NORTHEAST FLORIDA LUNG CLINIC

PATIENT REGISTRATION

Name (First, Middle, Last): _____

Date of Birth: _____ Gender: M F Social Security Number: _____

Marital Status: S M D W Race: _____

Email: _____

Street Address: _____

City, State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other Phone: _____

Employer: _____

Emergency Contact Information

Contact Name: _____ Relationship to Patient: _____

Phone Number(s): _____

Complete Address: _____

Physician Information

Primary Care Physician: _____ Phone: _____

Address: _____

Who referred you to our practice? _____

Phone: _____ Address: _____

Insurance Information

PRIMARY Insurance Company: _____

Address: _____ Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____

SECONDARY Insurance Company: _____

Address: _____ Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____

I hereby authorize my insurance benefits to be paid directly to Northeast Florida Lung Clinic. I understand I am responsible for all charges, including costs incurred due to any effort to collect for services rendered. **I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information required to file for medical benefits.**

Signature of Responsible Party: _____ **Date:** _____

1370 13th Avenue South, Suite 218, Jacksonville Beach, FL 32250 * 904.853.6154 * fax 877.543.5924

MEDICAL HISTORY

Name: _____ Date: _____

Date of Birth: _____

Please mark an "X" under the YES or NO column and provide a detailed explanation.

	YES	NO	Comments:
Do you use oxygen?			
Do you use a CPAP or BIPAP machine?			

Do you currently smoke?			Do you drink?		
How often?			How often?		
Have you ever smoked?			Do you currently use drugs?		
Start/Quit dates:			Do you have a history of drug use?		
Exposure to second hand smoke?			If YES, name of drug(s):		
Exposure to airborne irritants?			Start/Quit dates:		

PULMONARY CONDITIONS you have been diagnosed with OR are currently experiencing:

	YES	NO	Comments:		YES	NO	Comments:
Shortness of breath				Lung Cancer			
Wheezing				Bronchitis			
Asthma				Pneumonia			
Chest tightness				Recurrent cough			
Emphysema/COPD				Productive cough			
Pulmonary Embolism				Bloody cough			

OTHER MEDICAL CONDITIONS you have been diagnosed with OR are currently experiencing:

_____

_____

FAMILY MEDICAL CONDITIONS: _____

_____

_____

List any SURGERIES or HOSPITALIZATIONS:

Date:	Surgical Procedure and/or Reason for Hospitalization:	Name of Facility:

Please use the back of this form if you need additional space.

Assignment of Benefits

I hereby assign to Northeast Florida Lung Clinic all my rights, title, and interest in and to any and all health care and/or surgical benefits otherwise payable to me for medical treatment, including major medical, and personal injury protection, rendered by the assignee as described in the attached medical claim form.

I acknowledge that I am still responsible for paying the above referenced group if the relevant insurer, plan, or payer does not pay the physician in full at their billed amount, in accordance with **Florida Statue 627.736(5).**

Policy Name: _____ Policy Number: _____

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ☐ Guardian or conservator of patient
- ☐ Beneficiary or personal representative of deceased patient
- ☐ Spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

Physician Signature: _____

Cancellation/Missed/No-Show Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we ask that you read and sign our Cancellation and Missed Appointment Policy. This policy is intended to better utilize available appointments for those in need of immediate medical attention.

Cancellations:

Please be courteous and notify our office at least ***48-hours in advance***. Appointments are in high demand and an early cancellation allows other patients the ability to schedule an appointment. If leaving a message on our answering service, please state your name, phone number, and appointment information. Please note that late cancellations are subject to a missed appointment fee.

No-Show/Missed Appointments:

Patients who miss their appointment without calling ***48-hours in advance*** greatly inconvenience others who are waiting for an appointment. Failure to arrive at an appointment is recorded in a patient's chart as a "no-show" and a ***$30.00*** fee will be billed to the patient's account. This charge will **not** be covered by insurance and will be the patient's responsibility.

I have read and understand the Cancellation and Missed Appointment Policy.
I understand that I will be billed *$30.00* if I do not arrive at my appointment or if I fail to call at least *48-hours in advance*.

_____

PRINT PATIENT'S NAME

_____ _____

Patient's Signature **Date**

_____ _____

Signature of Legal Guardian Date

1370 13th Ave., S., Suite 218, Jacksonville Beach, FL 32250-5847 * P 904.853.6154 * F 877.543.5924

FINANCIAL POLICY

As your physician, I am committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

FINANCIAL RESPONSIBILTY
I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Northeast Florida Lung Clinic. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED
We accept cash, MasterCard, Visa, and Discover cards as payment.

