NORTHEAST FLORIDA INTERNAL MEDICINE
Elyssa Blissenbach, MD. PA.
2065 Herschel Street
Jacksonville, Florida 32204
904-387-4050

PATIENT INFORMATION SHEET

Name: _____ SSN: _____
First MI Last

Date of Birth: _____ Male:_____ Female: _____

Single: _____ Married: _____ Widowed: _____ Divorced: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Emergency Contact Name & Relation: _____

Phone Number: _____

Referred By: _____

PLEASE READ THE FOLLOWING AUTHORIZATION AND SIGN:

I hereby authorize my insurance benefit to be paid directly to Elyssa A. Blissenbach, M.D., P.A. for any services furnished to me, I acknowledge financial responsibility for non-covered services. I also authorize the physician to release any information required in order to process any and all claims.

Patient's Signature: _____ Date: _____

Patient Name: _____ DOB: _____

MEDICATIONS/VITAMINS/SUPPLEMENTS/BIRTH CONTROL

Name of Pharmacy: _____ Phone # _____

Please list ALL prescription medications:

NAME OF DRUG	DOSE	TIMES PER DAY

Name of Glucometer: _____

Vitamins/Minerals: _____

Dietary Supplements: _____

Aspirin: _____

Herbal Products: _____

Pain Relief Products: _____

ALLERGIES—Please list type of reaction next to each allergy:

_____

_____

Patient Name: _____ DOB: _____

SURGICAL HISTORY (Please list all surgeries with approximate date):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Describe your current state of health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

FAMILY HISTORY:

	Father	Mother	Brother	Sister	Grandparent
History Unknown	☐	☐	☐	☐	☐
Heart Attack, bypass surgery, angioplasty before age 55	☐	☐	☐	☐	☐
Heart Attack, bypass surgery, angioplasty after age 55	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Elevated cholesterol or triglycerides	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Other Cancer/Malignancy	☐	☐	☐	☐	☐
Arthritis, any type	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

SOCIAL HISTORY:

Occupation:_____ Current Employer:_____

How much caffeine (coffee, tea, soda, etc.) do you drink? Number of servings per day?_____ Per week?____

How much alcohol do you drink? Number of drinks per day?____ Per week?____ Per month?____

Do you use tobacco? No Yes Cigarettes Cigar Snuff/Chew E-cigarette

Number of packs per day? _____ Number of years you smoked? _____

When did you quit?_____

Have you ever used marijuana, cocaine, or other drugs? No Yes

REVIEW OF SYSTEMS

Patient Name:_____ Date:_____

Check either yes or no for each item except where it applies to only male or female

	Condition	Yes	No
GENERAL	Fever		
	Chills		
	Bruise Easily		
	Swollen Glands		
	Loss of Memory		
	General Weakness		
	Aches/Pains		
ENT	Double Vision		
	Light Flashes		
	Blurred Vision w/o Glasses		
	Halos Around Lights		
	Eye Pains		
	Ear Pains		
	Buzzing/Ringing in Ears		
	Nose Bleeds		
	Sinus Problems		
	Swallowing Problems		
	Deafness		
	Mouth/Tooth/Tongue Problems		
	Persistent Hoarseness		
	Severe Headaches		
	Other*		
SKIN	Rash		
	Changing Moles		
	Pigment Changes		
	Other*		
CHEST/HEART/LUNGS	Irregular Heart Beat		
	Shortness of Breath		
	Low Exercise Tolerance		
	Heart Flutters		
	Chest Pain		
	Frequent Cough		
	Cough up Blood		
	Wheezing		
	Night Sweats		
	Swollen Ankles		
	Leg Cramps		
	Other*		

	Condition	Yes	No
NECK	Stiffness		
	Swelling		
	Lumps		
	Other*		
GASTROINTESTINAL	Poor Appetite		
	Indigestion/Heartburn		
	Nausea		
	Vomiting Blood		
	Abdominal Pain/Cramps		
	Abdominal Tension		
	Diarrhea		
	Constipation		
	Bowel Changes		
	Rectal Bleeding		
	Black Tar-like Stool		
	Other*		
KIDNEY	Up Nights to Urinate		
	Blood in Urine		
	Burning/Pain while Urinating		
	Difficulty Urinating		
	Trouble Controlling Urine		
	Other*		
NEURO	Leg/Arm Weakness		
	Balance Problems		
	Dizziness		
	Fainting Spells		
	Speech Problems		
	Other*		
BONE/JOINT	Joint Pain		
	Joint Swelling		
	Muscle Weakness		
	Muscle Lump/Swelling		
	Lump on Bone		
	Back Pain		
	Other*		
ENDOCRINE	Constant Thirst		
	Always Cold		
	Always Warm		
	Very Sluggish or Tired		
	Jumpy/Nervous		
	Other*		

	Condition	Yes	No
PSYCHOLOGICAL	**Is your life:**		
	Satisfactory		
	Boring		
	Demanding		
	Unsatisfactory		
	Is there worry over:		
	Home Life		
	Marriage		
	Job		
	Children		
	Money		
	Do you:		
	Often Feel Depressed		
	Have Irrational Fears		
	Feeling Things Go Wrong Often		
	Feel Upset		
	Feel Shy		
	Cry Easily		
	Feel Inferior		
	Have you:		
	Attempted Suicide		
	Seriously Considered Suicide		
MALE	Lump in Testicles		
	Penile Discharge		
	Breast Lump		
	Sore on Penis		
	Erection Difficulty		
	Other*		
FEMALE	Breast Lump		
	Nipple Discharge		
	Vaginal Discharge		
	Non-Period Bleeding/ Spotting		
	Hot Flashes		
	Pain with Intercourse		
	Possibly Pregnant		
	Other*		

Explain Other*:

_____

_____

_____

_____

Patient Name:_____ Date:_____

PHYSICAL ACTIVITY:

1. How many **times per week** do you accumulate 30 minutes of daily activity such as walking, climbing stairs, raking leaves, or vacuuming/sweeping?
   Circle Number of Days: None 1 2 3 4 5 6 7
2. How many **times per week** do you engage in cardiovascular (aerobic) exercise of at least 20-30 minutes duration such as brisk walking, cycling, jogging, swimming, active sports, etc.?
   Circle Number of Days: None 1 2 3 4 5 6 7

PERSONAL HEALTH HISTORY:

Check each of the health conditions you have now or have had in the past.

Cardiovascular

- ☐ Heart Attack
- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Arrhythmias
- ☐ Heart Valve Disease
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ TIA/Mini Stroke
- ☐ Carotid Blockage
- ☐ Leg Artery Blockage
- ☐ Abdominal Aneurysm

Pulmonary

- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Recurrent Pneumonia
- ☐ Pulm Hypertension
- ☐ Restrictive Disease
- ☐ Lung Cancer
- ☐ Chronic Bronchitis

Psychosocial

- ☐ Depression
- ☐ Stress
- ☐ Anxiety

Musculoskeletal

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Low Back Pain
- ☐ Rotator Cuff Disorder
- ☐ Chronic Fatigue

Other Conditions

- ☐ Thyroid Disease
- ☐ Pancreatitis
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ PCOS
- ☐ Seizures
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ _____ Cancer
- ☐ Reflux (GERD)
- ☐ Stomach Ulcer
- ☐ Hepatitis
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ Neuropathy

☐ Other:

_____

_____

_____

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The charges listed below are not covered by any insurance plan are the patient's responsibility:

- Office visit no-show fee or less than 24-hour notice $50
- Procedure no-show fee or less than 24-hour notice $50
- Letters written $25 (unless requested at time of a scheduled visit)
- Medical records $1 per page
- Disability/FMLA paperwork requires an office visit regardless of how recently you were seen

If a patient is in collections, they cannot be seen unless it is an emergency visit, until their account is brought current.

Print Name:_____

Signature: _____ Date:_____

Office Policies

As your family practitioner, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our financial and office policies.

- **Payment For Services is Due at the Time Services are Rendered:** We accept cash, personal checks, debit cared, and credit cards. Returned checks are subject to a $35 service fee and you will lose your privilege to write checks.

- **PPO Insurance Coverage:** Co-Payment and Deductible must be paid at the time of service.

- **Medicare:** Your deductible and/or co-insurance are due at the time of service.

- **Automotive Accidents:** We will file your insurance claim when you are involved in an automobile accident, however it is your responsibility to provide us with your insurance information so that we can verify your coverage. You will be responsible for payment of your portion at the time of service.

- **Laboratory Billing Procedure:** All laboratory tests (blood work, cultures, PAP smears, etc.) are performed and billed by an outside laboratory. Any and all charges not covered by insurance are the patient's responsibility.

- **No Show Policy:** Failure to show for a scheduled appointment will result in a $50 charge. It is your responsibility to notify the office at least 24 hours in advance if you are unable to keep your appointment.

- **Consent For Medical Treatment:** I am the patient or the patient's duly authorized representative and do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatments considered medically necessary by my physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me because of treatment or examinations performed.

  I certify that I understand and accept all office policies.

Signature:_____ Date:_____

INFORMED CONSENT AND CONTROLLED SUBSTANCE AGREEMENT

Name:_____ Date:_____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent to the drug(s) recommended to you be me, as your physician.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request Dr. Elyssa Blissenbach, as my physician, and such associates, technical assistants, nurses and other health care providers as it may deem necessary or advisable, to treat my condition which has been explained to me and documented in my chart. I hereby authorize and give my voluntary consent to administer or follow prescribed prescription(s), controlled substance(s), or narcotic medication(s) as an element in the treatment of my diagnosis.

It has been explained to me that these medication(s) include narcotic drug(s), which can be harmful. I further understand that these medication(s) are addictive and may produce adverse effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I understand that I will undergo medical tests and examinations before and during my treatment at Northeast Florida Internal Medicine. Those tests include initial and subsequent random unannounced urine and/or blood tests for drugs and I hereby give permission to perform the tests or my refusal may lead to termination of treatment with controlled substances. Presence of unauthorized substances may result in my discharge from Northeast Florida Internal Medicine.

For Female Patients Only: To the best of my knowledge,

_____I am pregnant _____I am not pregnant

I understand that I must tell my physician immediately if I am pregnant, as the medications prescribed could have adverse affect upon me and/or my unborn child.

MOST COMMON SIDE EFFECTS: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment of reasoning and judgement, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive narcotic(s) for the treatment of my documented diagnosis.

I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time.

I understand that no guarantee has been made to me as the result of any drug therapy or cure of any condition. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy and I believe that I have sufficient information to give this informed consent.

I am aware that certain other medicines may reverse the action of the controlled substance I am using for my documented diagnosis.

CONTROLLED SUBSTANCE AGREEMENT: This informed consent also contains the following important requirements that I must fulfill in order to be treated with any controlled substances.

This agreement relates to my use of any controlled substance(s) (i.e., narcotics, painkiller, prescription medications) for my documented diagnosis prescribed by Dr. Blissenbach and/or any appropriately authorized prescribers in this practice. I understand that there are federal and state laws, regulations, and policies regarding the use and prescribing of controlled substance(s). The Florida Department of Health has specific requirements for the use of controlled substance(s).

Therefore, controlled substance(s) will only be provided so long as I adhere to the rules specified in this Agreement.

My doctor and/or any appropriately authorized prescribers may at any time discontinue the narcotic prescription(s) at his/her discretion. My progress will be periodically reviewed and if the narcotic(s) are not improving my quality of life the medication(s) will be discontinued. I will disclose to Dr. Blissenbach and/or and appropriately authorized prescribers, all medications I take at any time, prescribed by any physician.

I must keep all follow-up appointments as recommended by my physician or my treatment and/or medication(s) may be discontinued.

I will use the medication(s) exactly as directed by my doctor and/or any appropriately authorized prescribers.

All controlled substances must be obtained at the same pharmacy, where possible. I understand that my medication(s) will be refilled on a regular basis.

Refills will not be ordered before the scheduled refill date.

Information that I have been receiving medication(s) prescribed by other doctors, that have not been approved previously by Dr. Blissenbach and/or any appropriately authorized prescribers may lead to a discontinuation of medications and treatment.

My doctor and/or any appropriately authorized prescribers may try alternative medication(s) and/or may taper me off of narcotic. I will not hold my doctor and/or any other staff members at Northeast Florida Internal Medicine liable for problems caused by the discontinuance of controlled substances.

I agree to submit to urine and blood screens initially as my provider may, in his or her discretion, order. If I test positive for illegal substance(s) at any time, treatment with controlled substances may be terminated and I may be discharged from the care of all providers at Northeast Florida Internal Medicine.

I understand that the State of Florida tracks information provided by pharmacies regarding all controlled substance prescriptions. My physician may access this data at any time if there is concern that I may be violating this Controlled Substance Agreement.

I fully understand the explanations regarding the benefits and the risks of this method. I agree to the use of narcotic medication(s) as prescribed by Dr. Blissenbach and/or any authorized prescribers at Northeast Florida Internal Medicine.

_____	_____	_____
Patient Signature	Patient Full Name	Date

Northeast Florida Internal Medicine
2065 Herschel Street
Jacksonville, Florida 32204
ph:904-387-4050 fax:904-387-4860

Authorization for Release of Medical Information

Patient Name:	Birth Date:
Social Security # (Last 4 digits only):	Telephone #
Address:	

I HEREBY AUTHORIZE: _____ and its affiliates and agents.
(Facility Name)

RELEASE THE FOLLOWING MEDICAL INFORMATION ABOUT ME TO:

Organization/Person Name: _____
Address: _____ Telephone # _____
City: _____ State: _____ Zip: _____

FOR THE FOLLOWING PURPOSE:

☐Continued Care ☐Social Security Disability ☐Other:_____
☐Legal Reasons ☐DCF
☐Insurance ☐Personal Life

MEDICAL INFORMATION TO BE RELEASED:

Psychotherapy Notes. (If you are requesting Psychotherapy Notes, then you may not release any other information with this authorization and you may not check any of the other boxes in this section. To release your other records, you must submit a separate authorization.)

☐History & Physical ☐Laboratory Reports ☐Emergency Department Record
☐Discharge Summary ☐Radiology Reports ☐Other Medical Information: _____
☐Consultation ☐Pathology Reports _____
☐Operative/Procedure Report ☐Anesthesia Reports
☐Complete Record (excluding Psychotherapy Notes, if any)

DATES OF SERVICE NEEDED: ☐From _____ To _____
☐All dates of service

FEE SCHEDULE: $1.00 per page — paper records up to 25 pages **NOTE:** Fee will be waived if released to treating Doctor/Treatment Facility.

- I understand that the released information may include information relating to the diagnosis, treatment, and/or examination for **ALCOHOL,** and **DRUG USE; MENTAL HEALTH (psychiatry/psychology/psychotherapy);** and **HIV (Human Immunodeficiency Virus)** and **AIDS (Acquired Immune Deficiency Syndrome).**
  I acknowledge that I am signing this authorization voluntarily.
  I understand that I may revoke this authorization in writing at anytime, except to the extent already relied upon and except as stated in Dr. Blissenbach's Notice of Privacy Practices. Also, patients who believe information in their medical record is incorrect or incomplete may request an amendment of patient information. To revoke this authorization or request an amendment, contact Dr. Blissenbach's office.
- The law prohibits recipients of this information without the specific written consent of the patient. However, I understand that Dr.Blissenbach cannot guarantee that recipients of the information will not use or re-disclose it contrary to such legal prohibitions, and the information may no longer be protected by privacy laws once it has been so used or re-disclosed.
- The law prohibits the disclosure of mental health records to certain individuals in some circumstances, which may include patients and their family members.
- This authorization expires twelve months from the date listed below and covers only dates of service for the dates specified above.

I have read and understood this authorization. I hereby authorize the release of the above-requested medical information about me.

Patient/Authorized Representative Signature:_____ Date: _____

Witness: _____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND TO RELEASE SCRIPTS/MEDS

This form authorizes us to discuss your health with someone other than you. This form also authorizes us to release medications or prescriptions to someone other than you. Please provide us with their name, phone number, and relationship to you. It is your responsibility to provide us with their updated phone number and/or any changes to this policy.

_____ It is ok to discuss my health/release medications/prescriptions

_____ I do not want Northeast Florida Internal Medicine to discuss my health nor release medications/ prescriptions to anyone.

Who can we talk to regarding your health?

Name	Phone Number	Relationship

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

AUTHORIZATION TO LEAVE DETAILED VOICEMAIL

By signing this form, you authorize Northeast Florida Internal Medicine to leave a detailed voicemail. It is your responsibility to provide us with your updated phone number and/or any changes to this policy.

Patient Signature: _____

Best phone number: _____

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PATIENT'S ACKNOWLEDGEMENT

I hereby acknowledge that I have been provided with the practice's **NOTICE OF PRIVACY PRACTICES** and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this notice, please contact the office.

The terms of this Notice of Privacy Practices ("Notice") apply to Northeast Florida Internal Medicine, its affiliates and its employees. Northeast Florida Internal Medicine will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Northeast Florida Internal Medicine. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the practice.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment, or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. 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 your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management accreditation and licensing, etic. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved in Your Care: We may form time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing and emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information 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, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with your health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or alternative locations. 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. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the practice.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer;
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To coroner and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you; and
- If you are a member of the military, we may also release your protected health information for the national security or intelligence activities.

DISCLOSURES REQUIRING AUTHORIZATION:

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for your own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.

Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect renumeration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

- Public health activities;
- Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
- Treatment and payment purposes;
- Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
- Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only renumeration provided is for the performance of such activities;
- Providing you with a copy of your health information or an accounting of disclosures;
- Disclosures required by law;
- Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only renumeration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
- Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information for a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid Northeast Florida Internal Medicine in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the office staff.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the practice.

Complaints: If you believe your privacy right have been violated, you can file a complain in writing with the practice administrator or the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the office.