GULFSTREAM
UROLOGY
ASSOCIATES, P.A.

Adam J. Ball, MD, FACS, Diplomate of the American Board of Urology

F

DEMOGRAPHICS

Patient name: Female Male DOB:_ _/_ _/_ _ Age:

Residential Address: City/State/Zip Marital Status: Married Divorced Widowed Single

Phone Number:

Social Security Number:

Reason for visit: Referred by:

Emergency Contact Name: Emergency Phone Number:

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Gulfstream Urology Associates, P.A. for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning heath care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating & administering claims of benefits.

Patient Signature Date

Private Insurance Authorized for Assignment of Benefits:

I, the undersigned authorize payment of medical benefits to Gulfstream Urology associates, P.A. for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company/agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient signature Date

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Patient Name:_____ Date:_____

1. Please list all Allergies:_____
_____

2. Please place a check in the appropriate boxes below indicating if you have the following, or if it has occurred in self or family:

	SELF	FAMILY		SELF	FAMILY
Asthma	_____	_____	Kidney Stones	_____	_____
Bedwetting	_____	_____	Mental/Nervous	_____	_____
Blood disorders	_____	_____	Disorders	_____	_____
Cancer:	_____	_____	Sickle Cell Disease	_____	_____
Prostate			Thyroid Dysfunction	_____	_____
Other_____	_____	_____	Tuberculosis	_____	_____
Change in Weight	_____	_____	Urinary Tract Infection	_____	_____
Constipation	_____	_____			
Diarrhea	_____	_____	Other: _____		
Diabetes	_____	_____	_____		
Hypertension	_____	_____			

3. **Females** - Last menstrual period date?: _____
4. Have you ever had a reaction to: X-ray dye? _____
   Seafood ? _____ What kind?_____
   Iodine ? _____

5. ADULTS ONLY: Do you consume alcohol?____Never_____Occasionally___Frequently

6. ADULTS ONLY: Do you smoke cigarettes?_____
   If "NO", have you smoked cigarettes in the past?_____
   Please indicate the approximate date that you stopped:_____
7. List any serious illnesses, injuries, or disabilities you have or have had in the past:____
   _____
   _____
8. Please indicate if you have had any of the following Urologic procedures:
   Kidney X-ray (IVP, CT, U/S) YES/NO Date___/___/_____ Location:_____
   Cystoscopic Exam : YES/NO Date____/____/_____ Location:_____
9. Please list any surgical procedures that you have had in the past:

Procedure	Date Performed	Hospital

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Patient's Name: _____ Date_____

Urological History: (Please answer Yes or No)

1. Do you urinate frequently? Yes No
2. How many times a day? _____
3. Do you awaken at night to urinate? Yes No
4. How many times a night? _____
5. Do you experience pain or burning with urination? Yes No
6. Do you have blood in your urine? Yes No
7. Do you have a weak urinary stream? Yes No
8. Do you strain to urinate? Yes No
9. Have you had bladder or kidney infection? Yes No
10. Do you get sudden urges to urinate? Yes No
11. Do you leak urine at any time? Yes No
12. What causes you to leak?

Women

1. How many children have you had? _____
2. How many times have you been pregnant? _____
3. Do you have pain with intercourse? Yes No
4. Do you still menstruate? Yes No
5. If no, are you on Estrogen replacement? Yes No

Men

1. How many children have you had? _____
2. Have you had a vasectomy? Yes No
3. Do you have difficulty with erections? Yes No

Physician notes

_____

_____

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INCONTINENCE QUESTIONAIRE (UDI-6)

Name: _____ Date: _____

DO YOU EXPEREINCE ANY URINARY INCONTINENCE? _____ YES _____ NO

Please circle the number that best describes what you are feeling. Use the following as your guide.

