



**PHONE: 352-536-6340**

**Patient Registration Packet**

*Please read and sign the enclosed forms.*

**BRING THIS COMPLETED PACKET TO  
Clermont Ambulatory Surgical Center  
on your date of surgery.**

**255 Citrus Tower Blvd., Suite 100  
Clermont, FL 34711**



## **PRIOR TO YOUR SURGERY:**

- You will receive a link to our patient portal to fill out your medical history. This **MUST** be completely filled out for the clinical staff to effectively take care of your needs.
- Follow all pre-op instructions given to you by your surgeon to prepare for you procedure.
- **DO NOT EAT OR DRINK** after midnight leading up to your procedure day. This includes water, food, and mints.
- Fill out the enclosed demographic form and bring it with you on the day of your surgery.
- Our clinical staff will call you at least 24 hours prior to your surgery date with the time of your arrival. If you do not receive a call by 2:00 PM the day prior or if you require special needs, please call us at 352-536-6340.

## **DAY OF YOUR PROCEDURE:**

- If your procedure requires anesthesia, you must be accompanied by a competent adult over 18 years of age with a valid driver's license.
- Bring a legal picture ID, such as a driver's license or ID card, a military ID, or other government issued identification.
- Bring your insurance card(s).
- Bring a form of payment to take care of your copay, coinsurance, or deductible. Our insurance specialist will notify you prior to your surgery date if you have any financial responsibility.
- Please remove all jewelry and leave your valuables at home.

## **AFTER YOUR PROCEDURE:**

- You will receive another link to your patient portal to see how you are doing, and/or you will receive a phone call from our staff to enquire on how you are doing.
- At discharge, you received a Thank You card with a website and QR code to fill out our patient survey. **PLEASE TAKE THE TIME TO DO THIS** and let us know how we did. This tells us if there are any areas where we can improve or give recognition to staff members.

**\*PLEASE NOTE: IF YOU DO NOT HAVE A PHOTO ID, OR IF YOU DON'T HAVE A REQUIRED DRIVER, YOUR SURGERY WILL HAVE TO BE RESCHEDULED\***



**◆ CLERMONT ◆**  
**Ambulatory Surgical Center**

*at Citrus Tower Professional Center*

255 Citrus Tower Blvd., Suite 100  
Clermont, FL 34711

**NAME**

**ADDRESS**

**CITY**

**STATE**

**ZIP CODE**

( )

**HOME PHONE**

/ /

**DATE OF BIRTH**

( )

**CELL PHONE**

/ /

**SSN**

**SEX**

**RACE**

**NATIONALITY**

**LANGUAGE**

**MARITAL STATUS**

**EMAIL ADDRESS**

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

**NAME OF DRIVER**

**RELATIONSHIP**

**PHONE NUMBER**

**NAME OF EMERGENCY CONTACT**

**(NOT LIVING WITH YOU)**

**RELATIONSHIP**

**PHONE**

**The HIPAA Privacy Rule gives the individual the right to request that their confidential communications be decided by the individual. Please check off the all the ways we may contact you:**

**Home phone**

**OK to leave detailed message**

**Cell Phone**

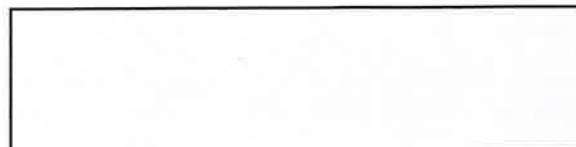
**OK to leave detailed message**

**Leave message with call back number only**

**X**

**Signature**

**Date**



COPY

ORIGINAL will be signed at the facility

## CLERMONT AMBULATORY SURGICAL CENTER

### AUTHORIZATION AND CONSENT TO SURGERY AND/OR OTHER MEDICAL SERVICES

Florida State Law guarantees that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advise, but as a member of the health care team, you must enter into the decision-making process. This form has been designed to acknowledge our acceptance of treatment recommendations by your physician at Clermont Ambulatory Surgical Center (hereinafter CASC).

