Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record

- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- Sale of your information

In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

We can use your health information and share it with other professionals who are treating you.

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. Your information may be shared w/ other providers, labs and radiology groups through our EHR system as listed:

1) Lab Corp 2) Quest 3) Beacon 4) eDoc4U

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Preventing or reducing a serious threat to anyone's health or safety
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence
- Reporting adverse reactions to medications
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions as military, national security, and presidential protective services
- Respond to lawsuits and legal actions

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

You Have A Right To File A Complaint If You Feel Your Privacy Has Been Violated

- **If you feel your Privacy Rights have been violated, please ask our staff for a Privacy Complaint Form. Our Security Officer will review the form and promptly notifiy you of the actions our office will take.**
- or You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting http://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html
- We will not retaliate against you for filing a complaint.

CFP Physicians Group

HIPAA Compliance Officer: Roseanna Fowler

Phone: 407-831-5252

This Notice of Privacy Practices is effective March 1, 2017

CFP PHYSICIANS GROUP

985 SR 436, Casselberry, FL 32707 • (407) 831-5252 • Fax (407) 831-3765

Today's Date: _____

PATIENT INFORMATION

Name:	Email:
Address One:	Communication Preference: Mail Phone Other_____
Address Two:	Social Security #:
City:	Date of Birth:
State: Zip:	Employer:
Primary Phone #:	Emergency Contact:
Home Phone #:	Emergency Phone #:
Work Phone #:	Emergency Relationship:
Cell Phone #:	

GUARANTOR INFORMATION (Parent, POA, Financial Responsibility)

Name:	Home Phone #:
Address One:	Work Phone #:
Address Two:	Cell Phone #:
City:	Date of Birth:
State: Zip:	Social Security #:

INSURANCE INFORMATION (Please provide an Insurance Card)

Primary Insurance:	Secondary Insurance:
Certificate #:	Certificate #:
Group Number:	Group Number:
Group Name / Employer Name:	Group Name / Employer Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Subscriber SS#:	Subscriber SS#:

MEANINGFUL USE

RACE:	LANGUAGE:
ETHNICITY:	SEX:

Financial Policy: Payment for co-payments, deductibles and coinsurance are expected at the time services are rendered. Any necessary financial arrangements are to be made prior to treatment. We bill only insurances we are contracted with and the patient is expected to know what coverage they have. The above information is accurate to the best of my knowledge.

Patient Signature (or parent if a minor) _____ Date:_____

CFP Physicians Group

Today's Date: _____

MEDICAL HISTORY FORM

Patient Name: _____ Age: _____ D.O.B.: _____

Please share with us the reason for your visit: _____

_____

_____

PAST MEDICAL HISTORY	NO	YES	If yes, please explain		NO	YES	If yes, please explain
Cancer- Breast							
Cancer- Cervical				ID- Unusual Childhood Disease			
Cancer- Colon				Neurology- Headaches / Migraines			
Cancer- Lung				Neurology- Memory Loss / Dementia			
Cancer- Other				Neurology- Neuropathy			
Cancer- Ovary				Neurology- Other			
Cancer- Skin				Neurology- Seizures / Epilepsy			
Cancer- Prostate				Neurology- Stroke / TIA			
Cardiac- Heart Arrhythmia				Ortho- Chronic Back Pain			
Cardiac- Heart Disease				Ortho- Degenerative Joint Disease			
Cardiac- High Blood Pressure				Ortho- Fractures			
Cardiac- High Cholesterol				Ortho- Other			
Cardiac- Other				Psych- ADD			
Dermatology- Acne				Psych- Anxiety Disorder			
Dermatology- Eczema / Psoriasis				Psych- Bipolar Disease			
Dermatology- Other				Psych- Depression			
ENT- Hearing Loss				Psych- Eating Disorder			
ENT- Other				Psych- Other			
Endocrinology- Diabetes				Psych- PMS / PMDD			
Endocrinology- Osteopenia				Pulmonary- Asthma			
Endocrinology- Osteoporosis				Pulmonary- COPD / Emphysema			
Endocrinology- Other				Pulmonary- Other			
Endocrinology- Thyroid Problems				Pulmonary- Seasonal Allergies/Allergic			
Eyes- Cataracts				Pulmonary- Sleep Apnea			
Eyes- Glaucoma				Rheumatology- Arthritis			
Eyes- Other				Rheumatology- Autoimmune Disease			
Eyes- Vision Loss				Rheumatology- Fibromyalgia			
GI- Colon Polyps				Rheumatology- Other			
GI- Crohn's / Ulcerative Colitis				Rheumatology-Restless Leg Syndrome			
GI- Gallbladder Disease				Urology- Frequent Urinary Tract Infec			
GI- Hemorrhoids				Urology- Hematuria (Blood in Urine)			
GI- Irritable Bowel Syndrome				Urology- Interstitial Cystitis			
GI- Liver Disease / Hepatitis				Urology- Kidney Disease			
GI- Other				Urology- Kidney Infec			
GI- Reflux / Stomach Ulcers				Urology- Kidney Stones			
GI- Vitamin Deficieny				Urology- Other			
Hematology- Anemia				Urology- Urinary Incontinence			
Hematology- Bleeding Disorder				Wt Management- Obesity			
Hematology- Blood Clotting Disorder				Wt Management- Other			
Hematology- Blood Transfusion							
Hematology-DVT/Pulmonary Embolism							
Hematology-Other							
ID- HIV							
ID- MRSA							
ID- Other							
ID- Tuberculosis / Positive PPD							

CFP Physicians Group

Today's Date: _____

Patient Name: _____ D.O.B.: _____

SURGICAL HISTORY *(Please list all procedures, not just OB-GYN)*

Date	Type of Surgery	Reason for Surgery

MEDICATIONS

Medication Name	Dose	Frequency

ALLERGIES / ADVERSE REACTIONS

Drug	What is your reaction?

GYN HISTORY *(please circle)* FEMALE ONLY

Frequency of Cycle:	Monthly	< 21 days	>35 days	very irreg.
Duration of flow in days:				
Amount of flow:	light	moderate	heavy	
Cramps:	no	yes		
Current birth control:	abstinence	condom	depo	essure
	IUD	nexplanon	patch	pills
	Ring	rhythm	tubal ligation	vasectomy
	none			
If applicable: Age at Menopause				
Sexual Orientation:	Heterosexual	Homosexual	Bisexual	
Sexually active:	yes	no		

CFP Physicians Group

FAMILY HISTORY Patient Name _____ D.O.B. _____

	Living Age	List Any Health Problems	Cause Of Death
FATHER			
MOTHER			
SIBLINGS			

SOCIAL HISTORY *(please circle)*

Smoking status:	never	former	daily	sometimes		
Smoking, how much?						
Alcohol intake:	none	occasional	moderate	heavy		
Illicit drugs?	none	yes				
Caffeine intake	none	occasional	moderate	heavy		
Exercise level:	none	occasional	moderate	heavy		
Diet:	regular/vegetarian	vegan	no gluten	cardiac	diabetic	
Marital status:	married	single	divorced	separated	widow	domestic partner
Hx of domestic violence:	yes	no				
Education:	<8th gr	8-12th	2 yr college	4 yr college	postgraduate	
Occupation:						
Religion:						
Seat belts used routinely?	yes	no				
Is a blood transfusion acceptable in an emergency?	yes	no				

PATIENT'S PHARMACY

Name	Address	Phone

PATIENT'S PROVIDERS *(Please list your primary doctor and any other doctors you see)*

Name	Specialty	Address & Phone Information

Patient Name:_____ Date of Birth:_____

1. Have you been in a **Hospital, ER or Skilled Nursing Facility** in the past 30 days? (Please circle one)

   YES or **NO**

   If you circled No please proceed to question 2

   If Yes

   Location you were at:_____

   Dates you were there:_____

   Reason for the visit:_____
   _____
   _____
   _____

2. Do you currently receive Home Health? (Please circle one)

   YES or **NO**

   If Yes

   Which company do you receive service from?_____
   _____

If you are ever Hospitalized, visit an ER, or are admitted to a Skilled Nursing Facility please contact our office at your earliest convince 407-831-5252

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

Print Patient Name: _____ Date: _____

Print Name of Parent/ Legal Guardian/ Authorized Representative _____ Date: _____

I hereby authorize the release or use of my/ or the patient's individually identifiable health information ("protected health information") and medical record information by CFP Physicians Group, P.L.© (the "Practice") in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

If you allow a third party other than one of our practice's physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your/ the patient's care, treatment or medical condition with you, by signing this Consent form you are consenting to the disclosure of your protected health information to that third party.

The Practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request, in writing, that we further restrict how your/ the patient's protected health information is released or used to carry out our treatment, payment, or health care operations. Our practice is not required to agree to such requested restriction(s); However, if we do agree, in writing, to your/ the patient's requested restriction(s), such restrictions are then binding on the Practice.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided, either in electronic or written format, a copy of CFP Physician Group's Notice of Privacy Practices.

Signature of Patient (or Authorized Representative): _____

I acknowledge and agree that the Practice may disclose my/ the patient's protected health information and medical record information to the following individuals: **(please initial line and write in name of individual)**

_____ Spouse _____ _____ Parent _____

_____ Child _____ _____ Legal Guardian _____

_____ Other _____ _____ Power of Attorney _____

I agree that the Practice may also disclose the following types of information contained in my/the patient's medical record unless initialed below. (Please initial to EXCLUDE)

	Substance Abuse Information		HIV/AIDS Information
	Sexually Transmitted Information		Mental Health Information
	Pregnancy Information if patient is under 18 years old.		Genetic Testing

I agree and consent to the Practice releasing information to me in the following alternative manners unless initialed to exclude being contacted in any of these below. (Only initial to EXCLUDE)

_____Via regular mail _____ Via telephone _____ Via email

_____ Via home answering machine _____ Via work voice mail

_____ Via fax to my designated fax number which is: _____

The Practice may refuse to treat you if you/ the patient's (or an authorized representative), do not sign this Consent Form. If you revoke this consent form (as can be done in writing) after signing, the Practice has the right to refuse further treatment.

Print Patient Name: _____

I have read and understand the information in this Consent. I am aware I can request a copy of this consent and I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Date: _____ Time: _____ AM/PM

_____

Signature of Patient (or Authorized Representative)

_____

Please Print Name

FINANCIAL POLICY

Payment for co-payments, deductibles and coinsurance are expected at the time services are rendered. Any necessary financial arrangements are to be made prior to treatment. We bill only insurances we are contracted with and the patient is expected to know what coverage they have. I understand and agree to comply with CFP Physicians Group©, P.L.'s financial policy.

_____

Signature of Patient (or Authorized Representative)

ASSIGNMENT OF INSURANCE BENEFITS

I authorize the release of any medical or other information necessary to process my/ the patient's claims. I assign payment directly to the physicians, the benefits which may be due to me from the Medicare program or any other insurance products including supplemental insurance, which may cover in whole or in part medical services which I/ the patient have received and I will assist in the collection of my insurance should there be any delay in payment. If my / the patient's insurance payment has not been received by the physician within 30 days of billing I agree to actively and vigorously pursue collecting the insurance payment for the physician. I understand that I am financially responsible to the physicians for charges that may not be covered in part or in full by my insurance company.

_____

Signature of Patient (or Authorized Representative)

ADVANCE DIRECTIVE

All adults in health care settings in the State of Florida have the right to an "advance directive". This is a written or oral statement made and witnessed in advance of a serious illness or injury, stating how medical decisions will be made. An advance directive enables you to state your choice or name someone to make your choice for you, should you become unable to make decisions about your medical treatment. An advance directive can enable you to make decisions.

Do you have a Living Will? ____Yes ____ No
If yes, please provide the office with a copy.

_____

Signature of Patient (or Authorized Representative)

IF THE PATIENT IS A CHILD

Should my minor child ever need medical attention and I am unavailable to give my consent for treatment, this signed statement will serve as my authorization for any physician at CFP Physicians Group©, P.L. to proceed with whatever medical care the physician deems advisable until I can be reached.

_____ _____

Child's Name

Parent/Legal Guardian/Authorized Representative Signature

_____

Print Name of Legal Guardian/Authorized Representative Signature

Patient Acknowledgement of Practice Policies, Procedures & Privacy Practices

Thank you for choosing CFP Physicians Group for your healthcare. We are committed to your care being successful and your experience in our office being pleasant. Information on our key office policies follows.

- Every time you visit our office:
  - There will be paperwork to review and/or complete.
  - You may be asked to show us your insurance card so please bring it with you.
  - You will be asked to pay your copay or coinsurance prior to the visit.
- We value your time and strive to have you in and out of our office within an hour of your scheduled appointment time.
  - If you are late for you appointment, you should expect a delay in being seen. We may need to reschedule you to an time later in the day and/or with another provider other than who you initially were scheduled to see. In some instances you may be asked to reschedule your appointment to another day.
  - If you are more than 15 minutes early for your appointment, please plan to wait until your scheduled appointment time to be seen.
- Annual/Preventative vs Sick/Problem Visits
  - Problems that you are having may not be able to be addressed at you annual physical.
  - We prefer to address your problems before we do you annual physical.
  - Insurance benefits are often different for annual/preventative verses sick/problem visits and we must comply with your insurance company contracts.
  - We try to avoid addressing multiple concerns in a single visit because the time your provider is allotted for your visit may not allow them to do so thoroughly. If you have multiple concerns, please understand that your provider may need to ask you to come back to complete your annual exam and/or your problem(s).
- Standards of Care developed by the American Academy of Family Physicians and/or required by insurance companies are adhered to by our providers. This means routine recommended tests will be performed in accordance with their guidelines. Most often these tests are paid for by your insurance but we have found occasionally some of the tests are not; it depends on your insurance coverage.
- Test Results are discussed during office visits. Please understand our providers and staff see patients during office hours and are not available to discuss test results with you over the phone.
- Medication and Rx refills are filled during office visits. We do not proscribe or refill Rx's over the phone. By reviewing and signing this form you agree to allow us to electronically obtain a list of your current medications using your insurance data.
- Fees for Appointment Cancellation and No-Shows: We require 24 hours advance notice to reschedule or cancel your appointment. The fee is $25 if less than 24 hours' notice is given or you do not show for the appointment.
- Payment Policies: Payment for co-payments, deductibles, and coinsurance are expected at the time of services is rendered. Any necessary financial arrangements are to be made prior to treatment. We bill only insurances we are contracted with and the patient is expected to know what coverage they have.

I understand and agree to comply with CFP Physicians Group's financial policy.

_____ _____

Patient/Guardian Signature Date

_____

Patient/Guardian Printed