My Medical Access

MMA

Your Personalized Medical Care is our Priority

www.My-Medical-Access.com

Welcome

Welcome to "My Medical Access" your choice Primary Care Providers!

We thank you for choosing us to be your primary care physician(s) and appreciate the opportunity to serve your family's health care needs.

In order for us to provide you with the excellent care and service in our office(s), we are presenting our policies to assist you in obtaining quality service. You may also visit our website : www.my-medical-access.com for more information and resources to assist you.

For your convenience our convenient Physician Office locations and information are listed below. Please feel free to contact our office(s) for your health concerns or questions.

Best wishes,
From the My Medical Access Physician Team

Physician Office	Address	Phone	Hours
William Alvarez, D.O.	3935 Tampa Road #6 Oldsmar, FL 34677	PH: 727-723-3921 FX: 727-723-1562	Mon, Tues, Thurs – 9am- 5pm Wed – 1:30 pm – 7pm Friday – 9am – 3pm
Hans A. Langschwager,M.D.	2595 Tampa Road, Suite 1C Palm Harbor, FL 34684	PH: 727-785-7402 FX: 727-784-7301	Mon, Tues, Thurs – 9am-4:30pm Wed, Friday - 9am – 1pm
Sheila Sagar, M.D.	28960 U.S. 19 North, Suite 100 Clearwater, FL 33761	PH: 727-787-7970 FX: 727-787-8524	Mon, Tues, Thurs – 9am – 5pm Wed – 9 am-12 pm Friday – 9 am – 2:30 pm

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Primary Care Physicians located in Oldsmar, Palm Harbor and Clearwater
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PATIENT REGISTRATION FORM

Today's Date:	Drivers license #:	**Age:**	**Date of Birth:**

Patient Name: *(Last) (First) (Middle)*	**Social Security #:**	Sex: ☐ Male ☐ Female

Billing Address: *Street / P.O. City State Zip*

Home Phone	**Cell Phone:**	Work Phone

Email Address:	**Ht:**	**Wt:**

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other

Ethnicity: ☐ American ☐ Hispanic ☐ Canadian ☐ Polish ☐ Irish ☐ Italian ☐ German ☐ Other

Primary Language: ☐ English ☐ Spanish ☐ Indian ☐ Korean ☐ Chinese ☐ Italian ☐ German ☐ Other:

Facility where you reside (if applicable):	Facility Phone:

Insured's Employer:	Contact Person:	Office Phone:
Employer Address:		Fax Phone:

Guarantor/ Legal Guardian Information

Emergency Contact Name:	Relationship	Primary Phone:
Address:		Secondary Phone:

Power of Attorney Name:	**Phone:**

Pharmacy Information

Pharmacy Name:	Pharmacy Phone #:
Pharmacy Address:	

Insurance Information

Primary Insurance

Co. Name:_____
Address: _____
City _____ State _____ Zip _____
Phone No: _____ Fax No: _____

Member ID#: _____Group #:_____
Insured Name: _____
Relationship: _____
SSN#:_____ DOB: _____

INSURANCE COPAY: _____ **DEDUCTIBLE:** _____

Secondary Insurance

Co. Name:_____
Address: _____
City _____ State _____ Zip _____
Phone No: _____ Fax No: _____

Member ID#: _____Group #:_____
Insured Name: _____
Relationship: _____
SSN#:_____ DOB: _____

INSURANCE COPAY: _____ **DEDUCTIBLE:** _____

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PATIENT HEALTH HISTORY

Date Today:	

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name:	Date of Birth:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had	Name the Drug	Reaction You Had

MEDICAL HISTORY

Please check YES or NO if you HAVE BEEN DIAGNOSED with ANY of these conditions in your past:

Common Conditions	YES	NO	Common Conditions	YES	NO
Hypertension			Hypothyroidism		
Type 1 Diabetes			Coronary Artery Disease		
Type 2 Diabetes			Congestive Heart Failure		
High Cholesterol			COPD		
Osteoporosis			Osteoarthritis (generalized)		
Depression			Anxiety		
Cancer			**Gastrointestinal**		
Have you ever been diagnosed with Cancer?			Acid Reflux		
TYPE:			Barrett's Esophagus		
Hearing/Eyes/ENT			Peptic Ulcer Disease		
Glaucoma			Ulcerative Colitis		
Macular Degeneration			Irritable bowel syndrome		
Diabetic Retinopathy			Diverticulosis		
Hearing Loss			H/O Colon Cancer		
Ear Infections			**Urinary/Renal**		
Sinusitis Chronic			Polycystic kidney disease		
Respiratory			Nephrolithiasis		
Asthma			Urinary Incontinence		
COPD			History of UTI's		
Chronic Bronchitis			**Musculoskeletal**		
Interstitial lung disease			Arthritis - Location(s):		
Emphysema			Osteopenia/Osteoporosis		
Pulmonary Embolism			Lumbar disc disease		
Obstructive Sleep Apnea			Restless Leg Syndrome		
Tuberculosis exposure			Rotator cuff syndrome		
Cardiology			Sciatica		
Atrial Fibrillation			Spinal Stenosis of:		
Pacemaker / Date of Placement:_____			Cervical Spine		
Angina			Lumbar Spine		
CHF (Congestive Heart Failure)			H/O compression - Fractures		
Heart Attack (myocardial infarction)			**Rheumatology**		
Aortic Valve Disorder			Gouty Arthritis		
Mitral Valve Disorder			Fibromyalgia		

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Patient Name:	Date of Birth:

MEDICAL HISTORY CONTINUED:

Neurology			SLE		
Alzheimer's Disease			Rheumatoid Arthritis		
Parkinson's Disease			Lupus Erythematosus		
Seizures			**Hematology**		
Stroke - Area Affected: _____			B-12 deficiency anemia		
Gait Instability with falls			Iron deficiency anemia		
Peripheral Neuropathy			Myelodysplastic Syndrome		
TIAs			Anemia		
Migraine Headaches					

SURGICAL HISTORY

Please check YES or NO if you HAD with ANY of these procedures in your past:

General	**YES**	**NO**	**Women**	**YES**	**NO**
Aortic aneurysm repair			Breast Implants		
Aortic Valve Repair			Breast reduction		
Appendix removal (Appendectomy)			C-Section		
Bariatric surgery			Endometrial biopsy		
Carpal tunnel release			Hysterectomy : Partial Complete		
Cataract surgery : Right Left			Lumpectomy : Right Breast Left Breast		
Colon resection (Colectomy)			Mastectomy : Right Breast Left Breast		
Coronary artery - Bypass surgery			**Men**		
Fracture repair – Where?			Prostate Biopsy		
Gallbladder removal (Cholecystectomy)			Prostate Removal		
Gastric Bypass surgery			**Joint Replacement**		
Hemorrhoid removal (Hemorrhoidectomy)			Left Hip		
Hernia Repair : Femoral Inguinal			Right Hip		
Kidney Removal: (Nephrectomy) Right Left			Left Knee		
Mitral valve replacement			Right Knee		
Parathyroid removal (Parathyroidectomy)			Left Shoulder		
Pacemaker placement			Right Shoulder		
Polyp Removal (Polypectomy)			Right Elbow		
Septum and nose repair			Left Elbow		
Spinal surgery – Where?			**Biopsy**		
Type:			Bone Marrow		
Thyroid removal (Thyroidectomy)			Liver		
Tonsillectomy			Skin		
Varicose vein surgery			Mass Excision - Where?		

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

FAMILY HEALTH HISTORY

please check (√) all that apply

MEMBERS	**STATUS** *(deceased or alive)*	**YOB**	**AGE**	**Diabetes**	**High Blood Pressure**	**Heart Disease**	**Stroke**	**Cancer**	**Mental Disease**	**Unknown**
FATHER										
MOTHER										
BROTHER (s) #____										
SISTER (s) #____										
SON (s) #____										
DAUGHTER (s) #____										

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Patient Name:	**Date of Birth:**

SOCIAL HISTORY

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Tobacco	**Are you a current smoker?** ☐ Yes ☐ No	# of Years:	Year Quit Smoking:	
	Status: ☐ Former Smoker ☐ Non-Smoker ☐ Current Every day smoker ☐ Current Occasional Smoker ☐ Unknown ☐ Light cigarette smoker (1-9/day) ☐ Moderate cigarette smoker (10-19/day) ☐ Heavy cigarette smoker (20-39/day)			
	If Current Tobacco User: What type of tobacco do you use? Other forms of tobacco: ☐ Chew ☐ Pipe			
	☐ Chew fine cut tobacco ☐ Chew Loose leaf tobacco ☐ Chew plug tobacco ☐ Chew twist tobacco ☐ Pipe Smoker			
	If Current Smoker: How often do you smoke cigarettes? ☐ Every day ☐ Some days, but not every day			
	How many Cigarettes a day do you smoke? ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 30 or more / full pack			
Alcohol	**Do you drink alcohol?** ☐ Yes ☐ No	History of Alcohol Use?	☐ Yes ☐ No How many Years? _____	
	If yes, what kind?			
	How often do you drink alcohol?	Socially ☐	Daily ☐	Occasionally ☐ Rarely ☐
	How many do you drink?	1-2 day ☐	2-3 day ☐	3-5 day ☐ More than 5 ☐
	Have you ever experienced blackouts?	☐ Yes	☐ No	
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No	
	Have you ever used recreational drugs? ☐ Yes ☐ No If yes, what date/year(s) ago did you quit?			
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
Diet	☐ Diabetic Diet ☐ Cardiac Diet ☐ Un-Restricted Diet ☐ Low Carbohydrate ☐ Low Fat ☐ Vegetarian ☐ Vegan ☐ Eat out several days a week ☐ Drink high sugar beverages ☐ Low salt Diet ☐ Low Cholesterol Diet ☐ Low Sugar Diet # of meals you eat in an average day?			
Education:	☐ High School ☐ Undergraduate ☐ Graduate ☐ Doctorate Other: _____			
Religion:				
Exercise	☐ Sedentary (No exercise)	☐ Difficult due to weight	☐ Occasionally	
	Exercise Frequency: ☐ Weekly ☐ Daily ☐ 2 times/week ☐ 3 times/week ☐ 1-2 times/week ☐ 2-3 times/week ☐ 3-4 times/week ☐ Less than 30 min./day ☐ 30-60 minutes/day ☐ 1-2 hours/day			
	☐ **Type of Exercise:** (i.e. golf, bicycling, walking, running, swim, weights):			
Living With:	☐ Alone ☐ Spouse ☐ Significant Other ☐ Family ☐ Friends			
Marital status:	☐ Single ☐ Married ☐ Male Partner ☐ Female Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married			
Employment:	☐ Retired ☐ Full- Time ☐ Part-Time ☐ Unemployed ☐ Self Employed ☐ Military ☐ Homemaker			
Travel:	☐ None in last six months ☐ Travels to South Africa ☐ Travels to Europe ☐ Travels to Asia ☐ Travels to Africa			

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Patient Name (*print name*):	**Date of Birth:**

FINANCIAL POLICY

It is our goal to provide you and your family the very best service possible. As a service to our patients we are participating in a large number of health plans, thereby making our services accessible to as many patients as possible. Please understand that in order to continue to provide outstanding services to our patients we need to maintain our administrative cost to a minimum.

Hereto is a summary of our financial and billing policies to identify clearly our processes, whereby your signature below acknowledges understanding of our financial policies outlined below:

1) FILED CLAIMS: the office will file all claims for services rendered to primary and secondary insurances. **It is the patient's responsibility to furnish accurate, complete and current insurance information.**

2) PAYMENTS: we file secondary insurance claims for all our patients. However, in many cases secondary insurances will pay patients directly or your insurance policy has deductibles, coinsurances or similar provisions that will result in a non-payment for balances after your primary insurance has paid a claim. **We reserve the right to bill any unpaid balances directly to the patient if no payment from a secondary insurance is received within 60 days after filing.** These balances are due in full from the patient at the time of statement receipt.

3) BILLING: questions regarding the billing process, charges on your account or to update or change information have to be addressed to the office in **care of Billing Department**. 3889 Military Trail, Ste 104, Jupiter, FL 34958. **Inquiries via phone should be directed to the Billing Department at 561-932-0995 ext. 8015** (located in top right corner of your statement) rather than the office, to avoid delays in processing.

4) CREDITS: In cases where patients pay an open balance and payment from a secondary insurance is received for the same claim, the office will refund any credits resulting from such payment to the patient provided the total credit balance is equal or greater than $20.00. Credit balances less than $20.00 will remain on the account and will be used towards future balances or refunded once the total credit amounts reach $20.00.

5) INSURANCE CO-PAYS: Because of the variety of different plans and contracts insurances have and the constant changes within each plan, we cannot be held responsible for the accuracy of co-payments collected. **In rare cases we have discrepancies between collected amounts and the amounts your insurance contract requires.** Adjustments of this nature will be made at the time the insurance notification is received and either credited to patient's account or billed to the patient.

6) COLLECTIONS: We try to work with patients to find ways to make the payment process as easy as possible. **However, if we do not receive payment after the stated grace period, accounts may be evaluated for further collection process and the office may consider discharging a patient from the practice for non-payment(s)**.

NO SHOW POLICY

As it is our mission to provide the best service to our patients, we do enforce a NO SHOW Policy at our practice as we have patients who may at times be waiting weeks for their scheduled appointment.

Below is our NO SHOW Policy outline for your understanding:

1.) We request out of respect for other patients waiting for appointment(s), **please notify our office at least 48 Hours prior to your appointment date if you must CANCEL OR RESCHEDULE**. We are available to assist with rescheduling.
2.) If you do not contact our office, and are a **NO SHOW** at your scheduled appointment date/time there **WILL BE A CHARGE OF $25.00 as a no show fee**.
3.) If you do not contact our office, with **NO CANCELLATION** of your scheduled appointment date/time there **WILL BE A CHARGE OF $25.00 as a no cancellation fee**.
4.) After **three (3) missed/no show** appointments you may be terminated as a patient at this practice.

We sincerely hope these policies promote our overall goal of transparency and team-oriented health care. Please feel free to let us know if there are any item(s) we can improve to make the administrative side of our practice as painless and easy for you as possible.

PATIENT ACKNOWLEDGEMENT

By my signature below, I acknowledge to have read the above polices and agree to the term outlines. I understand my responsibilities and the consequences for violation of the financial responsibilities. I was given opportunity to ask questions regarding the financial policies and understand their impact on my relationship to the practice.

Patient Signature:	Date:

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STANDING AUTHORIZATION FOR DISCLOSURE OF INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the use or disclosure of protected health information (PHI) other than treatment, payment or healthcare operations (TPO). Others that are permitted to receive disclosu re of information by law include: Judicial proceedings, coroners, medical examiners, research purposes, law enforcement, worker's compensation and other areas so designated by law.

Release or disclosure of information to family members, friends, clergy or others involved in a patient's care is NOT included in the General Rule and require specific authorization for disclosure of information.

If you would like us to share your PHI with family members or others, please fill in the information below for each individual, designate if unrestricted or limited release of information and date and initial each authorization. Please note that ABSOLUTELY NO INFORMATION WILL BE DISCLOSED to spouses, children, other family members, care givers or friends if not authorized below. You may rescind or change any authorization by a written request at any time.

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis, records, reports (including treatment, payment and health care operations):

Name:	Relation:	Phone;	☐ All Access ☐Appointments ☐Lab results
Name:	Relation:	Phone:	☐ All Access ☐Appointments ☐Lab results
Name:	Relation:	Phone:	☐ All Access ☐Appointments ☐Lab results
Name:	Relation:	Phone:	☐ All Access ☐Appointments ☐Lab results

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

Name:	Relation:	Phone:
Name:	Relation:	Phone:

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent ***if other than your home***. **(Confidential Communications):**

4. Print the telephone number or email address where you want to receive calls about your appointments, lab and x-ray results or other health care information ***if other than your home.***

Phone: _____ ***Email:***

_____

5. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or Voice Mail?

☐ YES ☐ NO

I understand the Privacy Protection Act and have been offered a copy of the Notice of Privacy Policies and do hereby authorize to disclose as I have identified above.

Patient Name:	**Date:**
Patient Signature:	
Legal Guardian/Representative Name:	**Legal Rep Signature:**

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AUTHORIZATION TO USE OR DISCLOSE MEDICAL RECORDS

For release of records from previous primary physician(s) and/or specialists seen.

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT		SS#	

TO: (Name, Address, Phone of **Recipient** of Records) (or as checked office location above)						
Name				Phone		
Address				Fax		
City/State Zip	City		State		Zip	

RECORDS FROM (Who is **Releasing** the Records):						
Name				Phone		
Address				Fax		
City/State Zip	City		State		Zip	

For the Following Purposes:

✓	Continued Medical Care		Personal Information		Legal Follow-up
	Disability Insurance		Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information and/or Medical Records, If Such Information and/or Records Exist:

	Please send the entire Medical Record (all information) to the above named recipient.				
✓	Office Notes and Reports		Most recent one year history		Most recent three-year history
	Rx History		Transcribed hospital reports		Laboratory reports
	Billing Statements	✓	Diagnostic Reports		Diagnostic Films
✓	Others Listed Here:	LAST 2 YEARS ONLY			

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases Mental
_____ Health Information and/or Records
_____ Domestic Violence
_____ Genetic Testing Information and/or records
_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date)_____.

Patient Name (Print):	
Patient Signature:	Date:
Legal Guardian Name:	Legal Rep. Signature:

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CONTROLLED SUBSTANCE AGREEMENT

Patient Name (*print name*):	Date of Birth:

Effective July 1, 2011, The Florida Department of Health, signed by Governor Rick Scott: Patients that are prescribed controlled substance medication will have regular follow-up appointments every (3) months in order to be prescribed and continue use of controlled substances.

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain or other conditions, I agree to the following:

Please INITIAL EACH BOX line item and complete information below:

	1. I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen, or if "I run out early", I understand that this medication **will not be replaced.**
	2. Refills of controlled substance medications:
	A.) Will be made only during regular office hours Monday through Friday, in person, once a month, and during a scheduled office visit. Refills will not be made at night, weekends, or during holidays.
	B.) Will not be made if "I lost my prescription", ran out early, or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.
	C.) I understand that I must call ahead within 72 hours to schedule an appointment.
	3. I agree to use a single pharmacy in the State of Florida, as listed below, for all of my controlled substance prescriptions. In the event my prescribed medication is unavailable at the pharmacy indicated below, I will immediately notify my Physician at *My Medical Access* prior to filling my prescription at a different pharmacy.

Pharmacy Name and Location :	**Phone Number:**

	4. I will not share, sell, or trade my medication with anyone.
	5. It may be deemed necessary by my physician that I see a medication- use specialist at the time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction); my medications will no longer be filled.
	6. I agree to comply with random urine drug testing, documenting the proper use of any medications and that it is my responsibility to comply with the laws of the State while taking prescribed medications. If my drug testing results reveal medication that is not prescribed to me, including but not limited to illicit drugs, or absence of medication that is prescribed to me is a violation of this agreement.
	7. I understand if I violate any of the conditions in this agreement, my prescriptions for controlled medications will be terminated immediately and I will be given a 30 day notice of discharge from the practice. IF the violation involves obtaining these medications from another individual, or combining use of non-prescription illicit (illegal) drugs, including but not limited to marijuana, cocaine etc., I may also be reported to all my physicians, medical facilities, pharmacies, and the appropriate authorities.
	8. I understand that the main treatment goal is to reduce pain,and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal. I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol**. I must comply with the treatment plan as prescribed by my physician.**
	9. I understand that the long- term advantages and disadvantages of chronic opioid use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with long term use of controlled substances and that my physician will advise me of advances in the field and will make necessary treatment changes.

According to Florida State Law (893.13) Section 7, it is illegal for persons to see multiple physicians to obtain controlled substance medication or a prescription for a controlled substance medication. To do so is in clear violation of Florida laws regarding drug abuse and can result in arrest. The Physician of My Medical Access will assist the local sheriff's office in all aspects regarding this law.

I give my consent to the Physicians at My Medical Access, and all its agents to make report to or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of or related to my receiving prescriptions as a patient of My Medical Access. I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my records held by my Physician at My Medical Access without order of clerk of court.

I have been fully informed by my Physician at My Medical Access regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve the desired effect, and that is a risk of becoming physically dependent on the medication. This will occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do so slowly and under medical supervision, or I may have withdrawal symptoms.

PATIENT ACKNOWLEDGEMENT

By my signature below, I acknowledge I have thoroughly reviewed this agreement and the same has been explained to me by my Physician at My Medical Access. In addition, I understand the consequences of violating this agreement.