1. **Consent to Surgical or Diagnostic Procedure:** I acknowledge that I have directed my physician Dr. \_\_\_\_\_, and / or associates or assistants of his/her choice to perform the following operation and/or diagnostic procedure(s) on me: \_\_\_\_\_ and/or such operation(s) or any other therapeutic procedure(s) upon me which they may deem necessary or advisable. My physician or his/her designee has explained to me the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards including bleeding, infection inherent in the proposed operation(s) or procedures(s). Based on the information provided by my physician or his/her designee, I have a general understanding of the operation to be performed on me and that no warranty or guarantee has been made as to the result or cure.
2. **Consent to Other Medical Services:** I hereby authorize and direct the above named physician and his/her associates or assistants to provide such additional services for me as he/she may deem necessary or advisable including, but not limited to, the performance of services involving pathology and radiology and I hereby consent to all such additional services.
3. **Authorization to Release Medical Information:** I hereby authorize CASC, Florida Anesthesia and Pain Management Associates, LLC (FAPMA), my insurance company, any treating physicians and my attorney, when applicable to obtain, use and/or release information for the purposes of treatment, payment, and/or operations, as outlined in the Notice of Privacy Practices. This may include collection agencies, credit bureaus, and myself, and will be limited to the minimum amount necessary. I hereby authorize CASC to obtain PHI from other facilities, if needed, for the continuation of my care or for the follow up care related to my procedure or visit at CASC.
4. **Consent for Anesthesia Services:** I understand that anesthesia services are needed in most cases so that my doctor can perform the procedure. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to a specific type of anesthesia. I understand that the types(s) of anesthesia service used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. This will be discussed and explained to me with the anesthesia personnel prior to my procedure. I hereby consent to anesthesia services to be provide to me from FAPMA, all of whom are credentialed to provide anesthesia services at CASC.
5. **Photography/Observation:** Here at CASC, I understand that medical personnel and students may observe my care under the supervision of a qualified instructor, physician and/or registered nurse. For the purpose of advancing medical knowledge, I consent to the admittance of healthcare students and technical representatives under the supervision in accordance with ordinary practices of CASC. Some procedures may be photographed or videotaped for medical documentation and/or to enable the surgical team to visualize the procedure.
6. **Diagnostic Laboratory Testing:** I hereby consent to diagnostic laboratory blood testing (i.e. HIV, Hepatitis as designated by my physician for the purposes of treatment, safety and accidental exposure. I understand these test results will be kept confidential and only those required or permitted by law will know the results and my identity and that of my physician will inform me of my test results and any follow-up testing/care required.

7. **Tissue Disposal:** I hereby consent to the removal and examination of appropriate tissue during surgery and authorize the physician and/or pathologist to use his/her discretion in the disposal of any severed tissue, member, organ or hardware removed from me during the operation or procedure described above.
8. **Consent to Transfer:** This is to certify that I voluntarily consent to be transferred from CASC to a regional hospital if deemed necessary, by my physician for continued medical care. I consent to authorize the release of information for medical necessity for transport a higher level of care. I hereby forever release CASC, its employees, representatives, other facility authorities and the attending Physician from any and all claims and actions for damages, of whatever kind, cause of nature, resulting from the transport to the hospital and care received after I leave CASC.
9. **Patient Rights and Responsibilities and Notice of Privacy Rights and Practices:** I acknowledge that I have been provided a copy of both and understand my patient rights and responsibilities and patients' privacy rights and practices. I consent CASC to disclose protected health information about me for treatment, payment and health care operations as described in CASC Notice of Privacy Rights and Practices. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Please indicate below (by name and relationship) the person(s) with whom we may discuss your protected health information: \_\_\_\_\_.