(0) Not at All
(1) Slightly
(2) Moderately
(3) Greatly

Do you experience, and if so, how much are you bothered by:

1. Frequent urination? (0) (1) (2) (3)
2. Urine leakage related to the felling of urgency? (0) (1) (2) (3)
3. Urine leakage related to physical activity, coughing, or sneezing? (0) (1) (2) (3)
4. Small amounts of urine leakage? (0) (1) (2) (3)
5. Difficulty emptying your bladder? (0) (1) (2) (3)
6. Pain or discomfort in the lower abdomen or genital area? (0) (1) (2) (3)

(For physician only) ----------

_____ Timed Voiding

_____ Double Voiding

_____ Conservative Fluid Management

_____ Kegel Exercise Program

_____ Anti-cholinergic or Other Medical Therapy

_____ Urodynamic Evaluation Discussed

_____ Surgical Intervention Discussed

Physician Signature: _____ Date: _____

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Medication list

Medication	Dosage	Frequency

Patient name & DOB: _____

Pharmacy name and location: _____

_____

_____

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Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No. Please explain any Yes answers in space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other		

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other		

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Other		

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N
Other		

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Other		

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other		

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other		

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other		

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other		

Hematological/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problems	Y	N
Other		

Patient Name: _____

Physician use only: Comments/Notes: _____

_____

_____

Physician: _____ Date :_____

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PELVIC EXAMINATIONS CONSENT FORM

Patient Name: _____

Date of Birth: _____

****

- **CONSENT:** I, the above listed Patient or as the legally authorized person for the Patient, hereby consent to receiving pelvic examinations being performed by my physician or other health care practitioner, any medical student or any student receiving training as a health care practitioner.

- **NATURE OF PELVIC EXAMINATIONS:** For the purposes of this Consent Form, a "pelvic examination" means the series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, external pelvic tissue, or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

- **VALIDITY OF CONSENT:** The Patient, or the Patient's legally authorized person, acknowledges that this consent will remain valid from the date the Patient, or the Patient's legally authorized person, dated this Consent Form below, unless otherwise revoked in writing by the Patient, or the Patient's legal authorized person.

I CONSENT TO RECEIVE PELVIC EXAMINATIONS AS DESCRIBED ABOVE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

_____	_____
Patient's Signature	Date
_____	_____
Legally Authorized Person Signature	Relationship to Patient
_____	_____
Legally Authorized Person Printed Name	Date
_____	
Witness Signature	
_____	_____
Witness Printed Name	Date

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Patient Bill of Rights

1. The patient has the right to high quality care delivered in a safe, timely, efficient, and cost-effective manner without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment.
2. The patient has the right to dignity, respect, and consideration of legitimate concerns.
3. The patient has the right to privacy and confidentiality of all information and records regarding their care.
4. The patient has the right to know the names and qualifications of the physicians, nurses, and other staff members involved in their care.
5. The patient has the right to considerate and respectful care in a clean and safe environment, free of unnecessary restraints.
6. The patient has the right to be involved in all aspects of care. An informed consent following a discussion of risks, benefits, and alternatives should be obtained. The patient has the right to information about current diagnosis, treatment, and prognosis. If it is not advisable to give such information to the patient for health reasons, it should be available to a person designated by that patient or a legally authorized person.
7. The patient has the right to be advised of all reasonable options and alternative care and treatment and the potential advantages and disadvantages of each.
8. The patient has the right to refuse any diagnostic procedure or treatment, and to be advised of the likely medical consequences of such refusal.
9. The patient has the right to education to address his or her needs. The education process will consider the patient's values, abilities, and readiness to learn, and patient and family responsibilities in the care process.
10. The patient has the right to change the practitioner if other qualified are available.
11. The patient has the right to request and receive information about alternate sources of appropriate care.
12. The patient has the right to inspect and obtain a copy of his or her medical records. In addition, the patient has the right to expect a reasonable and timely transfer of information from one practitioner to another when required. Charges for copies of medical records shall not exceed the charges provided for by Section 17 of the Public Health Law.
13. The patient has the right to request and receive information concerning the bill for services regardless of the source of payment.
14. The patient has the right to know about the expectations of the office based practice with regards to his or her behavior and the consequence of failure to comply with these expectations.
15. The patient has the right to help with understanding these rights if they need help.

