❑ Chest tenderness
- ❑ Gynecomastia
- ❑ Irregular lactation
- ❑ Nipple discharge

CONSTITUTIONAL
- ❑ Anorexia
- ❑ Chills
- ❑ Cravings
- ❑ Daytime hypersomnolence (sleepy)
- ❑ Diaphoresis (sweating)
- ❑ Experience high stress
- ❑ Fatigue
- ❑ Fever
- ❑ Generally feel cold
- ❑ Generally feel hot
- ❑ Insomnia
- ❑ Low libido
- ❑ Malaise
- ❑ Night sweats
- ❑ Poor sleep
- ❑ Recent illness
- ❑ Weakness
- ❑ Weight gain
- ❑ Weight loss

EYES
- ❑ Amblyopia (lazy eye)
- ❑ Blindness
- ❑ Blurred vision
- ❑ Cataract
- ❑ Color blindness
- ❑ Diabetic retinopathy
- ❑ Double vision
- ❑ Dry eyes
- ❑ Eye discharge
- ❑ Eye erythema (redness)
- ❑ Eye foreign body
- ❑ Eye pain
- ❑ Eye trauma
- ❑ Eyelid edema (swelling)
- ❑ Eyelid pain
- ❑ Floaters in vision
- ❑ Glasses/contacts
- ❑ Glaucoma
- ❑ Impaired vision/blurriness
- ❑ Itchy eyes
- ❑ Macular degeneration
- ❑ Photophobia (aversion bright light)
- ❑ Scotomata (defect in vision)
- ❑ Vision change
- ❑ Vision disturbance
- ❑ Watery eyes

EAR, NOSE & THROAT
- ❑ Broken tooth
- ❑ Cancer of the head/neck
- ❑ Cerumen (earwax)
- ❑ Cosmetic deformity
- ❑ Dental pain
- ❑ Difficulty hearing
- ❑ Dizziness
- ❑ Dry mouth
- ❑ Dysphagia (difficulty swallowing)
- ❑ Earaches
- ❑ Epistaxis (nose bleed)
- ❑ Eustachian tube dysfunction
- ❑ Facial fracture
- ❑ Facial mass
- ❑ Facial pain
- ❑ Facial swelling
- ❑ Facial weakness
- ❑ Gagging/choking
- ❑ Gastroesophageal reflux
- ❑ Globus sensation (lump in throat)
- ❑ Halitosis (bad breath)
- ❑ Hay fever
- ❑ Headache
- ❑ Hearing difficulty/loss
- ❑ Hiccups
- ❑ Hoarseness
- ❑ Hyposmia (reduced ability to smell)
- ❑ Jaw pain
- ❑ Laceration of head or neck
- ❑ Laryngeal lesion
- ❑ Laryngeal mass
- ❑ Mucosal bleeding
- ❑ Nasal allergies
- ❑ Nasal discharge
- ❑ Nasal lesion
- ❑ Nasal mass
- ❑ Nasal obstruction
- ❑ Nasal pain
- ❑ Nasal polyps
- ❑ Nasal trauma
- ❑ Neck mass
- ❑ Neck pain
- ❑ Neck swelling
- ❑ Odynophagia (painful swallowing)
- ❑ Oral lesion
- ❑ Oral mass
- ❑ Oral pain
- ❑ Otitis externa (swimmers' ear)
- ❑ Otitis media (middle ear infection)
- ❑ Otorrhea (ear drainage)
- ❑ Postnasal drip
- ❑ Scar of the head or neck
- ❑ Sinus congestion
- ❑ Sinus problems
- ❑ Sinusitis
- ❑ Sleep apnea-obstruction
- ❑ Sleep disordered breathing
- ❑ Snoring
- ❑ Sore throat
- ❑ Taste change
- ❑ Teeth grinding
- ❑ Tinnitus (ear ringing)
- ❑ Tonsillitis
- ❑ Tooth pain
- ❑ Tracheotomy problems
- ❑ Trauma of the head or neck
- ❑ Tympanic membrane perforation
- ❑ Vocal cord paralysis
- ❑ Voice change
- ❑ Xerostomia (dry mouth)