10. **Assignment of Benefits:** I hereby assign all my insurance benefits under the described policies and authorize CASC and FAPMA to bill for charges incurred and to provide any medical information necessary to process this claim. I authorize payment to be made directly to CASC and FAPMA. I understand that I am responsible for all charges, even if I have insurance coverage including co-payment and/or deductible.
11. **Medicare Part B Signature Authorization Release of Information and Payment Request:** Medicare patient – I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I request payment under the medial insurance program to be made either to me or CASC to inquire about and receive any information about any and all of my Medicare Part B claims, assigned and/or assigned.
12. **Notice of Disclosure of Ownership Interest:** CASC is owned by Healthcare Services of FL. And two local physicians, Leonor Santos, M.D., and Richard Smith, M.D. one of whom may be your physician. These physicians have become owners to ensure their patients receive quality health care and services. Under Florida Law, a physician-owned facility may not provide items or service unless the patient signs a written notice disclosing certain matters. A schedule of typical fees for services provided by CASC is available at your request. You have the right to have your procedure at any other facility where your physician has privileges.
13. **Advance Directives:** Ambulatory Surgery Centers perform predominantly elective procedures. CASC, as per our policy, will not honor any patient or family request for a "No Code" or "DNR" for any procedure scheduled at the facility. We will keep a copy of any Advance Directive on the patients chart if provided to us. In case of transfer of patient to another healthcare facility, CASC will send a copy of the Advance Directive to the receiving medical facility.

Patient's Signature \_\_\_\_\_ Date/Time \_\_\_\_\_

Witness or Legal Authorized Representative \_\_\_\_\_ Date/Time \_\_\_\_\_  
 Agendamento, Consulta, 66181, Mudança

**Florida Anesthesiology and Pain Management Associates, LLC**  
483 North Semoran Boulevard, Suite 204, Winter Park, FL 32792

Dear Patient or Guardian,

Our goal is to provide you with the best anesthesia care available to you, regardless of insurance. We are in-network with a vast majority of insurances, however, if with your insurance we are not in-network, there is a possibility that you may receive an Explanation of Benefits (EOB) from your insurance company with a larger than normal balance due. We will work diligently with your insurance company to negotiate reimbursement for these services and keep your out-of-pocket expenses to a minimum. If you receive a statement in the mail, you may contact the Clermont Ambulatory Surgical Center, 352-536-6340, with questions about your bill or to set up a payment plan. If your insurance covers these charges in full, you will not receive a statement.

We will do everything that we can to ensure that your insurance company pays for services rendered. If there is a financial obligation on your part, we will work with you to find an agreeable arrangement for everyone.

Sincerely,

**Florida Anesthesiology and Pain Management Associates, LLC**



255 Citrus Tower Bl, Suite 100  
Clermont, FL 34736  
352-536-6340

**Clermont Ambulatory Surgical Center is conveniently located at the Citrus Tower Professional Center. We are across from the Publix Shopping Plaza.**

**TRAVELING FROM THE NORTH (LEESBURG, THE VILLAGES, OR OCALA):**

Take HWY 27/441 South until you come to the traffic signal at Citrus Tower Blvd and turn LEFT. There will be a right turn lane you will want to be in so you can turn RIGHT at the second entrance. We are the two-story building with the green roof.

**TRAVELING FROM THE SOUTH (POLK COUNTY, DAVENPORT):**

Take HWY 27 North. \*\*\*Please note, there are TWO different Citrus Tower Blvd cross streets, you want to turn RIGHT at the second Citrus Tower Blvd. (It is approximately 1-2 miles after the Walmart on John's Lake Blvd). After you turn on to Citrus Tower Blvd, there will be a right turn lane you will want to be in so you can turn RIGHT at the second entrance. We are the two-story building with the green roof.

**TRAVELING FROM THE WEST (GROVELAND, BROOKSVILLE):**

Take HWY 50 East. Take the exit onto HWY 27 North and drive approximately 1 mile till you get to Citrus Tower Blvd and turn RIGHT. After you turn on to Citrus Tower Blvd, there will be a right turn lane you will want to be in so you can turn RIGHT at the second entrance. We are the two-story building with the green roof.