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I acknowledge receipt of this summary of Gulfstream Urology Associates, P.A. Notic of Privacy.

Print Name: _____ Signature:_____ Date:_____

At times patients may wish to have information regarding their medical condition(s), lab reports, medications, appointment times, etc. Discussed verbally with other individuals suc as spouse, other family members, friend and caregiver in the office or by the telephone. If this applies to you please indicate below any person authorized to receive verbal informatic regarding your care.

Name:_____ Relationship:_____ Date:_____

Name:_____ Relationship:_____ Date:_____

Authorization for Treatment

I hereby authorize Dr. Adam J. Ball, or a physician designated by him, or whomever he ma designate as assistant to render medical care to me. I consent to care and treatment that may encompass laboratory, diagnostic, or medical treatment that my physician or his assistant may deem necessary for my health and well being.

Signature of Patient

_____ Date _____

Signature of Parent/Guardian

_____ Date _____

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FINANCIAL DISCLOSURE

Dear Valued Patient,

Government regulations require that all patients having services provided must be notified prior to the service the financial relationship between the referring provider and the treatment facility or modality.

Adam J. Ball, MD, FACS is a physician investor and/or has financial interests in several companies and products. They are listed below for your convenience.

- **Theralogix, LLC**
- **University Lithotripter, Ltd.**
- **Tradition Surgery Center**
- **United Medical Systems (UMS)**

Your signature below will also confirm that you have been made aware of your physician's ownership in the companies listed above.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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Patient Payment Policy

It is your responsibility to provide GUA with your updated insurance and demographic information at the time of your visit. (i.e. current address, telephone, etc.) The following is the payment policy of Gulfstream Urology Associates, PA. We have put this policy in writing so that all patients clearly understand our billing and collections procedures.

If applicable, a co-payment is required on each visit. There are no waivers for co-payments or deductibles.

From time to time your physician must request tests that are medically necessary, but may not be covered by your insurance company. If an Advanced Beneficiary Notice (ABN) form must signed in order to allow you to receive services not covered by your insurance carrier, the form and its financial responsibility will be reviewed with you at the time of service. No services will be provided until the form is signed. After signing an ABN, you are responsible for the total charges due for services provided to you which are not covered by your insurance.

For any procedures performed in the office, verification of insurance benefits will be done prior to your visit. A deposit may be required to pay at the time of service, regardless of benefits. Any monies exceeding your responsibility will be refunded.

The following are allowable forms of payment: cash, check, money order, and ATM/credit card (Mastercard and Visa only).

If you need to cancel your appointment, you must give this office notice at least 24 hours notice in advance of the scheduled appointment. Failure to give proper notice may result in a charge of **$50** to your account, for a follow-up appt, and **$100** for a procedure appointment.

Extended payment plans should be discussed with our billing office. In the event that full payment is not received within six (6) months of our initial billing statement to you, your remaining balance and account may be turned over to collections. If your account is turned over to collections, you may be dismissed from the practice for financial non-compliance and you will not be entitled to any medical services except in the event of an emergency, and only for thirty (30) days after you are reported to collections unless your accounts paid in full or are being paid pursuant to a payment plan. A list of other physicians in the area is available upon request.

In the event your check is returned because of insufficient funds in your account, there will be a **$35** charge added to your account for each returned check. Refund consideration upon patient request.

Billing questions will be handled only during office hours, Monday-Friday, 9:00am-4:00pm.
We welcome the opportunity to discuss any aspect of our financial policy with you.

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Patient Name: _____

Authorization for Treatment

I hereby authorize **Dr. Adam J. Ball**, or a physician designated by him, or whomever he may designate as assistant to render medical care to me. I consent to care and treatment that may encompass laboratory, diagnostic, or medical treatment that my physician or his assistant may deem necessary for my health and well-being.