CARDIOVASCULAR
- ❑ Arrhythmia
- ❑ Blood clots
- ❑ Chest pain/pressure
- ❑ Claudication
- ❑ Cold hands/feet
- ❑ Dyspnea (difficulty breathing)
- ❑ Easy bleeding or bruising
- ❑ Exercise intolerance
- ❑ Fatigue
- ❑ Hypertension
- ❑ Irregular heart beat
- ❑ Murmur
- ❑ Near-syncope/dizziness

- ❑ Palpitations
- ❑ Swelling in ankles/feet
- ❑ Syncope
- ❑ Tachycardia

RESPIRATORY

- ❑ Apneic events (cessation of breath)
- ❑ Asbestos (silicate minerals)
- ❑ Aspiration (inhaled fluid/object)
- ❑ Asthma
- ❑ Broncholiths (calcifications)
- ❑ Chest congestion
- ❑ Chest tenderness
- ❑ Chest tightness
- ❑ Cigarette smoking
- ❑ COPD/emphysema
- ❑ Cough
- ❑ Dyspnea (difficult breathing)
- ❑ Dyspnea on exertion
- ❑ Foul smelling sputum
- ❑ Hemoptysis (coughing blood)
- ❑ Hiccups
- ❑ Nocturnal (nighttime) cough
- ❑ Occupational exposure
- ❑ Orthopnea (dyspnea lying flat)
- ❑ Passive smoking
- ❑ Pleuritic pain (sharp on inhalation)
- ❑ PPD positive (TB skin test)
- ❑ Productive sputum
- ❑ Snoring
- ❑ Stridor (high pitched wheeze)
- ❑ Tuberculosis exposure
- ❑ Wheezing

GASTROINTESTINAL

- ❑ Abdominal pain
- ❑ Anorexia
- ❑ Belching/passing gas
- ❑ Black/bloody stool
- ❑ Change in thirst
- ❑ Constipation
- ❑ Decreased abdominal girth
- ❑ Diarrhea
- ❑ Dyspepsia (indigestion)
- ❑ Dysphagia (difficulty swallowing)
- ❑ Gas and bloating
- ❑ Gastroesophageal reflux
- ❑ Gum problems
- ❑ Heartburn
- ❑ Hematemesis (vomiting blood)
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hernia
- ❑ Increased abdominal girth
- ❑ Itching/burning anus
- ❑ Jaundice (yellow skin/eyes)
- ❑ Liver/gallbladder trouble
- ❑ Melena (blood in the stool)
- ❑ Nausea
- ❑ Odynophagia (painful swallowing)
- ❑ Rectal pain
- ❑ Vomiting

GENITOURINARY/NEPHROLOGY

- ❑ Acute renal failure
- ❑ Anuria/oliguria (low urine output)
- ❑ Breast complaint
- ❑ Change in sex drive
- ❑ Chronic renal failure
- ❑ Dysuria (painful urination)
- ❑ Flank pain (side or mid-back)
- ❑ Frequency at night
- ❑ Frequent infections
- ❑ Genital lesion
- ❑ Hematuria (blood in the urine)
- ❑ Hernia
- ❑ Hyperkalemia (high potassium)
- ❑ Hypernatremia (high sodium)
- ❑ Hypertension
- ❑ Hypokalemia (low potassium)
- ❑ Hyponatremia (low sodium levels)
- ❑ Impotence (unable to have sex)
- ❑ Inability to hold urine
- ❑ Kidney stones
- ❑ Menopausal symptoms
- ❑ Menstrual irregularity
- ❑ Nocturia (waking to urinate)
- ❑ Ovarian cysts
- ❑ Pap smear abnormality
- ❑ Pelvic pain
- ❑ Penile pain/discharge
- ❑ Pregnancy
- ❑ Testicular mass
- ❑ Testicular pain
- ❑ Urinary frequency
- ❑ Urinary incontinence
- ❑ Urinary retention/hesitancy
- ❑ Urinary tract obstruction
- ❑ Urinary urgency
- ❑ Vaginal discharge
- ❑ Vaginal dryness