**TRAVELING FROM THE EAST (WINTER GARDEN, ORLANDO):**

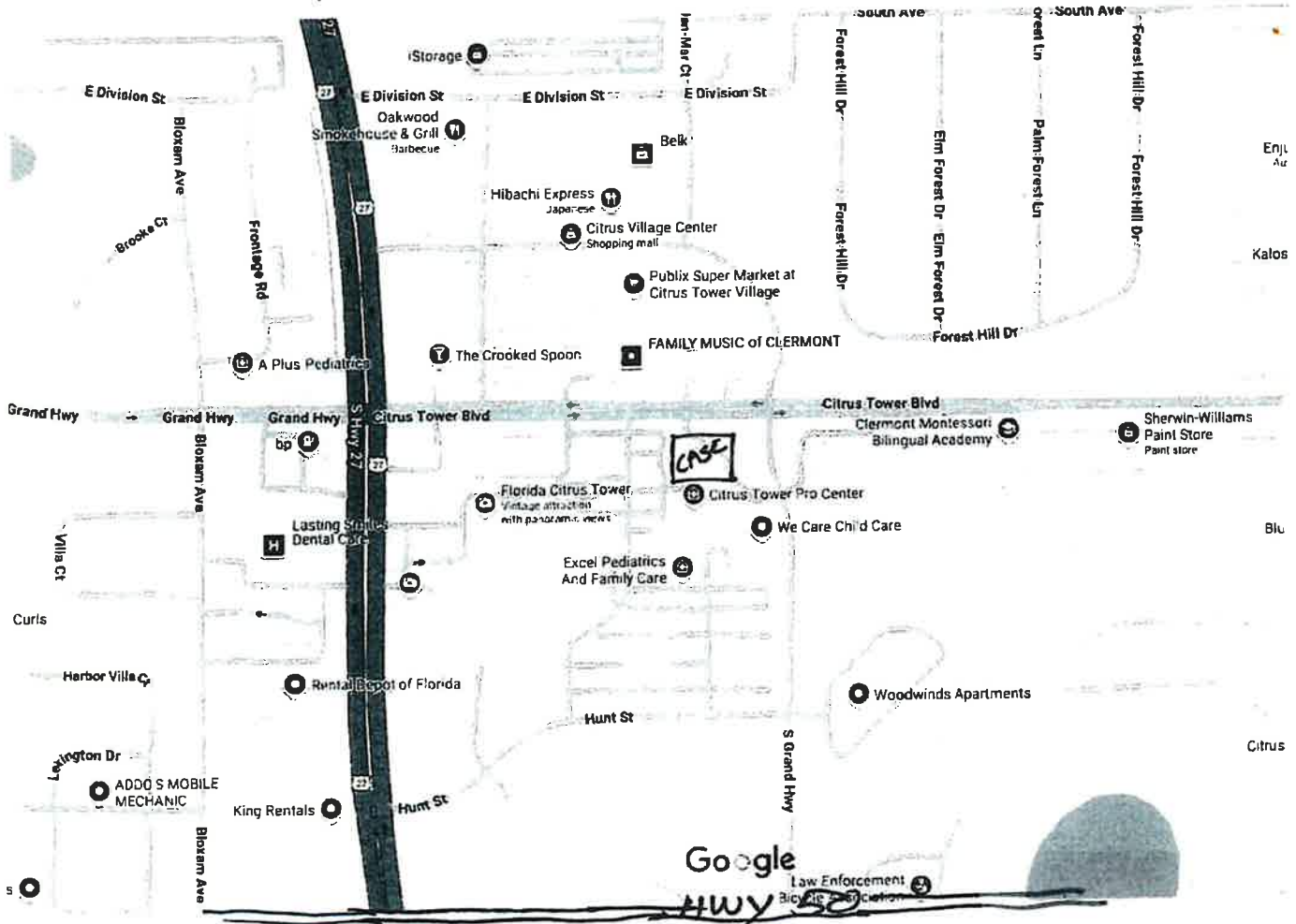
Take HWY 50 West until you come to Citrus Tower Blvd and turn RIGHT. You will go past South Lake Hospital and travel approximately 1-2 miles, through a residential district. After the fourth traffic signal, Grand HWY Blvd., there will be a left turn lane. Use that to turn into a large parking area. We are the two-story building with the green roof in front of you.