Signature of Patient:

_____

Date: _____

Receipt of Notice of Gulfstream Urology Associates, P.A. Payment Policy

I hereby acknowledge receipt of Gulfstream Urology Associates, P.A.'s Payment Policy. The "Notice" provides detailed information about how the practice processes your account. I understand that the practice has reserved the right to change its policies and procedures that are described in the "Notice". I also understand that a copy of any future revisions will be provided to me or made available. I understand that if I cannot keep my follow-up appointment or my procedure appointment, I need to call Gulfstream Urology Associates, P.A. twenty-four (24) hours in advance to cancel. I agree to pay **$50** (follow-up appt) or **$100** (procedure appointment) if I do not comply.

I have read and I understand the aforementioned policy. I hereby agree to each and every provision.

Signature of Patient

_____

Date: _____

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CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at GULFSTREAM UROLOGY ASSOCIATES, PA, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis will not involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with GULFSTREAM UROLOGY ASSOCIATES, PA to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Signature of Patient

_____

Printed Name of Patient

_____

Date

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Please DO NOT use Patient Portal to communicate with your Practice for urgent or emergency medical issues. If you are experiencing an urgent medical need, please contact us by phone. For emergencies call 911.

Patient Portal User Agreement and Consent Effective: October 9, 2015

The Patient Portal (defined below) is owned and operated by the practice to which you are seeking to online access (the "Practice"). The Practice has adopted this user agreement ("User Agreement" or "Agreement") to make you aware of the terms and conditions of your use of the Patient Portal and any derivative websites of the Patient Portal (collectively, the "Patient Portal"). In the event that you purport to be the agent of, represent, or otherwise act on behalf of any other person, references to "you," "your" or "User" shall include such entity or person in addition to such representative, and your acceptance of this Agreement shall constitute acceptance on behalf of such person.

The Practice uses reasonable efforts to maintain the Patient Portal, but the Practice is not responsible for any defects or failures associated with the Patient Portal, any part thereof or any damages (such as lost profits or other consequential damages) that may result from any such defects or failures. The Patient Portal may be inaccessible or inoperable for any reason, including, without limitation: (a) equipment malfunctions, (b) periodic maintenance procedures or repairs which the Practice may undertake from time to time or (c) causes beyond the control of the Practice or which are not foreseeable by the Practice. In addition, the Practice makes no guarantees as to the web sites and information located worldwide throughout the Internet that you may access as a result of your use of the Patient Portal, including as to the accuracy, content, or quality of any such sites and information or the privacy practices of any such site. The Practice is not a backup service for storing data you submit to the Patient Portal, and the Practice shall have no liability regarding any loss of such data. You are solely responsible for creating backups of any data you submit using the Patient Portal

The Patient Portal is a secure website that allows you to use a computer to interact with medical information via the internet. The Patient Portal also allows you to communicate with the Practice via secure messaging. Please note that all communication via the Patient Portal will be included in your permanent patient record.

Responsibilities, Risks and Benefits:

The Patient Portal is provided as a convenience to you at no cost and is only available in English at this time. We do not sell or give away any private information, including email addresses. We reserve the right to suspend or terminate the Patient Portal access at any time and for any reason. All messages sent to you will be electronically secure. Messages and emails from you to any staff member must be sent through the Patient Portal for security and confidentiality reasons. The Patient Portal messages will be handled by our staff in a manner similar to how phone communication is handled. Although we strive to reply to Patient Portal messages within one business day, we cannot guarantee that we will be able to address your messages in that timeframe. We encourage you to use the Patient Portal at any time but understand that we can only reply to messages during our office hours, excluding holidays recognized by the Practice. If