MUSCULOSKELETAL

- ❑ Arthralgia (joint pain)
- ❑ Back pain
- ❑ Body aches
- ❑ Bone fracture
- ❑ Bone pain
- ❑ Carpal tunnel syndrome
- ❑ Fatigue/low energy
- ❑ Jaw pain
- ❑ Joint complaint
- ❑ Joint pain
- ❑ Knee pain
- ❑ Leg pain
- ❑ Low back pain
- ❑ Mid-back pain
- ❑ Muscle weakness
- ❑ Myalgias (muscle pain)
- ❑ Neck pain
- ❑ Osteoporosis
- ❑ Restless leg syndrome
- ❑ Sciatica
- ❑ Shoulder pain
- ❑ Stiffness
- ❑ Swelling

DERMATOLOGIC

- ❑ Acne
- ❑ Acrochordon (skin tags)
- ❑ Alopecia (loss of hair)
- ❑ Arthropod bite (insect bite/sting)
- ❑ Callus
- ❑ Cellulitis (bacterial skin infection)
- ❑ Cyst
- ❑ Dermatitis
- ❑ Dry skin
- ❑ Ecchymosis (large bruised area)
- ❑ Eczema
- ❑ Folliculitis (infection of hair follicle)
- ❑ Fungal infections
- ❑ Hair loss
- ❑ Hair problem
- ❑ Hemangioma (“strawberry”)
- ❑ Herpes simplex
- ❑ Hyperhidrosis (sweat excessively)
- ❑ Impetigo (skin infection)
- ❑ Keloid (scar with extra scar tissue)
- ❑ Lesions of concern
- ❑ Lupus erythematosus
- ❑ Melanoma (skin cancer)
- ❑ Milium (tiny white cysts)
- ❑ Mole change

- ❑ Nail problem
- ❑ Neoplasm (tumor)
- ❑ Night sweats
- ❑ Paronychia (infection around nails)
- ❑ Pruritus (itching)
- ❑ Psoriasis
- ❑ Rash
- ❑ Scabies
- ❑ Scar
- ❑ Skin cancer
- ❑ Skin laxity (lack of firmness)
- ❑ Sores
- ❑ Telangiectasia (spider veins)
- ❑ Thrombocytopenia
- ❑ Thrombocytosis
- ❑ Venous thrombosis

NEUROLOGIC

- ❑ Alteration of consciousness
- ❑ Aphasia (language disorder)
- ❑ Ataxia (uncoordinated movement)
- ❑ Blurred vision
- ❑ Burning
- ❑ Disturbances of memory
- ❑ Disturbances of thinking
- ❑ Dizziness
- ❑ Drop foot
- ❑ Dyskinesia or tremor
- ❑ Easily stressed
- ❑ Gait abnormality
- ❑ Headache
- ❑ Headache/migraine
- ❑ Hearing loss
- ❑ Memory loss
- ❑ Mental status change
- ❑ Neck pain
- ❑ Numbness or tingling
- ❑ Pain, back
- ❑ Pain, generalized
- ❑ Pain, extremity
- ❑ Paresis
- ❑ Paresthesia ("pins and needles")
- ❑ Seizure
- ❑ Spasms/spasticity
- ❑ Speech difficulties
- ❑ Syncope (fainting)
- ❑ Tinnitus (ear ringing)
- ❑ Tremor
- ❑ Vertigo (type of dizziness)
- ❑ Vision change
- ❑ Weakness

PSYCHIATRIC

- ❑ Alcohol abuse
- ❑ Anxiety
- ❑ Brain fog
- ❑ Dissociative phenomenon
- ❑ Depression
- ❑ Disturbances of consciousness
- ❑ Disturbances of emotion
- ❑ Disturbances of memory
- ❑ Disturbance of thinking
- ❑ Drug abuse
- ❑ Eating disorder
- ❑ Hallucination
- ❑ Insomnia
- ❑ Mania
- ❑ Mood swings
- ❑ Poor concentration
- ❑ Poor memory
- ❑ Psychosis
- ❑ Seasonal depression
- ❑ Suicidality