HMO/PPO INSURANCE COVERAGE
CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. I understand that it is my responsibility to provide Northeast Florida Lung Clinic (NEFL) with a copy of my current insurance card and, if required by my insurance, to obtain a referral from my primary care physician. Northeast Florida Lung Clinic is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a self-pay patient and I am financially responsible for the total amount of the services provided. I will notify Northeast Florida Lung Clinic immediately upon any change to my insurance. We will file your insurance if we are under contract with your insurance company. I understand that all charges not covered by my insurance are my responsibility. If the insurance company fails to pay Northeast Florida Lung Clinic in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Northeast Florida Lung Clinic.

MEDICARE
Your deductible and 20% of the allowable charges are due at the time of service; however, since we are Medicare providers we will file your Medicare claim. I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or procedures rendered to patient, directly to Northeast Florida Lung Clinic. I hereby authorize Northeast Florida Lung Clinic to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed and Advance Beneficiary Notice ("ABN"). If we do not know the allowable charge for a specific service, you will be billed after payment is received from Medicare. Please bring your Medicare Explanation of Benefits to show that you have met your deductible for the year.

WORKER'S COMPENSATION
We will call your employer to authorize your visit prior to your appointment. We will file with your company's insurance.

AUTOMOBILE ACCIDENTS
We will file your insurance claim when you are involved in an automobile accident; however, it is your responsibility to provide us with your insurance information so that we can verify your coverage. You will be responsible for payment of your portion at the time you receive medical treatment.

FEE ASSESSMENT CHARGES (please initial below)

_____**NO SHOW POLICY** There may be a **$30.00** charge if you fail to show for your scheduled office appointment or procedure AND you have not informed us of your intention of not keeping your appointment. It is your responsibility to notify the office 48-hours in advance if you are unable to keep your office appointment.

_____**APPOINTMENT CANCELLATION FEE of $30.00** will be accessed for cancelling an existing appointment with less than 48-hours' notice to our office. There is no charge for rescheduling an appointment with more than 48- hours 'notice.

_____ **ARRIVING LATE** If you are more than 15 minutes late to your appointment you are not guaranteed to be seen and may need to re-schedule for another day.

_____ **DISABILITY FORMS** All disability/FMLA/parking passes forms will be charged a minimum of $30 + based on pages and complexity.

_____**NON-SUFFICIENT FUND CHARGE** A charge of **$35.00** will be accessed for any payment returned.

_____**LATE PAYMENT FEE** A late fee charge of **$30.00** will be accessed if you do not make your payment in accordance with your fee arrangement(s) made with our office.

FINANCIAL POLICY CONT...

CONSENT FOR MEDICAL TREATMENT

I am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

CHILDREN OF DIVORCED PARENTS

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, NO MATTER WHO IS RESPONSIBLE BY ORDER OF THE DIVORCE DECREE.

FORM COMPLETION FEE

Due to the large volume of forms that we are required to complete, our office reserves the right to charge up to $25.oo per page for the completion of forms. Dictated letters are dealt with on a case-by-case basis.

PRIVACY POLICY

I have received a copy of Northeast Florida Lung Clinic's privacy policy and have been given the opportunity to have my questions, if any, answered.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, and your employer and the insurance company. We are not a party to that contract.
- Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company.

ALL CHARGES ARE YOUR RESPONSIBILTIY FROM THE DATE SERVICES ARE RENDERED

Collection action will be taken for any charges; including those that insurance has not paid, older than 90 days. We realize that emergencies do arise that may affect timely payment of your account. If extreme circumstances occur, please contact us promptly for assistance in the management of your account.

I do hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, Northeast Florida Lung Clinic. In the event I receive payment directly from my insurance company for services rendered by Northeast Florida Lung Clinic, I agree to endorse any check received to Northeast Florida Lung Clinic.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature: _____ Date: _____

Name of Patient (print):_____

Parent, Guardian or Legal Representative Signature: _____ Print:_____

Relationship to Patient: _____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate):_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At NORTHEAST FLORIDA LUNG CLINIC (NEFL), we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule effective March 26, 2013. It applies to all PHI as defined by federal regulations.

NORTHEAST FLORIDA LUNG CLINIC participates in an Organized Health Care Arrangement ("OHCA") with local hospitals. An OHCA is an arrangement or relationship, recognized in the HIPAA privacy rules, that allows two or more Covered Entities who participate in joint activities to share the PHI about their patients in order to manage and benefit their joint operations.

NORTHEAST FLORIDA LUNG CLINIC will share PHI with participants in the OHCA for treatment, payment and health care operations of the OFICA. Understanding Your Health Record/Information Each time you visit NEFL; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve. Comply with state and federal laws that require us to disclose your PHI.

Understanding what is in your record and how your PHI is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your PHI, and make more informed decisions when authorizing disclosure to others. Your Health Information Rights, although your health record is the physical property of NEFL, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. You have the right to inspect and/or request a paper copy of your medical record. If the NEFL office where you receive services maintains an electronic medical record ("EMR"), you have the right to access your health record in a machine readable electronic format. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity. NEFL may charge you a reasonable, cost-based fee for the labor and supplies associated with copying or transmitting the electronic PHI.

- Amend your health record which you believe is not correct or complete. NEFL is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for NEFL; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by NEFL, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

- Obtain a written accounting of certain non-routine disclosures of your Pill. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and health care operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years prior to the date of your request. If the NORTHEAST FLORIDA LUNG CLINIC office where you receive services maintains your medical records in an EMR system, you may request that the accounting include disclosures for treatment, payment and health care operations for the three (3) years prior to the date of such request. You must submit your request in writing to the Privacy Officer. The first list you request within a 12-month period is free of charge, but NEFL may charge you for additional lists within the same 12-month period. NEFL will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

- Communications of your PHI by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).

• Place a restriction to certain uses and disclosures of your information. In most cases NORTHEAST FLORIDA LUNG CLINIC is not required to agree to these additional restrictions, but if NEFL does, NEFL will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). NEFL must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.

• Revoke your authorization to use or disclose PHI except to the extent that action has already been taken.

Our Responsibilities

NEFL is required to:

- Maintain the privacy of your PHI
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you. We will not use or disclose your PHI without your written authorization, except as described in this Notice. For More Information or to Report a Problem
If have questions and would like additional information, you may contact:

Privacy Officer
NORTHEAST FLORIDA LUNG CLINIC
Medical Office Bldg. #A
1370 13th Avenue South, Suite 218
Jacksonville Beach, FL 32250
Telephone: 904-853-6154 Fax: 904-853-6412

If you believe your privacy rights have been violated, you can file a written complaint with NORTHEAST FLORIDA LUNG CLINIC'S Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, NEFL operates an EMR. This is an electronic system that keeps PHI about you.

NEFL may also provide a subsequent healthcare provider with PHI about you (e.g., copies of various reports) that should assist him or her in treating you in the future. PMPJ may also disclose PHI about you to, and obtain your PHI from, electronic PHI networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

NEFL may use a prescription hub which provides electronic access to your medication history. This will assist NEFL health care providers in understanding what other medications may have been prescribed for you by other providers.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to perform functions or activities on behalf of, or certain services for, NEFL that involve the use or disclosure of PHI and disclose your PHI to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail, in reference to any items that assist NEFL in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist NEFL in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam room, it is considered implied consent that a disclosure of your PHI is acceptable.

Open Treatment Areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

To Avert a Serious Threat to Health or Safety: We may use your PHI or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. NEFL may use a single compound authorization to combine conditioned and unconditioned authorizations for research (e.g. participation in research studies, creation or maintenance of a research database or repository), provided the authorization: (i) clearly differentiates between the conditioned (provision of research related treatment is conditioned on the provision of a written authorization) and unconditioned research components; and (ii) provides the individual with an opportunity to opt in to the unconditioned research activities.

Coroners, Medical Examiners and Funeral Director: In the unfortunate event of your death, we may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

Organ Procurement Organizations: Consistent with applicable law, we may disclose PHI to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Fund Raising: We may contact you as part of a fund-raising effort. We may also disclose certain elements of your PHI, such as your name, address, phone number and dates you received treatment or services at NEFL, to a business associate or a foundation related to NEFL so that they may contact you to raise money for NEFL. If you do not wish to receive further fundraising communications, you should follow the instructions written on each communication that informs you how to be removed from any fundraising lists. You will not receive any fundraising communications from us after we receive your request to opt out, unless we have already prepared a communication prior to receiving notice of your election to opt out.

Sale of PHI: NEFL may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception. Health Oversight Activities: We may release your PHI to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement. Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Workers Compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement: We may disclose PHI for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your Pill to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your PHI if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

If Required by Law: We may use or disclose your PHI.

Acknowledgement

I have received a copy of the Northeast Florida Lung Clinic Notice of Privacy Practices.

Date _____

Signed _____ Print Name _____

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

We are required by law to maintain the privacy of protected health information ("PHI"). PHI includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a copy of our most current privacy notice from our office.

PERMITTED USES AND DISCLOSURES

The following categories describe the different ways in which we may use and disclose your PHI without obtaining your authorization:

- Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.
- Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your HMO information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the HMO for the services rendered to you, we can provide the HMO with information regarding your care if necessary to obtain payment.
- Health care operations means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.
- We have an indirect treatment relationship with you, that is, we provide health care to you based on the orders of another health care provider. For example, if you have come to us for a diagnostic procedure, we can disclose the results of that test to the physician who ordered the procedure.

OTHER USES AND DISCLOSURES OF PHI

We may contact you to notify you of lab or test results, to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

We may disclose your PHI only to those people that you have authorized. We will only disclose the PHI directly relevant to their involvement in your care or payment. We may also use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the PHI that is directly relevant to their involvement in your care. When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts. We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, and similar forms of PHI with your authorization.

We may contact you as part of our marketing efforts as permitted by applicable law.

Except for the special situations listed below, we will not use or disclose your PHI for any other purpose unless you provide written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

SPECIAL SITUATIONS

• Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

• Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

• Worker's Compensation: We may release medical information about you for programs that provide benefits for work-related injuries or illness.

• Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of product, recalls, repairs or replacements;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

• Health Oversight Activities: We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose PHI to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

• Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

• Law Enforcement. We may release medical information if asked to do so by a law enforcement official: • In response to a court order, subpoena, warrant, summons or similar process;

- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct on our premises;
- In emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

• Coroners. Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

• National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counter- intelligence, or other national security activities authorized by law.

• Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

• Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

• Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

YOUR RIGHTS

1. Requesting Restrictions: You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Practice Office Manager at (904) 495-7200. Your request must describe in a clear and concise fashion:

a) the information you wish restricted;
b) whether you are requesting to limit our practice's use, disclosure or both; and
c) to whom you want the limits to apply.

2. Confidential Communications: You have the right to reasonably request to receive communications of PHI by alternative means or at alternative locations. However, you are required to provide our office with a daytime telephone number.

3. Inspection and Copies: You have the right to inspect and copy the PHI contained in your medical and billing records, except for:

i. psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;
ii. information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
iii. Pill involving laboratory tests when your access is required by law;
iv. if you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;
v. if we obtained or created PHI as part of a research study for as long as the research is in progress,
vi. provided that you agreed to the temporary denial of access when consenting to participate in the research;
vii. your PHI is contained in records kept by a federal agency or contractor when your access is required by law; and
viii. if the PHI was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

We may also deny a request for access to PHI if:

• a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
• the PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
• the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. Requesting an Amendment: You have the right to request an amendment (correction) to your PHI, but we may deny your request for correction, if we determine that the PHI or record that is the subject of the request:

- was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
- is not part of your medical or billing records;
- is not available for inspection as set forth above; or
- is accurate and complete.

To request an amendment, your request must be made in writing and submitted to the practice office manager at (904) 495-7200. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing.

In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

5. Accounting of Disclosures: You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you, except for disclosures:

i. to carry out treatment, payment and health care operations as provided above;
ii. to persons involved in your care or for other notification purposes as provided by law;
iii. for national security or intelligence purposes as provided by law;
iv. to correctional institutions or law enforcement officials as provided by law; or
v. that occurred prior to April 14, 2003.

6. Copy of Privacy Notice: You have the right to request and receive a paper copy of this notice from us.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the Practice Office Manager at (904) 495-7200. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the Department of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact (904) 586-0031.

BY SIGNING THIS NOTICE, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature: _____ Date: _____

Printed Name of Patient: _____

Parent, Guardian or Legal Representative Signature: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Relationship to Patient: _____

Legal Representative's Authority to Act for Patient
(Power of Attorney, Healthcare Surrogate,):_____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Florida law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: ( )_____ Email (Optional):_____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Phone: ( )_____ Fax: ( )_____

Information regarding person or entity who can receive and use this information:

Name: Northeast Florida Lung Clinic

Address: 1370 13th Ave S., Suite 218 City: Jacksonville Beach State: FL Zip Code:32250

Phone: (904) 853-6154 Fax: (877) 543-5924

Specific information to be disclosed:

- ☐ Medical Record from _____ to _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing)*

_____ Drug, Alcohol, or Substance Abuse Records

_____ Mental Health Records (Except Psychotherapy Notes)

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:

(*Choose all that Apply*)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other (*Specify*): _____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: Day: Year: .

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____

NORTHEAST FLORIDA LUNG CLINIC

Patient Communication Consent Form

Patient Name (Last, First, Middle Initial): _____

Date of Birth: _____

I authorize the Northeast Florida Lung Clinic and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below.

Name Relationship to Patient Contact Information

_____

_____

_____

By my signature below, I acknowledge that I have read and understand the information provided on this consent form.

Patient Name: (Print) _____

Patient Signature: _____ Date: _____

1370 13th Avenue South, Suite 218, Jacksonville Beach, FL 32250 * P 904.853.6154 * F 877.543.5924