you do not receive a response within two business days, please feel free to call our office. You are responsible to provide us with your correct email address and inform us immediately of any change. You are also responsible for the protection of your login information and password. Please understand that all electronic communications carry some degree of risk, even in a secured environment. Even with all due precautions, online communications may be intercepted, forwarded or changed without a patient's or the healthcare provider's knowledge. By using or accessing the Patient Portal, you expressly accept these risks. Note that it is easier for a patient's identity to be stolen or for someone to try to impersonate a patient via online communication. Online communications are admissible as evidence in court just as medical records are in the event the physician-patient privilege is waived or if a court orders disclosure. Online communications may disrupt or damage a computer if a computer virus is transmitted via an attached file, hyperlink or other method. You assume liability for such disruptions or damages caused by such transmissions. Responses to online communications are limited by the information provided and your question may necessitate a follow-up phone call or a request to meet with you in person to gain further information. Electronic communications will be viewed by not only the physician, but the staff members assigned to handle such communications and any other provider covering for the patient's physician if the patient's physician is unavailable to respond. Applicable law may allow a health care professional to determine that a minor patient is "mature" to keep a portion of the minor's medical information confidential. If the minor patient is determined "mature" by his or her physician, all Patient Portal communication will be with the minor directly and a new consent form with the minor's email address will be required. Applicable law may also permit confidential communication with a minor patient in regards to treatment and reporting of sexually transmitted diseases to the minor and communications with pregnant minors in regards to questions about the health of her fetus. In these situations, all Patient Portal communications will be directly with the minor and a new consent form with the minor's email address will be required. The Practice will keep a copy of all medically important online communications in your medical record secure pursuant to applicable federal and state laws and regulations. Print or store in a secure place (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you. The Practice will not forward online communications with you to third parties except as authorized or required by law. Please note that online communications should never be used for emergency communications or urgent requests. These should occur via telephone or using existing emergency communications tools as noted above. Follow-up is solely your responsibility. You are responsible for scheduling any necessary appointments and for determining if an online communication did not receive a response. You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. The Practice is not responsible for breaches of confidentiality caused by you or an independent third-party.

Guidelines for Safe Online Communications:

Take steps to keep your online communications to and from the Practice confidential, including:

Do not store messages on your employer-provided devices (e.g. computer, cell phone, tablet, etc.); otherwise personal information could be accessible or owned by your employer. Use a screen saver or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private. Do not allow other individuals or third parties

access to the devices(s) upon which you store medical communications. Keep your login and password information secure and confidential. Do not use email for medical communications. Standard email lacks the necessary security and privacy features and may expose medical communications to employers or other unintended third-parties.

Access to Online Communications:

The following pertains to access to and use of online communications:

Online communications do not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement. The Practice may stop providing online communications with you or change the services provided online at any time without prior notification to you.

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All of my questions have been answered and I understand and concur with the information

Print Patient Name: _____

Date of Birth _____

Email address: _____

Signature: _____

Date: _____

I am over the age of 18 and have sole responsibility of my medical care

□ Yes
□ No

(We do not offer the Patient Portal to minors or those patients which do not make their own medical decisions at this time. We apologize for the inconvenience.)

I choose not to participate in Patient Portal at this time because:

□ I do not have an E-mail address
□ I do not wish to share my E-mail address
□ English is not my preferred language
□ Other

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Notice of Privacy Practices (HIPPA)

Effective Date: 5/1/2007

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INROMATION ABOUT YOU 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 of Privacy Practices ("Notice"), please contact:

NAME: Gulfstream Urology Associates, P.A.
PHONE NUMBER: 772-465-2020

Section A: Who Will Follow This Notice?

This Notice describes our practices and that of any health care professional in Gulfstream Urology Associates, P.A. ("Practice") authorized to enter information into your medical record.

- Any member of a volunteer group we allow to help you while you are receiving care from this Practice.
- All our employees, staff, and other personnel.
- Cleveland Clinic Tradition Medical Center & Traditional Medical Center

All these entities, sites and locations follow the terms of this Notice. In addition, these entities, sites, and locations may share medical information with each other for treatment, payment or practice operations purposes described in this Notice. This list may not reflect recent acquisitions or sales of entities, sites, or location.