ENDOCRINE

- ❑ Acromegaly (excess HGH)
- ❑ Adrenal excess
- ❑ Adrenal insufficiency
- ❑ Carcinoid (type of cancer)
- ❑ Chills
- ❑ Cold intolerance
- ❑ Diabetes insipidus
- ❑ Diabetes mellitus Type 1
- ❑ Diabetes mellitus Type 2
- ❑ Fatigue
- ❑ Flushing
- ❑ Frequent hunger
- ❑ Frequent thirst
- ❑ Frequent urination
- ❑ Galactorrhea (nipple discharge)
- ❑ Goiter (enlarged thyroid)
- ❑ Gynecomastia
- ❑ Hair loss
- ❑ Heat intolerance
- ❑ Hirsutism (excess hair growth)
- ❑ Hypercalcemia (increased calcium)
- ❑ Hyperglycemia (increased glucose)
- ❑ Hyperlipidemia (increased lipids)
- ❑ Hyperthyroidism (overactive)
- ❑ Hypocalcemia (decreased calcium)
- ❑ Hyponatremia (decreased sodium)
- ❑ Hypothyroid (underactive)
- ❑ Muscle spasm
- ❑ Obesity
- ❑ Pheochromocytoma (tumor)
- ❑ Primary amenorrhea
- ❑ Seasonal depression
- ❑ Secondary amenorrhea
- ❑ Thirst
- ❑ Thyroid nodule
- ❑ Virilization (high testosterone)

HEMATOLOGIC/LYMPHATIC

- ❑ Abnormal bleeding
- ❑ Abnormal ecchymosis (bruising)
- ❑ Anemia
- ❑ Arterial thrombosis (blood clot)
- ❑ Eosinophilia
- ❑ Erythrocytosis
- ❑ Leukocytosis
- ❑ Leukopenia
- ❑ Lymph node enlargement/mass
- ❑ Neutropenia
- ❑ Petechiae (small purple spots)
- ❑ Prolonged bleeding time
- ❑ Prolonged PT (INR)
- ❑ Prolonged PTT
- ❑ PE (blocked pulmonary artery)
- ❑ Swollen glands
- ❑ Tinea (ringworm)
- ❑ Varicose veins
- ❑ Verruca (warts)
- ❑ Vitiligo (loss of pigmentation)

ALLERGY/IMMUNOLOGY

- ❑ Anaphylactic reaction
- ❑ Angioedema
- ❑ Animal allergies
- ❑ Chronic infections
- ❑ Food allergy
- ❑ Frequent colds
- ❑ Hay fever
- ❑ Loss of smell
- ❑ Medication allergies
- ❑ Raynaud's phenomenon
- ❑ Rhinitis
- ❑ Seasonal allergies
- ❑ Seasonal depression
- ❑ Sinus problems
- ❑ Slow wound healing
- ❑ Stuffiness
- ❑ Urticaria

CONTEXT OF CARE

We would like to take a moment to welcome you to our office. Whether you are here for a one-time visit, or are looking for a longer-term comprehensive health solution, we look forward to our role in your care. Below are a few questions that really assist us in understanding "where you're coming from" and how we can best support your health.

1. How did you discover this clinic and how did you decide to see us?

2. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

   0% **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** 100%

   If you answered less than "10", what stands between your current commitment and 100%?

3. What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

4. What do you love most about your life at this time?

5. What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

6. What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that I will be sharing with you?

7. What are your top three expectations of your office visit?

INFORMED CONSENT

The purpose of this form is to present risks and benefits of the therapies I offer. **Please initial the sections that apply to you. This must be signed before treatment is rendered.** Ask me of you have any questions or concerns at anytime.

MODERN MEDICINE

Initials:_______Date:__________________________

Modern Medicine is the science and art of treating and preventing disease. Modern medicine has progressed over time. From the discovery of the first antibiotic to the rise of chemotherapy, nothing has stopped scientists from broadening the medical field. Much of modern medicine is now directed toward problems our society faces such as cancer and heart disease. Modern medicine emphasizes the physician's responsibility to help patients and families in the overall management of their health problems.

SUPPLEMENTS, HERBALS, HOMEOPATHICS

Initials:_______Date:__________________________

These are products that can aid in healing by nutritional, energetic, and mechanical support; they can be effective for many conditions. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, and less commonly allergic reaction. If biomechanical support is needed, back braces, cervical pillows, cervical traction, or orthotics may be suggested for your particular case.

