



## **Items to Bring to Your Appointment**

- A current copy of your medical insurance card
- Photo Identification
- A list of all medications and any over-the-counter drugs or herbal supplements that you are currently taking, including strength and dosage
- Current record of immunizations
- If you have one, a current copy of your Durable Power of Attorney for Health Care and/or Living Will document
- New patient registration paperwork, either from our website, mailed or emailed to you
- Any recent hospitalization or specialist's records



**Patient Registration Form**

Patient's Name (Last, First, MI): \_\_\_\_\_

Patient's Home Phone Number: \_\_\_\_\_ Alt. Phone Number (cell or work): \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F Social Security Number: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

Patient's Employer: \_\_\_\_\_

Employment Status:  Full time  Part time  Unemployed  Retired  Student  Other: \_\_\_\_\_

Race:  Asian  Black or African American  Native American  White / Caucasian  Other: \_\_\_\_\_

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: \_\_\_\_\_

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_

Patient is Subscriber/Policy Holder: Y or N, If not, who is? \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Patient is Subscriber/Policy Holder: Y or N, If not, who is? \_\_\_\_\_ DOB: \_\_\_\_\_

**INSURED INFORMATION (IF OTHER THAN PATIENT)**

Policy Holder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy Holders Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

***JS Healthcare Inc., reserves the right to charge a fee for any scheduled visits that are: 1.) Cancelled with less than 24 hours notice 2.) Are missed without calling to cancel (no show). Any of these fee's must be paid on full prior to being seen by the physician.***

Patient / Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**If YOU or a FAMILY MEMBER has had any of the following, please check and indicate which family member when applicable:**

ADD/ADHD	High Blood Pressure	Chest Pain
Alcoholism	Nervous Problems	Thyroid Disorder
Allergies/Hay fever	Heart Attack	Dizziness
Anemia	High Cholesterol	Circulatory problems
Anxiety/Depression	Neurological Disease	Seizure Disorder
Arthritis	Liver Disease	Stroke
Asthma	Kidney Disease	Epilepsy
Blood Clots	Numbness or Burning in Feet	Sexually Transmitted Disease
Cancer, Type:	Osteopenia/Osteoporosis	Fainting
Fractures	Skin Disease	Ulcers
Gynecological Disease	Stomach/Colon Disease	Tuberculosis
Type 1 or 2 Diabetes	Respiratory Disease	Foot or Leg Cramps

Please list any SURGERIES you have had and include the month/year:

Year:	Surgery:

**SOCIAL INFORMATION:**

Tobacco Use: Do you smoke? \_\_\_\_ If so, how many cigarettes/cigars per day: \_\_\_\_ No. of years smoking: \_\_\_\_

Do you chew tobacco? \_\_\_\_ Have you thought about quitting? \_\_\_\_ Have you quit before? \_\_\_\_

How long? \_\_\_\_ Alcohol Use: Do you drink alcohol? \_\_\_\_ If so, what type? \_\_\_\_\_ How many in 1 week? \_\_\_\_

Drug Use: Any history of illegal drug use? \_\_\_\_ If so, what type/s? \_\_\_\_\_ When? \_\_\_\_\_

Do you exercise? \_\_\_\_ What activities do you do, and how often in 1 week?

Are you on any special diet? \_\_\_\_ If so, what? \_\_\_\_\_

Do you consume any caffeinated products? \_\_\_\_ If so, what and how much per day? \_\_\_\_\_

Have you recently noticed an increase in sadness or gloominess? \_\_\_\_

Have you lost interest in enjoyable activities? \_\_\_\_

Do you have a living will? \_\_\_\_ If yes, please provide us a copy

**Additional information** (Please list any additional medical information here):

\_\_\_\_\_

**Notice of Assignment of Benefits to a Provider**

An assignment of benefits is an arrangement by which a patient requests that his or her health insurance benefit payments be made directly to a designated person or facility, such as a physician or hospital.

**Insurance Authorization and Assignment of Benefits**

Please be advised that the patient’s signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian now absolutely provides for the assignment of benefits to Shwetanshu M. Shukla, M.D., JS Healthcare, INC. authorizing this transfer of payment from the insured to the healthcare provider, Shwetanshu M. Shukla, M.D., JS Healthcare, INC. medical practice.

I, \_\_\_\_\_,  
[Print the full name of the undersigned]

herby absolutely authorize JS Healthcare Inc. and all of its medical staff to apply for benefits on my behalf for services rendered to me or my dependent(s) and request that payment be made by my insurance company(ies) and that payments be sent directly to JS Healthcare Inc. medical practice. I understand that it is the policy of JS Healthcare Inc. medical practice to only bill my insurance company(ies) if they participate in that company’s network, and if they do not, it will be my responsibility to bill my insurance company(ies) for reimbursement of my expenses.

I certify that I (or my dependent(s)) have active and valid insurance coverage and have supplied JS Healthcare Inc. medical practice with the up-to-date and correct insurance identification card(s) as well as supplied JS Healthcare Inc. medical practice all necessary information regarding the guarantor of the insurance policy(ies) and the necessary information regarding the subscriber(s) eligible for insurance benefits which is required to submit medical claims for reimbursement. Failure to provide updates to any of the information supplied within may result in denial of payment(s) to JS Healthcare Inc. medical practice and resubmitted claims with corrected updated information that are still denied due to the fact that the corrected information was not supplied in a timely fashion to JS Healthcare Inc. medical practice and I understand that it will be my responsibility to pay JS Healthcare Inc. medical practice for those medical services rendered to me or my dependent(s).

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney for collection or taken to court, I agree to pay any collection fees, reasonable legal fees (25% is deemed reasonable), court costs, and other expenses incurred as a result of said collection or court date, all actions having a venue of Orange County, FL, other venues notwithstanding. Further, I understand that there is a \$30.00 fee for returned checks and a late payment charge not to exceed 1.5% applies to any balance carried forward to next month’s bill.

I understand that JS Healthcare Inc. medical practice will report to commercial credit bureaus only when an account becomes delinquent. Accounts having no payments within 30 days of the initial debt notice are considered delinquent for payment purposes. JS Healthcare Inc. medical practice will report a delinquent account to the credit bureau if they do not receive a payment within 62 days of the date of the initial debt notification letter. All delinquent accounts are reported as a "collection account" on the consumer credit report. The debt will remain as a collection account while on the credit bureau report; however, any subsequent payment activity is reported to the credit bureaus on a monthly basis.

I certify that the information I have reported with regard to my insurance coverage is correct and I herby authorize JS Healthcare Inc. medical practice, the release of any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Signed (Patient or Other Person Authorized to Act for Patient): X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witnessed By Office Representative:

Sign: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Print Name: \_\_\_\_\_

## HIPAA Right of Access Form for Family Member/Friend

HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

I, \_\_\_\_\_, direct my health care and medical services providers and payers to disclose and release my protected health information described below to ( if none, please write none):

Name	Relationship	Contact Info

Health Information to be disclosed upon the request of the person named above *(Check either A or B)*:

\_\_\_\_ A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

**OR**

\_\_\_\_ B. Disclose my health record, as above, **BUT do not disclose** the following

*(check as appropriate)*: \_\_\_\_ Mental health records

\_\_\_\_ Communicable diseases (including HIV and AIDS) Alcohol/drug abuse treatment

\_\_\_\_ Other (please specify): \_\_\_\_\_

This authorization shall be effective until *(Check one)*:

\_\_\_\_ All past, present, and future periods, **OR** until: (Date) \_\_\_\_\_, unless revoked before then in writing.

*(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)*

Printed Name of the Individual Giving this Authorization: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Office Use Only:**

Printed Name of Employee Receiving: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

\_\_\_\_\_  
Signature of Patient /Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient/Responsible Party & Relationship to Patient

**ACKNOWLEDGEMENT OF RECEIPT**

**Notice of Privacy Practices**

Your name and signature on this form indicates that you have read and received a copy of JS Healthcare Inc.'s Notice of Privacy Practices on the date and time indicated below. Be advised that if you have any questions regarding the information contained in JS Healthcare Inc.'s Notice of Privacy Practices, you may contact our office at 321-444-6560 to discuss and questions or concerns you may have.

Printed Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date Received: \_\_\_\_\_

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**FOR FACILITY USE ONLY:**

We attempted to obtain written acknowledgement of patient's receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained from the patient for the following reason:

- Individual Refused to Sign
- Emergency Situation Prevented Signature
- Patient Requested Above Individual Sign on His / Her Behalf
- Other (please specify)

\_\_\_\_\_

Office Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_





**HIPAA Privacy Authorization Form**

**\*For use in obtaining records from other physicians, specialist and hospitals and other healthcare facilities ONLY\***

**Attention: THIS FORM IS TO COLLECT RECORDS AND SEND RECORDS FROM PHYSICIAN TO PHYSICIAN ONLY- PLEASE DO NOT ADD FRIENDS AND FAMILY TO THIS FORM**

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

**1. Authorization**

Name of Physician/Business	Address	Telephone Number	Fax Number

**2. Effective Period**

This authorization for release of information covers the period of healthcare from:

- a.  \_\_\_\_\_ to \_\_\_\_\_.
- \*\*OR\*\***
- b.  all past, present, and future periods.

**3. Extent of Authorization**

a.  I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**\*\*OR\*\***

- b.  I authorize the release of my complete health record with the exception of the following information:
  - Mental health records
  - Communicable diseases (including HIV and AIDS)
  - Alcohol/drug abuse treatment
  - Other (please specify): \_\_\_\_\_

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until \_\_\_\_\_ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Printed name and Date of Birth of patient or personal representative and relationship to patient

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date



Authorization for Claims Payment and Reviews

1. Assignment and Coordination of Insurance Benefits - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Inova Health System (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Inova Health System (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.
2. Unauthorized, Non-Covered, or Out of Plan Services - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Inova Health System for this admission or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge. In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.
3. For Medicare Recipients Only - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.
4. Residents, Interns or Medical Students- I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Inova Health System's education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova Health System. I understand and agree this document will remain in effect for all future outpatient or physician office visits to Inova Health System, unless specifically rescinded in writing by me.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## 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.

Who Will Follow This Notice JS Healthcare Inc. (“JS Healthcare Inc.” or “we”), through its affiliated hospitals and facilities (“JS Healthcare Inc.”) and the employees and staff of each JS Healthcare Inc., provide healthcare to patients, together with other healthcare providers and other organizations. This Notice applies to the following persons and entities, who have agreed to be bound by this Notice:

- JS Healthcare Inc., as well as all employees, staff and other personnel, who may need to access your information to perform their job functions.
- Members of the medical staff of each JS Healthcare Facility, as well as other health care professionals who provide health care services at a JS Healthcare Inc.
- Any member of a volunteer group or student program we allow to help you while you are receiving care.

This Notice applies to all of the records related to your health care provided to you in a JS Healthcare Inc. and generated by the applicable JS Healthcare Inc., whether made by JS Healthcare Inc. personnel or your personal healthcare provider. Your personal healthcare provider may have different policies or notices regarding the use and disclosure of your medical information created or maintained in the healthcare provider’s office or clinic. You should review your healthcare provider’s notice for information on how your healthcare provider will handle your medical information outside of JS Healthcare Inc.

Our Pledge Regarding Medical Information: We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive while in our care. We need this record to provide you with quality care and to comply with certain regulatory requirements. This Notice will tell you about the ways in which we may use and disclose medical information about you. This Notice also describes your rights, and certain obligations we have regarding the use and disclosure of your medical information. We are required by law to:

- Keep medical information that identifies you private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

How We May Use And Disclose Medical Information About You: The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to healthcare providers who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different healthcare professionals within a JS Healthcare Inc. also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you outside the JS Healthcare Inc. that treated you to people who may be involved in your medical care after you leave a JS Healthcare Inc.

Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to, and payment may be collected from, you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at a JS Healthcare Inc. so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your insurance will cover the treatment.

Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information

to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without knowing the identities of the specific patients. We may disclose your medical information to another health care professional that you have seen so they may improve their quality or costs of care.

**Health Information Exchange (HIE).** JS Healthcare Inc. may make your individual medical information available to a local, regional and/or national Health Information Exchange (“HIE”) including, but not limited to, the National Health Information Network (“NHIN”). An HIE is a state and/or federal government sponsored initiative that provides a mechanism for healthcare providers in our community to share information electronically, all with a common goal of improving the quality of care for our patients while protecting the privacy and security of your medical information. For example, if you received treatment in a JS Healthcare Inc. hospital’s emergency department over the weekend and you were following up with your regular physician in their office that next week, the physician would be able to access and review your emergency department record during your office visit. This type of access provides your physician with the most current information about your care and treatment. JS Healthcare Inc. will only transmit your medical information to an HIE for the purposes of treatment, payment, or healthcare operations, or as required by law. Individual health information that currently by law requires an additional signed authorization for release WILL NOT be transmitted to an HIE without your consent, or as otherwise mandated by law or regulatory requirement.

**Florida Immunization Registry.** JS Healthcare Inc. may share your immunization or tuberculosis (TB) screening test records with the Florida Immunization Registry (FLShots), a statewide, secure and confidential database of patient immunization information. FLShots is used by health care professionals, agencies, and schools to keep track of all shots and TB tests you take, and can provide proof about immunizations needed to start child care, school, or a new job. If you do not want your immunization or TB records to be shared with other registry users, please fax or email the “Decline or Start Sharing/ Immunization Information Request Form,” available on the FLShots website at [www.flshots.com](http://www.flshots.com) or Contact Desk at P: 877.888.7468 (SHOT)

**Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at a JS Healthcare Inc.

**Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**Facility Directory.** We may include certain limited information about you in the facility directory of a JS Healthcare Inc. hospital while you are a patient at that hospital. This information may include your name, location in the hospital and your general condition (e.g., fair, good, etc). Unless there is a specific written request from you to the contrary, this directory information may also be released to people who ask for you by name. This information is released so your family and friends can visit you in the hospital and generally know how you are doing. If you wish to “opt out” of the facility directory, please contact the admitting department at the JS Healthcare Inc. where you are being treated and request that your information not be included in the facility directory.

**Individuals Involved in Your Care or Payment for Your Care; Disaster Relief Efforts.** We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends about your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients’ need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave

our site. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the JS Healthcare Inc.

**Business Associates.** There are some services provided for our organization through contracts with an outside organization, also known as a business associate. Examples include billing services to submit your claim to the insurance company for payment, transcription services to transcribe dictated reports from the health professionals caring for you in the hospital and copy services for making copies of your health record. When these services are performed by a business associate, we may disclose your information to our business associates so they can perform the job we have asked them to do.

**As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

**Averting a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**Marketing and Sales.** Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

**Fundraising Activities.** We may use certain information about you (including demographic information and dates you received service) to contact you in the future in an effort to raise money for a JS Healthcare Inc. We may also disclose this same information to our JS Healthcare Inc. affiliated philanthropic foundations for the same purpose. The money raised will be used to expand and improve the services and programs we provide to the community. If you do not wish to be contacted for our fundraising efforts, you must notify the foundation director or a manager at the JS Healthcare Inc. location where you were treated. Notification may be made in writing, including email, by phone or in person.

**Special Situations: Organ and Tissue Donation.** We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to 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 release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military.

**Workers' Compensation.** We may release medical information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical 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 (which may include written notice to you) or to obtain an order protecting the information requested.

**Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:

- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has 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 prevent or control disease, injury or disability;
- to report births and deaths;
- to report the abuse or neglect of children, elders and dependent adults;
- to notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

Law Enforcement. If permitted by applicable law, we may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the hospital; and
- in emergency circumstances to report a crime, the location of the crime or victims; or the identity, description or location of the person who committed the crime Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Protective Services for the President, National Security and Intelligence Activities. We may release medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official, if the release 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) for the safety and security of the correctional institution.

Multidisciplinary Personnel Teams. We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

Note on Other Restrictions. Please be aware that certain federal or state laws may have more strict requirements on how we use and disclose your medical information. If there are stricter requirements, even for the purposes listed above, we will not disclose your medical information without your written permission, or as otherwise permitted or required by such laws. For example, we will not disclose your HIV test results without obtaining your written permission, except as permitted by state law. We may also be restricted by law to obtain your written permission to use and disclose your information relate/inspect for certain conditions such as mental illness, or alcohol or drug abuse.

Your Rights Regarding Medical Information About You: You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy the information that we have about you that may be used to make decisions about you and your care, including your medical and billing records. We may deny your request to inspect and copy in certain very limited circumstances. To inspect and copy your information that may be used to make decisions about you, you must submit your request in writing to the Medical Records Department at the JS Healthcare Inc. Facility where you received health care services. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend. If you feel that information we have about you 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 the JS Healthcare Inc. Facility where you were treated. To request an amendment, your request must be made in writing and submitted to the medical records department of the JS Healthcare Inc. where you were treated. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for the JS Healthcare Inc. where you were treated;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

You also may have the right to ask us to add an addendum to your records, which can be up to 250 words for each item you believe to be incorrect or incomplete. Please submit your request for an addendum to the medical records department of the JS Healthcare Inc. where you were treated.

Right to an Accounting of Disclosures. You have the right to request an “Accounting of Disclosures.” This is a list of the disclosures we made of medical information about you other than disclosures for certain purposes, such as for treatment, payment and health care operations purposes, as those functions are described above, or any disclosures that have been specifically authorized by you. To request this list or accounting of disclosures, you must submit your request in writing to the Medical Records Department of the JS Healthcare Inc. where you were treated. Your request must state a time period, which may not be longer than six (6) years or three (3) years depending on the JS Healthcare Inc. implementation date of an electronic health record (EHR). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. In addition, we will notify you as required by law following a breach of your unsecured protected health information.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations purposes. You also have the right to request a limit on the medical 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. We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you. If we agree to another special restriction, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the medical records department of the JS Healthcare Inc. where you were treated. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you in a certain way or at a certain location. 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 the medical records department at the JS Healthcare Inc. where you seek treatment. 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 Authorize or Refuse to Authorize Other Uses and Disclosures of Medical Information. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us your authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

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 are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website (<http://www.jshealthcaremd.com>). A paper copy of this Notice is also available in the front office of 201 N Lakemont Ave., Winter Park, FL 32792.

Changes To This Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in each JS Healthcare Inc., as well as our website ([www.memorialcare.org](http://www.memorialcare.org)). The Notice will contain on the first page, in the bottom left-hand corner, the effective date.

Complaints If you believe your privacy rights have been violated, you may file a complaint with us and with the Secretary of the United States Department of Health and Human Services. For information on filing a complaint with us, contact the JS Healthcare Inc. Chief Compliance/Privacy Officer at 321-444-6560 for information on how to file your complaint. All complaints must be submitted in writing. We will take no action against you and you will not be penalized for filing a complaint.

**JS Healthcare Inc. Chief Compliance/Privacy Officer Contact Information:**  
**Chief Compliance Officer/Privacy Officer**  
**JS Healthcare Inc.**  
**201 N Lakemont Ave, #2300**  
**Winter Park, FL 32792**  
**(321)444-6560 Fax: (407)960-1902**