API

SOUTH FLORIDA ENT ASSOCIATES

PLEASE PRINT PATIENT'S COMPLETE LEGAL NAME

HAVE YOU REGISTERED ON OUR PATIENT PORTAL? **Y / N** **If not, please go to www.sfenta.com and Click on the Portal Link.**

Patient Name: _____ **Social Security Number:** _____ - _____ - _____

Date of Birth: _____ / _____ / _____ **Home Tel:** (_____) _____ **Cell:** (_____) _____

Address: _____ **APT /UNIT:** _____

City: _____ **State:** _____ **Zip:** _____

Please circle or fill in for the below section.

Sex: Male Female **Marital Status:** Single Married Widowed Divorced **Language:** English Spanish _____

Race: White Black Hispanic Asian _____ **Ethnicity:** Hispanic/Latino or Non-Hispanic/Non-Latino

Appointment Reminders Via: Home Cell Text Email **Visit Summary Provided Via:** Portal Printed Decline

Email: _____ **How did you hear about us:** _____

PHARMACY NAME: _____ **PHONE:** (_____) _____

Pri Care Prov: _____ **Phone:** (_____) _____ **Fax:** (_____) _____

Referring Phy: _____ **Phone:** (_____) _____ **Fax:** (_____) _____

Employer: _____ Phone**:** (_____) _____ Occupation**:** _____

Spouse Name: _____ **Spouse DOB**: _____ / _____ / _____ **Spouse's Phone:** (_____) _____

****

EMERGENCY CONTACT/RELATIONSHIP _____

PHONE NUMBER: (_____) _____ ALTERNATE NUMBER: (_____) _____

Would you like to designate a personal representative which grants your physician permission to discuss your personal health information (PHI) with your spouse or other family member? **(CIRCLE) YES NO**

NAME OF FAMILY MEMBER_____ **RELATIONSHIP**_____

Do you give permission to our physicians to leave messages on your answering machine/voicemail regarding your Personal Health Information (i.e. test results, etc.)? **(CIRCLE) YES NO**

IF YES, WHAT PHONE NUMBER? (_____) _____

IS THIS VISIT RELATED TO AUTO ACCIDENT (CIRCLE) YES NO WORKER'S COMPENSATION (CIRCLE) YES NO

HEALTH INSURANCE

***A photocopy of these assignments shall be valid as the original**

***PRIMARY INSURANCE:** _____ POLICY# _____ GRP# _____

INSURED'S NAME: _____ INSURED'S DOB: _____ / _____ / _____

INSURED'S SS#: _____ - _____ - _____ RELATIONSHIP TO PT: _____

***SECONDARY INSURANCE**: _____ POLICY# _____ GRP# _____

INSURED'S NAME: _____ INSURED'S DOB: _____ / _____ / _____

INSURED'S SS#: _____ - _____ - _____ RELATIONSHIP TO PT: _____

NOTICE TO PATIENTS: Provider will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary.

I declare that all information presented at date of service is complete and accurate. In the event that insurance is inaccurate or incomplete the patient will be responsible for all charges incurred.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize South Florida ENT Associates, P.A. to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to South Florida ENT Associates, P.A. I understand that I am financially responsible to the Doctor for all charges, for any balance or fee not covered in the event that I have no insurance or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

SIGNATURE: _____ **DATE**: _____

SOUTH FLORIDA ENT ASSOCIATES

MEDICAL HISTORY

Patient Name: _____ Birthdate: _____/_____/_____ Age: _____

SEX: ☐M ☐F If female, are you pregnant? ☐Y ☐N Height: _____ Weight: _____

Chief Complaint/Reason For Visit: _____ Referring Doctor/PCP: _____

Curent Symptoms (Circle any positives):