IMAGING, REFERRALS

Initials:_______Date:__________________________

Further lab work (X-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested. The following are examples: medical management (referral to a specialist such as neurologist, ENT, allergist, etc.), physical therapy, vestibular testing, psychological evaluation, injection therapy, surgery, naturopathic, chiropractic, acupuncture, massage, etc.

Please inform our office of any changes in symptoms, medications, diagnoses by other doctors, and if there is a chance of pregnancy at any time during your care.

I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments initialed above.

Patient Name (Please Print) ____

FINANCIAL POLICIES

1. **Unless prior arrangement is made, full payment is due at the time of service.**

   Your payment options are: cash, check, or credit/debit cards. We accept Visa, Master Card, Discover, or American Express.

2. Insurance Billing

   If you would like us to bill your insurance, we will contact your insurer(s) and bill them based upon the **non-guaranteed** information they provide to us.

   You are responsible for all co-payments, deductibles and other adjustments made by your insurer(s).

   If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service.

   Insurance companies may reimburse differently than the information they initially provide to us.

   You are responsible for and will be billed for any resulting unpaid balance.

3. Missed Appointments/Late Cancellations

   All appointment cancellations must occur within 24 hours of the appointment. If it is less than 24 hours, **you will be charged based on the provider for the missed appointment.** Missed appointment charges are subject to change. If you have any questions regarding the missed appointment fee per provider, please contact the staff at (727) 498-8898.

   Medical New Patient missed appointment fee: $100.00
   Medical Follow-up missed appointment fee: $ 50.00

4. Past Due Accounts

   Accounts greater than 30 days past due will be charge a $10 administrative fee.

   Accounts greater than 90 days overdue will be sent to a collections agency.

These policies are subject to change without notice.

I have read, understood and agree to the policies described above:

Print Name: ____

Signature: ____ Date: ____________________

Notice of Privacy Practices

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected health information," including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice. New Notices will be posted in the office and you may obtain one at any time. This Notice goes into effect July 01, 2013.

Uses and Disclosures

We may use and disclose your health information for different reasons.

- **Treatment:** To assist in your diagnosis and treatment.
- **Payment:** In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.
- **Health Care Operations:** For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

We must disclose, when required by law, for the following examples:

- **Avoid threat to health or safety.** To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.
- **Coroners, Funeral Directors, Organ Donation.** To said professionals such that they can carry out their duties.
- **Health oversight activities.** To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.
- **Health-related benefits or services.** For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.
- **Law Enforcement, judicial and administrative proceedings.** In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.
- **National security and intelligence.** As required by military officials for security and military purposes.
- **Public health activities.** To public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Research.** For medical research – Such circumstances include taking steps to protect your privacy.
- **Victims of abuse, neglect or domestic violence.** To government agencies and law enforcement personnel as required by law.
- **Workers' compensation.** In compliance with workers' compensation laws.

Authorization

Any uses or disclosures other than those described above will be made **only** with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

Patient Rights

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to our office. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact the office. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.

Right to inspect and copy. Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to the office and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.

Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to the office staff. We will respond within 60 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.

Right to receive an accounting of disclosures. This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee inadvance.

Right to get a paper copy of this Notice. At any time even if you previously agreed to receive an electronic copy.

Right to file a complaint. If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact our office at (727) 498-8898 to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with the DHHS or us.

I acknowledge having carefully read this copy of the Notice of PrivacyPractices.

Patient Name (Please print)______________________________

Patient/Guardian Signature______________________________Date______________

Relationship to Patient (if other than self):______________________________

Note: If a legal representative is signing this acknowledgement, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

___Appointment Date/Times ___Diagnosis ___X-ray Results ___Medications
___Lab Tests/Results ____ Summary of Medical Record ___Care Plan
___ Other (specify): ____

Patient Name: ____
Date of Birth: ____

Information to be given to:

Name: ______________________________________
Relationship: ______________________________________
Address: ______________________________________
Phone: ______________________________________

This authorization shall remain in effect from the date signed below until (please check one):
□ (specify expiration date or event)
□ NO EXPIRATION DATE

______________________ ______________________
Signature: Date: