Frank Averill, MD
Medical Director
802 N. Belcher Road
Clearwater, FL 33765
Phone 727.447.3000
Fax 727.210.4600
www.StFrancisMed.com

"Giving of ourselves...so you receive... excellent care."

PLEASE PRINT- PATIENT INFORMATION

Last Name_____ First Name_____Date of Birth_____

Social Security #_____Sex (Please Circle) M F Race_____Marital Status _____

Street Address_____City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____ Work Phone _____

Occupation_____ Employer_____ Email _____

Emergency Contact (Name/ Relationship) _____ Phone #_____

Hispanic, Latino or Spanish Origin? Yes_____ No_____ **DME Company:** _____

PRIMARY CARE PHYSICIAN_____TELEPHONE_____

PHARMACY_____ PHONE_____

LOCATION _____ FAX _____

INSURANCE INFORMATION:

Insurance Carrier: _____ Insurance Policy#: _____

WHO IS THE SUBSCRIBER OF YOUR INSURANCE? _____

If (Husband, Wife, Parent, etc) is Subscriber of insurance we need their:

Name: _____ SS#: _____ DOB: _____

INSURANCE INFORMATION – **SECONDARY**

Insurance Carrier: _____ Insurance Policy#: _____

Insurance Information of Subscriber ***IF NOT*** SELF INSURED (Husband, Wife, Parent, etc…)

Name: _____ SS#: _____ DOB: _____

ALL PATIENTS – LIFETIME AUTHORIZATION

I HEREBY AUTHORIZE ST. FRANCIS SLEEP, ALLEGY & LUNG INSTITUTE. TO REQUEST MY MEDICAL RECORDS FROM ALL PHYSICIAN'S OR MEDICAL FACILITY THEY DEEM NECESSARY FOR MY CONTINUITY OF CARE.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

INSURANCE AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF PAYMENTS:
NON-MEDICARE PATIENTS & MEDICARE PATIENTS WITH A SECONDARY INSURANCE

I HERBY AUTHORIZE ST. FRANCIS SLEEP, ALLERGY & LUNG INSTITUTE TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY(S), THAT IS NECESSARY TO PROCESS MY MEDICAL CLAIMS. I FURTHER AUTHORIZE ALL INSURANCE PAYMENTS BE MADE DIRECTLY TO ST. FRANCIS SLEEP, ALLERGY, & LUNG INSTITUTE. I UNDERSTAND THAT I WILL BE HELD FINANCIALLY RESPONSIBLE FOR ANY CHARGES THAT ARE NOT PAID BY THE INSURANCE COMPANY.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

MEDICARE PATIENTS – LIFETIME AUTHORIZATION

I HERBY AUTHORIZE ST. FRANCIS SLEEP, ALLERGY, & LUNG INSTITUTE TO RELEASE ANY INFORMATION THAT IS NECESSARY TO PROCESS MY MEDICAL CLAIMS. I FURTHER AUTHORIZE ALL MEDICARE PAYMENTS BE MADE DIRECTLY TO ST. FRANCIS SLEEP, ALLERGY, & LUNG INSTITUTE. I UNDERSTAND THAT I WILL BE HELD FINACIALLY RESPONSIBLE FOR MY DEDUCTIBLE AND ANY BALANCE NOT PAID BY MY INSURACNE CARRIER.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to St. Francis Sleep Allergy and Lung Institute. When you schedule an appointment with St. Francis Sleep Allergy and Lung Institute we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective January 1, 2019 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and may be charged a **$25.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment without a 24 hour notice a **second** time may be charged a **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule with no 24-hour notice occurs, the patient may be **dismissed** from St. Francis Sleep Allergy and Lung Institute.
- Any new patient who fails to show for their initial visit may not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Clinic Supervisor so she may be able to waive the No Show fee. You may contact St. Francis Sleep Allergy and Lung Institute 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message.

St. Francis Sleep Allergy and Lung Institute (727) 447-3000

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS, PER HIPAA REGULATIONS

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided with a "***Notice of Patient Privacy Practices***" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the *" Notice"* Prior to acknowledge this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Please Print

RESTRICTIONS:
Please tell us with whom we may NOT discuss your protected health information: [I would NOT like my information shared with the following family or friends.]

_____

_____

PERMISSIONS:
Please tell us with whom we may discuss your protected health information: [I would like to share my information with the following family and friends.]

_____

_____

May we leave a message at your **home/cell** using doctor's/practice name: Yes [ ] No [ ]
May we leave a message at your **work** using doctor's/practice name: Yes [ ] No [ ]
(Messages will be of a non-sensitive nature, such as, appointment reminders.)

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

Signing below confirms that I completely understand and accept the information of this consent.

_____
Patient Name (print)

_____ _____
Patient/ Guardian Signature **Date**

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A MESSAGE TO OUR PATIENTS

Dear Patient,

It is necessary from time to time to verify critical billing data. This can include copies of insurance cards to ensure accurate addresses and often may include social security numbers and dates of birth for the insured party. **IF YOUR INSURANCE REQUIRES A REFERRAL OR AUTHORIZATION, IT IS YOUR RESPONSIBILITY TO OBTAIN OR PROVIDE US THIS INFORMATION.**

St. Francis Institute understands and supports the protection of this information under HIPAA guidelines. Failure to provide the necessary information may result in the need to bill you directly.

As it continues to be our goal to provide you with quality medical care, including the filing of your claims, we will anticipate with appreciation your full cooperation. **Your signature and date below indicates you have read this message and understand fully the policy of St. Francis Institute.**

_____ _____

Patient Signature Date

_____

Patient Name Printed

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MEDICAL QUESTIONNAIRE

NAME: _____ DOB: _____Date: _____
Referring Physician Name? _____
Reason for visit: _____
Approx. Height: _____ Approx. Weight: _____

PAST MEDICAL HISTORY: *(please circle all that apply)*

Alcohol problem	COPD	Heart Disease	*Specify:*	Sleep Apnea
Allergic Rhinitis	Cystic Fibrosis	*Specify:*	_____	Stroke
Anemia	Depression	_____	Leukemia	Thyroid condition
Aneurysm	Diabetes	Hepatitis	Lung nodules	Specify:
Anxiety	Drug problem	Hernia	Mental illness	_____
Asthma	DVT	Hives	Narcolepsy	Tuberculosis
Back pain	Emphysema	HIV	Pneumonia	Other_____
Bronchitis	Epilepsy	Hypertension	Pulmonary	_____
Cancer	Fibromyalgia	Hyper Cholesterol	Embolus	_____
Specify: _____	GERD	Insomnia	Pulmonary Fibrosis	_____
Cirrhosis	Headaches	Kidney Disease	Sickle Cell Anemia	_____

PAST SURGICAL HISTORY: *(Please circle all that apply. Please specify.)*

Back surgery	Cholecystectomy	Thoracotomy	Hysterectomy
CABG	Mastectomy	Bladder Surgery	Appendectomy

Other: _____
_____

MEDICATION ALLERGIES: **[ ] CHECK BOX IF NO KNOWN ALLERGIES**

_____
_____

FAMILY HISTORY: *(Please check all that apply and fill in who the family member is…mother, father, grandparents, etc.)*

Family Member	**Asthma**	**Cancer** (Specify)	**COPD**	**Diabetes**	**Heart Disease** (Specify)	**High Blood Pressure**	**Lung Disease** (specify)	**Mental Illness**	**Heart Attack**	**Sleep Apnea**	**Stroke**
Father											
Mother											
Brother											
Sister											
Grandmother											
Grandfather											

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SOCIAL HISTORY

NAME: _____ DOB: _____Date: _____

(Please check all that apply)

ALCOHOL CONSUMPTION:
☐ Does not drink ☐ Social drinker: Drinks per day _____.

DRUG HISTORY:
☐ Denies drug use ☐ Cocaine use ☐ Excessive caffeine use
☐ Prescription drug abuse ☐ Heroin use ☐ Light caffeine use
☐ Marijuana use ☐ Former drug abuser ☐ No caffeine use
Comments: _____

SEXUAL HISTORY:
☐ Sexually active and monogamous ☐ Promiscuous
☐ Sexually active ☐ Current/Previous STD(s)
☐ Not sexually active ☐ Alternative lifestyle
Comments: _____

TOBACCO:
☐ Former smoker _____ packs per day and year stopped _____ ☐ Never a smoker
☐ Currently smoking _____ packs a day. ☐ Smokeless tobacco

CHILDREN: #_____ **BROTHER: #_____** **SISTER: #_____**

LIVING ARRANGENTS:
☐ Lives alone ☐ Lives with family ☐ Other:_____
☐ Lives with spouse member_____ _____
☐ Lives with significant other

MARITAL STATUS:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Engaged

PETS:
☐ None ☐ Dog ☐ Cat ☐ Other: _____

DWELLING:
☐ Apartment ☐ Multi-family house ☐ Condo
☐ Single family house ☐ Mobile home ☐ Other: _____

MISCELANEOUS:

Place of birth: _____
Hours of sleep: _____
Hours of exercise per week: _____ ☐ No Exercise
Hobbies: _____
Occupation: _____
Travels in USA: _____

Where have you traveled outside of the USA?
_____
Do you have difficulty sleeping? ☐ Yes ☐ No
Are you on a CPAP machine? ☐ Yes ☐ No
Are you on Oxygen? ☐ Yes ☐ No
Would you like to lose weight? ☐ Yes ☐ No

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HEALTH QUESTIONNAIRE

NAME: _____ DOB: _____Date: _____

RISK FACTORS (Please check all that apply)

☐ Daytime Tiredness	☐ Red, Watery Eyes	☐ Mood Disorder	☐ Accident Prone
☐ Shortness of Breath	☐ Heart Disease	☐ Kidney Disease	☐ Attention Deficit
☐ Weight Issues/Obesity	☐ Chronic Fatigue	☐ Snoring	☐ Night Talking/Walking
☐ Difficulty Falling Asleep	☐ Restless Sleep	☐ Depression	☐ Restless Legs/Cramps
☐ Reduced Concentration	☐ Night Terrors	☐ Insomnia	☐ Sexual Dysfunction
☐ High Blood Pressure	☐ Diabetes	☐ Fibromyalgia	☐ Accident Prone
☐ Nighttime Shift Worker	☐ Irritability	☐ Stroke	☐ Itching/Hives
☐ Sneezing/Wheezing	☐ Headaches	☐ Night Eating	☐ Neck Size:_____

EPWORTH SCALE

Situation	Chance of dozing (0-3)
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place – (for example, a theater or meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3
Total Score:	

Chance of Dozing:

How likely are you to doze off or fall asleep in the following routine daytime situations? (This refers to your usual way of life in recent times)

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

MEDICATION, NUTRITIONAL SUPPLEMENT and VITAMINS HISTORY:

(Attach your medication and nutritional supplement/vitamins list, if available)

Name	***Dosage***	***Directions***

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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. PLEASE REVIEW IT CAREFULLY.

St. Francis Sleep, Allergy and Lung Institute understands that medical information about you and your health is personal. We are committed to protecting this information. Our practice will create a record of the care and services you receive as a basis for planning your care and treatment, for communicating with the many healthcare professionals involved in your care, to obtain payment for services provided, as a source of information for public health officials, and to provide you with quality care while complying with certain legal requirements.

By law, this office is required to provide you with our Notice of Privacy Practices. If you should have any questions about this Notice or to submit requests pursuant to this Notice, please contact the Operations Manager at St. Francis Sleep, Allergy and Lung Institute. A copy of this Notice is available upon request.

We have a legal duty to safeguard your protected health information.

We are required by law to maintain the privacy of our patients' personal health information. We call this information "protected health information" or PHI for short. We must provide patients with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. You may receive a copy of any revised notices at our office, or a copy of the current Notice of Privacy Practices may be obtained by mailing a request to St. Francis Sleep, Allergy and Lung Institute, Attention: Privacy Officer, 802 North Belcher Road, Clearwater, Florida 33765. You may also view a copy of the notice on our website at StFrancisMed.com.

Uses and disclosures of your protected health information

Your Authorization. We will not use or disclose your PHI for any purpose other than treatment, payment and healthcare operations unless you have signed a form authorizing the use or disclosure with the exceptions of the situations outlined below. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment. We will make uses and disclosures of your PHI as necessary for your treatment. For instance, doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc.

Uses and Disclosures for Payment. We will make uses and disclosures of your PHI as necessary for payment purposes. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment. We may make uses and disclosures of your PHI to another entity or healthcare provider for payment of the entity that receives the information. For instance, we may forward information to the ambulance company that brought you to the hospital so they can prepare a bill for you or your insurance company for the ambulance service.

Uses and Disclosures for Healthcare Operations. We will use and disclose your PHI as necessary, and as permitted by law, for our healthcare operations, which include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your PHI for purposes of improving the clinical treatment and care of our patients.

Family and Friends Involved In Your Care. With your approval, we may disclose your PHI to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in your care or payment for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, outsourced billing and collection services, appointment reminder and answering service agencies, etc. At times, it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our healthcare operations. In all cases, those business associates are required to appropriately safeguard the privacy of your information.

Appointments and Services. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to request to receive communications regarding your PHI from us by alternative means or at alternative locations. Requests can be made at the time of registration. We agree to comply with reasonable requests. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. Some requests, as determined by our registration department, may need to be submitted to our Privacy Officer for evaluation. In this case, you would need to complete a Confidential Communication Request Form and submit it to ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE, HIPAA Privacy Officer, Attention Compliance Department, 802 North Belcher Road, Clearwater, Florida 33765.

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Confidentiality of Alcohol and Drug Abuse Records. Federal law and regulations protect the confidentiality of alcohol and drug program records maintained by this facility. PHI containing information on your alcohol or drug use may not be disclosed without 1) your written authorization; 2) a court order; or 3) unless the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation. Federal law or regulations do not protect any information about a crime committed by you at our facility or about any threat to commit a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Confidentiality of HIV Test or Diagnosis of AIDS or AIDS Related Condition. Florida law requires that we have your authorization or a court order before disclosing the results of an HIV test or diagnosis of AIDS or AIDS- related conditions.

Other Uses and Disclosures. We are permitted or required by law to make other uses and disclosures of your PHI without your authorization. The following apply:

We may release your PHI for any purpose required by law: if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence; to law enforcement officials to report wounds, injuries and crimes; to a government oversight agency conducting audits, investigations, or civil or criminal proceedings; and if required to do so by a court or administrative ordered subpoena or discovery request. You will have notice of such release in most of these cases;

We may release your PHI for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations; we may release your PHI to coroners and/or funeral directors consistent with law;

We may release your PHI to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;

We may release your PHI to your employer when we have provided healthcare to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;

We may release your PHI if necessary to arrange an organ or tissue donation from you or a transplant for you;

We may release your PHI if in limited instances we suspect a serious threat to health or safety;

We may release your PHI for certain research purposes without your authorization when such research is approved by an institutional review board with established rules to ensure privacy or with researcher representation that limit the use and disclosure of the PHI;

We may release your PHI if you are a member of the military as required by armed forces services; we may also release your PHI if necessary for national security or intelligence activities; and

We may release your PHI to workers' compensation agencies if necessary for your workers' compensation benefit determination.

We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician will attempt to obtain your acknowledgment of this Notice as soon as reasonably practicable after the delivery of treatment.

From time to time, we may use and disclose protected health information to tell you about certain health-related benefits or services that may be of interest to you.

We may release protected health information if asked to do so by a law enforcement official, in response to a court order, subpoena, warrant, summons, or similar process. Other related disclosures may include disclosures relating to individuals who are Armed Forces personnel, to national security and intelligence agencies, as well as disclosures to authorized federal officials for the protection of the President of the United States or other authorized persons or foreign heads of state.

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

Rights that you have regarding your PHI

Access to Your Protected Health Information. You have the right to receive a copy and/or inspect much of the PHI we retain on your behalf, unless excluded by law. All requests for access must be made in writing and signed by you or your legal representative. We may charge you a fee for copying the information and for postage if you request a mailed copy. You may obtain an authorization for release of patient protected health information form from ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE Medical Record Services, 802 North Belcher Road, Clearwater, Florida 33765.

Amendments to Your Protected Health Information. You have the right to request in writing that PHI that we maintain about you be amended. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment request. If an amendment you request is made by us, we may also notify others who work with

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us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE HIPAA Privacy Officer, Attention Compliance Department, 802 North Belcher Road, Clearwater, Florida 33765.

Accounting for Disclosures of Your Protected Health Information. You have the right to receive an accounting of certain disclosures made by us of your PHI after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. You may obtain an accounting request form from ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE HIPAA Privacy Officer, Attention HIPAA Privacy Officer, Attention Compliance Department, 802 North Belcher Road, Clearwater, Florida 33765. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request a restriction on the uses and disclosures of your PHI for treatment, payment and healthcare operations. For example, you have the right to request that we not disclose your PHI to a health plan for payment or healthcare operations purposes, if that PHI pertains to a healthcare item or service for which we have been involved and which has been paid out of pocket in full. We are required to comply with your request for this type of restriction. For all other requests for restrictions on use and disclosures of your PHI, we are not required to agree to your request, but will attempt to accommodate reasonable requests when appropriate; we also retain the right to terminate an agreed to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You have the right to terminate, in writing to the Privacy Officer, any requested restrictions. You may obtain a request for restriction form from ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE HIPAA Privacy Officer, Attention Compliance Department, 802 North Belcher Road, Clearwater, Florida 33765.

Right to Confidential Communications. You also have the right to request to receive private health information communications by alternative means or at alternative locations. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE HIPAA Privacy Officer, Attention Compliance Department, 802 North Belcher Road, Clearwater, Florida 33765. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

You may obtain a copy of this Notice at our website: StFrancisMed.com
* To obtain a paper copy of this Notice, contact ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE HIPAA Privacy Officer, Attention Compliance Department, 802 North Belcher Road, Clearwater, Florida 33765.

How to complain about our privacy practices
If you believe your privacy rights have been violated, you may file a complaint with ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE HIPAA Privacy Officer, Attention Compliance Department, 802 North Belcher Road, Clearwater, Florida 33765. The complaint must be filed in writing. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in writing within 180 days of an alleged violation of your rights. There will be no retaliation for filing a complaint

Breach Notification
In the event of any Breach of Unsecured PHI, ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE shall fully comply with the HIPAA/HITECH breach notification requirements, which will include notification to you of any impact that Breach may have had on you and/or your family member(s) and actions ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE undertook to minimize any impact the Breach may or could have on you.

Person to contact for further information or assistance
If you have questions or need further assistance regarding this Notice, you may contact ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE's Privacy Office by telephone at **(727) 447-3000** or by mail at ST. FRANCIS SLEEP, ALLERGY AND LUNG INSTITUTE HIPAA Privacy Officer, Attention Compliance Department, 802 North Belcher Road, Clearwater, Florida 33765. As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by email or other electronic means.

Effective date
This Notice of Privacy Practices is effective April 14, 2003, with revisions effective January 13, 2014.

We strive to provide quality healthcare to all our patients.

_____ _____ _____
Signature of Patient or Representative | Relationship/Authority of Representative | Date

_____ _____
Witness | Date