HEAD-SINUSES: FACIAL PAIN / HEADACHES / PRESSURE / CONGESTION / BLEEDING / SNEEZING / RUNNY NOSE / LOSS OF SMELL / ITCHING / POST NASAL DRAINAGE	NONE ☐
EARS-HEARING: PAIN / HEARING LOSS / RINGING IN THE EARS / PRESSURE / LOSS OF BALANCE / ITCHING / DRAINING / EAR WAX	NONE ☐
MOUTH: DENTAL PROBLEM / DRY MOUTH / BAD BREATH / COLD SORES / ULCERATIONS / PAROTITIS / BLEEDING	NONE ☐
THROAT: SORE / HOARSENESS / LOSS OF TASTE / BAD TASTE / WHITE SPOTS / LESIONS / SNORING / DIFFICULTY SWALLOWING	NONE ☐
RESPIRATORY: SHORTNESS OF BREATH / COUGH / WHEEZING / ASTHMA	NONE ☐
GI: HEARTBURN / REFLUX / DIARRHEA / NAUSEA / VOMITING / GASTRITIS	NONE ☐
NEUROLOGICAL: HEADACHES / PASSING OUT / DIZZINESS / NUMBNESS	NONE ☐
CONSTITUTIONAL SYMPTOMS: FATIGUE / FEVER / CHILLS / NIGHT SWEATS / WEIGHT LOSS OR GAIN / FAINTING	NONE ☐
EYES: DOUBLE VISION / ITCHING / VISION LOSS / PAIN / BURNING / TEARING / DRY EYES	NONE ☐
SKIN: RASH / ITCHING / LESIONS / HIVES	NONE ☐
MUSCULOSKELETAL: JOINT PAIN / JAW PAIN	NONE ☐
HEMATOLOGIC-LYMPHATIC: NECK MASS / BRUISING	NONE ☐

Medical History (Check if you have history of the following)

- ☐ HEAD OR FACIAL TRAUMA
- ☐ SINUS SURGERY
- ☐ MASTOIDITIS
- ☐ ASTHMA
- ☐ SLEEP APNEA
- ☐ REFLUX
- ☐ HIATAL HERNIA
- ☐ STROKE
- ☐ SEIZURES
- ☐ HYPERTENSION
- ☐ MITRAL VALVE PROLAPSE
- ☐ PAST HEART ATTACKS
- ☐ PACEMAKER
- ☐ HIGH COLOSTEROL
- ☐ GLAUCOMA
- ☐ SKIN CANCER
- ☐ ARTHRITIS
- ☐ MUSCULAR DYSTROPHY
- ☐ CONGENITAL PROBLEMS
- ☐ KIDNEY STONES
- ☐ ANXIETY
- ☐ SLEEP DISORDER
- ☐ MEMORY LOSS
- ☐ DRUG ADDICTION
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ OBESITY
- ☐ THYROID DISEASE
- ☐ PARATHYROID DISEASE
- ☐ PITUITARY DISEASE
- ☐ NECK MASSES
- ☐ ANEMIA
- ☐ IMMUNE PROBLEMS
- ☐ PVT PULMONARY EMBOLISM
- ☐ FRACTURES
- ☐ OSTEOPOROSIS
- ☐ LUPUS
- ☐ DIALYSIS
- ☐ PROSTATE PROBLEMS
- ☐ OTHER _____

Surgical History (List all past surgeries)

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History of Medical Problems

Relationship	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently using **tobacco** products? ☐Y ☐N If yes, quantity per day: _____

If you are a former tobacco product user, what was the frequency of use per day? _____ For how long? _____

Do you drink **alcohol**? ☐Y ☐N If yes, amount: _____ How often: _____

Do you currently have or have you in the past had a problem with **substance abuse** ? ☐Y ☐N

Please list all **allergies** below(including medication, environmental, and/or food allergies): ☐ No Allergies

_____

List all **medications** w/mg you are currently taking (including all over the counter medications and vitamins): ☐ None

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

(If patient is a minor, please indicate the person completing the Medical History and the relationship to patient)

Relationship to Patient: _____ Name of Parent/Guardian: _____

SOUTH FLORIDA
ENT ASSOCIATES

Designation of Personal Representative

As required by the Health Information Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Patient Name: _____ Date: _____/____/_____
(Last) (First) (MI)

Address: _____

Telephone: _____ Date of Birth_____/_____/_____

I request the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my protected health information:

Name: _____

Address: _____

Telephone: _____

What relationship is this person to you? _____

I authorize the above person(s) to have the same rights to obtain my medical history.

_____ _____
Patient Signature Date

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to **South Florida ENT Associates, P.A.** I further understand that any such revocation does not apply if that person or person's authorized use or disclosure of my protected health information have already taken action on my behalf.

I hereby revoke this designation of a personal representative.

_____ _____
Patient's Signature Date

SOUTH FLORIDA ENT ASSOCIATES

FINANCIAL AND ADMINISTRATIVE POLICIES AGREEMENT and RELEASE FORM

Thank you for selecting South Florida ENT as your Care Provider. It is very important that you understand your responsibilities as a patient when receiving care in our offices.

Patient Financial Responsibility

If you have health insurance that we will be filing for payment, the patient is expected to present a current insurance card and valid picture ID at each visit. All co-payments and any previous outstanding balances are due at time of check-in, unless previous arrangements have been made with a billing coordinator. For your convenience, we accept cash, check or credit cards/debit cards. No post-dated checks will be accepted.

Insurance Claims

You have a contract between you and your insurance company. It is your responsibility to understand your insurance plan benefits. We will bill your primary insurance company if we are contracted providers. In order to properly bill your insurance company we require that you disclose ALL insurance information including primary and secondary insurance, as well as, any change of insurance information PRIOR to receiving services.

Failure to provide complete and accurate insurance information may result in the entire bill being your responsibility. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Once the claim is processed, if there is any additional liability you will be billed accordingly.

Services unexpectedly denied by your insurance plan due to retroactive terminations, Coordination of Benefits (other health insurance that may be primary) denials, payment offset due to retroactive termination, failure to respond to your insurance plans with requested information or failure to provide our office with any NEW health insurance changes are all reasons patients may be responsible for payment of services received in our office. All of these circumstances are beyond our control. It is the patient's responsibility to resolve any issues that arise with their eligibility and benefits.

If we are NOT contracted with your insurance plan/Network, and we are filing on your behalf, you agree to pay any portion of the charges not covered by insurance including, but not limited to, those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment of the charges in full and agree to issue the payment to us immediately. We highly recommend you also contact your insurance carrier and check your available benefits before care is received from SFENTA. Do not assume that you will not owe anything, even if you have more than one insurance policy.

Referrals and Pre-authorizations

Certain health insurance plans require that you obtain a referral or prior authorization from you Primary Care Provider before visiting a specialist. If your insurance plan requires this, you are responsible for obtaining it. Failure to obtain a referral and/or preauthorization may result in a lower or no payment from the insurance plan, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If you have health insurance and there is a discrepancy regarding your coverage or eligibility, the patient will be considered self-pay unless otherwise proven.

Missed Appointments

South Florida ENT Associates, P.A. (SFENTA) requires 24-hour notice of appointment cancellation. Appointments missed and not previously canceled may be charged a fee of up to $25.00 for office visits and additional fees for other scheduled services. A separate document explaining the additional fees for canceled services will be provided.

Disability, Insurance Forms, and Other Forms:

There will be a charge for the completion of medical forms or you may be required to schedule an appointment. Payment is due upon pick-up of these forms. If you would like the forms mailed to you or the insurance, payment will be due prior to mailing.

Returned Checks/Credit Card Disputes

The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check. Unsubstantiated credit card disputes will incur a $35 administrative fee.

Medical Record Copies

We will provide you a copy of your medical records upon receipt of a signed release of medical records request form. Please allow up to 30 days for this request to be processed. Patients requesting copies of medical records will be charged up to $1.00 per page and payment must be received prior to the copying of your medical records for release.

Outstanding Balance Policy

It is our office policy that all past due accounts be contacted via statements, letters and/or phone calls in accordance with our internal policy. If resolution is not made after the attempts from our internal collection department, the account will be sent to our collection agency. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Collection Fees

I understand that in the event my account is placed in collection status and, as a result, turned over by the practice to a debt collector, a fee, in the amount of 30% of my account balance, will be added to my outstanding balance. I understand this amount is a fee and not interest, which fee will be added to my account balance, to be collected by those debt collectors engaged by the practice. I understand this fee, together with my account balance, will be my personal responsibility to pay in full.

Notice to Patients

Provider will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary. We do our best to determine if the patient will be covered for the services to be provided during your visit, however, plan benefits vary from plan to plan and we may not be aware of any specific limitations included in your specific benefit plan.

Authorization & Assignment of Benefits

I authorize SFENTA to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to SFENTA I understand that I am financially responsible to the Provider for all charges, for any balance or fee not covered in the event that I have no insurance or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

Divorced Parents of Minor Children

I acknowledge that, if my minor child is treated by SFENTA and his or her parents are divorced, the parent who signs in such minor child into the practice on the date this Agreement is executed (the "Responsible Parent"), accepts responsibility for payment for services rendered on such day, as well as for all future services rendered by the practice for such minor child. We do not promise nor are we obligated to send bills, patient records or related communications to the other parent/legal guardian pertaining to issues of payment or communications. We will communicate about treatment and payment with the Responsible Parent as to any and all matters from and after the date of this Agreement. I acknowledge that the parents are responsible to communicate with each other about treatment and payment issues involving their minor child.

Communication

I consent to receive calls, text messages and emails from SFENTA and its Business Associates regarding my account information, which may contain Personal Health Information (PHI), at the listed phone number(s) below, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Cell Phone: _____ Home Phone: _____

Definitions

For purposes of this Agreement, the terms “we”, “our” the "practice" and “SFENTA” shall mean South Florida ENT Associates and the terms “I”, “my”, “you” and “your” refer to the patient or responsible party for such patient executing this Agreement below.

I have read and understand the practice's financial and administrative policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____
Patient Name Patient DOB

_____ _____
Responsible party member’s name Relationship

_____ _____
Responsible party member’s Signature Date

SOUTH FLORIDA ENT ASSOCIATES

NOTICE OF PRIVACY PRACTICES

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

South Florida ENT is committed to protecting your personal health information. We strongly encourage you to contact our office first if you have any issues or a question arises in regards to your personal information being used by South Florida ENT.

Effective Date: June 1, 2013
This Notice was revised on May 16, 2013

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Stacey Citrin
Mailing Address: 8181 NW 154th Street, Suite 200, Miami Lakes, FL 33016
Telephone: (305)558-3724
Fax: (786) 662-3555
Email: scitrin@southfloridaent.com

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you

to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. *(Optional, only included if applicable.)*
- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information 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 Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, 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 confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.
- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.
- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as 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 disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is 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) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. *(Optional)* If you do not want to receive these materials, please submit a written request to the Privacy Officer.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.
- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for

a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.
- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

REVISIONS OF NOTICE OF PRIVACY PRACTICES.

We reserve the right to change the terms of this Notice, making any revisions applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at South Florida ENT Associates, P.A. and will make paper copies of the revised Notice of Privacy Practices available upon request.

SOUTH FLORIDA
ENT ASSOCIATES

Patient Acknowledgement of Receipt of the Notice of Privacy Practices and Consent to Use and Disclose Health Information

I acknowledge that I was provided with a copy of the South Florida ENT Associates, P.A.'s Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that South Florida ENT Associates, P.A. continues to its good faith effort to comply with the requirements of the Federal privacy law, I hereby consent to the use and disclosure of my Health Information for the purposes and the activities permitted under the federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the South Florida ENT Associates, P.A Corporate office at (305) 558-3724.

I acknowledge that I have received a copy of the South Florida ENT Associates, P.A. Notice of Privacy Practices.

_____ _____
Patient Name Date

_____
Signature of Patient

_____ _____
Patient Legal Representative (if applicable) Date

_____
Signature of Legal Representative

FOR PHYSICIAN'S OFFICE USE ONLY

_____
Office Staff Member Obtaining Signature

<u>Reason Signature and Date were not obtained</u>

☐ **Individual Refused to Sign**

☐ **Communication barriers prohibited obtaining the acknowledgement**

☐ **An emergency situation prevented us from obtaining acknowledgement**

☐ **Other (Please specify)** _____