Patient Signature:	**Date:**
Physician Name (please print)	Location:
Physician Signature:	Date:

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Consent to Share My Health Information With the BayCare Electronic Health Exchange

BayCare Health System

The BayCare Electronic Health Exchange (BayCare eHX) is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your "**health information**") to the BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. *Your choice will not affect your ability to get medical care of health insurance coverage. Your choice to give or to deny consent may not be the basis for denial for health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.*

If you check the "I GIVE CONSENT", you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you decide to DENY CONSENT, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

Please carefully read the "Details About Your Health Information" form before making your decision.

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NOTICE OF ACKNOWLEDGEMENT / CONSENT

Patient Name:	**Date of Birth:**

RECEIPT FOR NOTICE OF PRIVACY PRACTICES

I have been notified of and provided a copy of this company's Notice of Privacy Practices per HIPAA Regulations.

Patient/Legal Guardian Signature:	**Date:**

Consent to Share Health Information with BayCare Electronic Health Exchange

I have been provided the consent form to review regarding the option(s) to allow my health information being shared with *BayCare Health System.*
I understand if I give Consent I am saying YES for members of the *BayCare eHX* that my see and get access to all of my health information through the *BayCare eHX.* If I choose to deny this option I will not sign this form.

☐ **Yes,** I give consent for my doctors to enroll me in the BayCare eHX and for the members of BayCare eHX to access ALL of my health information as set forth in the Consent Form provided to me.

Patient Name/Representative:

Signature of Patient/Representative:	**Date:**

I _____, do hereby state I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient:	Date:

OPTIONAL

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions:

Declaration to Decline Life-Prolonging Procedures (LIVING WILL) : *(please check one)*

☐ I have made such declaration ☐ I have NOT made such a declaration

Health Care Surrogate :

☐ I have designated a Health Care Surrogate ☐ I have NOT designated a Health Care Surrogate

Durable Power of Attorney :

☐ I have appointed a Durable Power of Attorney for Health Care decisions

☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

Print Patient Full Name:	Social Security #: - -
Patient Signature:	Date:
Relationship of Patient Representative if applicable:	

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

Signature of Patient or Legal Representative:	Date:
Signature of Patient or Legal Representative:	Date:
Signature of Patient or Legal Representative:	Date:
Signature of Patient or Legal Representative:	Date:

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Legal Representative:	**Date:**

OPTIONAL

LIVING WILL

Declaration made this _____ day of _____, 20_____ in the State of Florida, _____ COUNTY.

I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and,

_____ *(Initial)* I have a terminal condition,

_____ *(Initial)* I have an end stage condition,

_____ *(Initial)* I am in a persistent vegetative state,

And if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I DO _____, I DO NOT _____, desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express or informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to delegate, as my health surrogate to carry out the provisions of this declaration:

Name _____

Street Address: _____

City: _____ State: _____ Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____

_____

_____

Patient Signature:	**Date:**

Witness Signature:	Address:	Date:
Witness Signature:	Address:	Date:

At least one witness must sign, must not be husband or wife or blood relative of the principal.

My Medical Access
MMA Your Personalized Medical Care is our Priority

Primary Care Physicians located in Oldsmar, Palm Harbor and Clearwater
William Alvarez, D.O. Hans A. Langschwager, M.D. Sheila Sagar, M.D.

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Section 381.026, Florida Statutes

The purpose of this section is to promote the interests and well-being of patients and to promote better communication between the patient and the health care provider. 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 follows.

A PATIENT HAS THE RIGHT TO:

- Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare. .
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
- Express complaints regarding any violation of his or her rights.

A PATIENT IS RESPONSIBLE FOR:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His or her actions if treatment is refused or if the patient does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

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HIPAA NOTICE OF PRIVACY PRACTICES
Effective Date: March 26, 2013

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

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.
You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.
You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.
You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.
You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.
You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at _____.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.
Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.
We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization.

However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health
Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:
To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.
As Required By Law. For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.
In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.

To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.
For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues. For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at anytime. Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in should with written notice.
• Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require will require a separate written authorization.
• Use or Disclosure of Psychotherapy Notes. *Written a*uthorization is required if our practice intends to use or disclose psychotherapy notes.
• Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations. Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:
Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.
Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

VI. Our Duties.
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.
We are also required to abide by the terms of this Notice.
We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.
You may make complaints to our HIPAA Privacy Officer or the Security of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.
We will review all complaints in a professional manner and keep you informed of your rights as our patient.
We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer at _____.

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775