**SURGERY CENTER ENTERANCE:**

When facing our building, go down the walkway on the right of the building. You will come to a set of glass double doors that you need to go through. We are Suite 100, it is on the right side across from the elevator.



Leesburg/Ocala  
 ↑



← Groveland

↓ Clermont

→ Orlando



**CLERMONT**  
AMBULATORY SURGICAL CENTER  
**PATIENT'S RIGHTS**

The rights of patient(s) include, but are not limited to:

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities are as follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office, or cannot be reasonably accommodated by the facility or provider.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.



A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

#### **PATIENT'S RESPONSIBILITIES**

Responsibilities of the patient at this center, as follows:

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

**AHCA PATIENT COMPLAINT NUMBER 1-800-669-3534**

#### **ADVANCE DIRECTIVES**

The Clermont Ambulatory Surgical Center, in accordance with Florida Law, must inform you that we are not required to honor, and do not honor DNR/Advance Directives. A healthcare Power of Attorney (POA) will be honored. If a patient should provide his/her Advance Directive, a copy will be placed in the patient's medical record and transferred with the patient, should a hospital transfer be ordered. If a patient wishes to receive more information regarding Advance Directives, they will be referred to the following website:

**[www.MyFlorida.com](http://www.MyFlorida.com)** or call 1-850-245-4440

Your Medicare rights are explained at: **<http://www.medicare.gov/claims-and-appeals/medicare-rights/medicare-rights-overview.html>**

#### **PHYSICIAN OWNERSHIP OF CLERMONT AMBULATORY SURGICAL CENTER**

This is to inform you that the physicians below are the owners of Clermont Ambulatory Surgical Center Healthcare services of Florida, LLLC Sandeep Bajag, MD and Rohini Bajaj, MD



## NOTICE OF PATIENTS' PRIVACY RIGHTS

THE NOTICE OF PRIVACY PRACTICES IS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU OR YOUR LEGAL DEPENDENT (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS THAT YOU HAVE GIVEN US.

Please Review This Notice Carefully

### OUR COMMITMENT TO YOUR PRIVACY:

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). 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 PHI. By federal and state law, we must follow the terms of the Notice of Patient's Privacy Rights ("Notice") 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:

- Your privacy rights in your PHI;
- Our obligations concerning the use and disclosure of your PHI; and
- How we may use and disclose your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. 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.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: The Administrator at (352) 536-6340.

### ■ YOUR RIGHTS UNDER THE FEDERAL PRIVACY STANDARD

Although your health records are the physical property of the health care provider who completed the records, you have the following rights with regard to the information contained therein:

**CONFIDENTIAL COMMUNICATION.** 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 make a written request to the office specifying the requested method of contact and/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.

**REQUESTING RESTRICTIONS.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. "Health care operations" consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under the following sections of the federal privacy regulations: § 164.502(a)(2)(i) (disclosures to you), § 164.510(a) (for facility directories, but note that you have the right to object to such uses), or § 164.512 (uses and disclosures not requiring a consent or authorization). The latter uses and disclosures include, for example, those required by law, such as Mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction, except in the situation explained below. If we do, we will adhere to it unless you request otherwise or we give you advance notice. You may request restriction or alternate communications on the consent form for treatment, payment, and health care operations. If, however, you request restriction on a disclosure to a health plan for purposes of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.

**OBTAINING A COPY OF THIS NOTICE.** Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a hard copy upon request.

**INSPECT AND COPY YOUR HEALTH INFORMATION.** Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:

- Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
- Information compiled in reasonable anticipation of or for use in civil, criminal or administrative actions or proceedings.
- Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.A. § 263a, to the extent that giving you access would be prohibited by law.
- Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonable likely to reveal the source of information.

In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:

- A licensed health care professional, such as your attending physician, has determined, in the

exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.

- PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
- The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.

For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.

**REQUEST AMENDMENT / CORRECTION OF YOUR HEALTH INFORMATION.** We do not have to grant the request if the following conditions exist:

- We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment / correction from the party creating the record. If the party amends the record, then we will put the corrected record into our records.
- The records are not available to you as discussed immediately above. The record is accurate and complete.

If we deny your request for amendment / correction we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

**OBTAIN AN ACCOUNTING OF NONROUTINE USES AND DISCLOSURES.** After January 1, 2011 a date that was set by the federal Department of Health and Human Services, we will provide an accounting to you upon request for uses and disclosures for treatment, payment, and healthcare operations. We do not need to provide an accounting for the following disclosures:

- To you for disclosures of protected health information to you.
- For the facility directory or to persons involved in your care or for other notification purposes as provided in § 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care, of the your location, general condition, or death).
- For national security or intelligence purposes under § 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
- To correctional institutions or law enforcement officials under § 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
- That occurred before April 14, 2003.

We must provide the accounting within 60 days. The accounting must include the following information:

- Date of each disclosure.
- Name and address of the organization or person who received the protected health information.
- Brief description of the information disclosed.
- Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.

The first accounting in any 12 month period is free. Thereafter, we reserve the right to charge a reasonable, cost based fee.

Revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

## ■ OUR RESPONSIBILITIES UNDER THE FEDERAL PRIVACY STANDARD

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this notice.
- Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy / confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm of) any breach of privacy / confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

### HOW TO GET MORE INFORMATION OR TO REPORT A PROBLEM:

If you have any questions and / or would like additional information, you may contact the practice privacy officer as shown above, or the Department of Health and Human Services (DHHS).

### EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS:

**TREATMENT.** Our practice may use your PHI 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 PHI in order to write a prescription for you, or we might disclose your PHI 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 disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your PHI to other healthcare providers for purposes related to your treatment.

**PAYMENT.** Our practice may use and disclose your PHI 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 PHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your PHI to bill you directly for service and items. We may disclose your PHI to other healthcare providers and entities to assist in their billing and collection efforts.

**HEALTHCARE OPERATIONS.** Our practice may use and disclose your PHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other healthcare providers and entities to assist in their healthcare operations.

**APPOINTMENT REMINDERS.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.

**TREATMENT OPTIONS.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

**HEALTH-RELATED BENEFITS AND SERVICES.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

**RELEASE OF INFORMATION TO FAMILY/FRIENDS.** Our practice may release your PHI 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 pediatricians' office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

**DISCLOSURES REQUIRED BY LAW.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

### USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES:

The following categories describe unique scenarios in which we may use or disclose your PHI:

**PUBLIC HEALTH RISKS.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths;
- Reporting child abuse or neglect;
- 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;
- Notifying appropriate governmental agency(ies) and authority(ies) regarding the 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; or
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

**HEALTH OVERSIGHT ACTIVITIES.** Our practice may disclose your PHI 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 healthcare system in general.

**LAWSUITS AND SIMILAR PROCEEDINGS.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI 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.

**LAW ENFORCEMENT.** We may release PHI 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; and
- In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identity, or location of the perpetrator).

**DECEASED PATIENTS.** Our practice may release PHI to a medical examiner or coroner 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.

**ORGAN AND TISSUE DONATION.** Our practice may release your PHI 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.

**RESEARCH.** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain written authorization to use your PHI for research purposes except when the Practice's Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following:

- (i) The use or disclosure involves no more than a minimal risk to your privacy based on the following:
  - a. An adequate plan to protect the identifiers from improper use and disclosure;
  - b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and
  - c. Adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted.
- (ii) The research could not practicably be conducted without the waiver.
- (iii) The research could not practicably be conducted without access to and use of the PHI.

**SERIOUS THREATS TO HEALTH OR SAFETY.** Our practice may use and disclose your PHI when necessary to reduce or prevent a 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.

**MILITARY.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

**NATIONAL SECURITY.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.

**INMATES.** Our practice may disclose your PHI 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: (1) for the institution to provide healthcare services to you; (2) for the safety and security of the institution; and/or (3) to protect your health and safety or the health and safety of other individuals.

**WORKERS' COMPENSATION.** Our practice may release your PHI for workers' compensation and similar programs.