Section B: Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at this Practice. We need this record to provide you with quality care and to comply with certain legal requirements.

This Notice applies to all of the records of your care generated or maintained by this Practice. Any medical institution such as a hospital or nursing home at which
we may treat you may have different policies or Notices regarding that medical institution's use and disclosure of your medical information created in that medical institution.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept 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.

Section C: How We May Use and Disclose Medical Information About You?

The Following categories describe different ways that we may use and disclose medical information. For each category of uses or disclosures 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 doctors, nurses, technicians, medical students, or other Practice personnel or personnel in medical institutions such as a hospital or nursing home in which you receive care. For example, a doctor working for a hospital or for another physician practice who is 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 the hospital or nursing home can arrange for appropriate meals. We may share your medical information with different departments of a hospital or nursing home in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose your medical information about you to other people outside this Practice who may be involved in your medical care such as family members, clergy or others who provide services that are part of your care.

- Payment: We may use and disclose medical information about you so that the treatment and services you receive from this Practice may be billed to and payment may be collected from you, and insurance company or a third party. For example, we may give your health plan information about a medical procedure such as surgery that we performed for you 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 plan will cover the treatment.

- Health Care Operations: We may use and disclose medical information about you in order to operate this Practice. These uses and disclosures are necessary to run this Practice and 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 combine medical information about other patients to decide what additional services that we can offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to other doctors, nurses, technicians, medical students, and even personnel from other medical institutions such as a hospital or nursing home fro review and learning purposes. We may also combine the medical information we have with the medical information from other medical institutions such as hospitals, nursing homes or other physician practices 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 learning who the specific patients are.

- 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 this Practice.

- 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.

- Hospital Directory: We may disclose certain information about you to a medical institution such as a hospital or nursing home in order for that medical institution to list you in its directory while you are a patient at that medical institution. This information may include your name, location in the medical institution, your general condition (e.g, fair, stable, etc.) and yoru religious affiliation. This is so your family, friends and clergy can visit you in the medical institution and generally know how you are doing.

- Individuals Involved in Your Care or Payment for Your Care: 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. We may also tell your family or friends your condition and that you are
in a medical institution such as a hospital or nursing home. 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, however, disclose medical information about you to the people preparing to conduct the 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 the location in which it was generated or maintained. We will almost always generally ask you 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 our Practice location(s).

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

- To Avert 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.

- 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 authority.

Section D: Special Situations

- Organ and Tissue Donation: If you are an organ donor, 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.

- 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.

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

  - To Prevent or control disease, injury, or disability;
  - To report births and deaths;
  - To report child abuse or neglect;
  - To report reactions to medications or problems with products;
  - To notify people or recalls of products they may me 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.

- Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law.

- 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 or to obtain an order protecting the information requested.

- Law Enforcement: 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 a criminal conduct:
  - About criminal conduct at a medical institution such as a hospital or nursing home; 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 identity of a deceased person or determine the cause of death. We may also release medical information about our patients to funeral directors as necessary to carry out their duties.

- National Security and Intelligence Activities: We may release medical information about you to authorize federal officials for intelligence, counterintelligence and other national security activities authorized by law.

- Protective services for the President and Others: We may disclose medical protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- 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 to provide you with health care, to protect your health and safety or the health and safety of others, or the safety and security of the correctional institution.

Section E: 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 some of the medical information that may be used to make decisions about your care.

Usually, this includes medical and billing records, but does not include Psychotherapy notes. 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 medical 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 Practice. In addition, you must provide a reason that supports your request.

- Denial: 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 amen 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 Practice.
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- 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. Your request must state a time period, which may not be longer than six years and may not include dates before August 1, 2005. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- 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. 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. For example, you could ask that we not use or disclose information about a surgery you had.

In your request, you must tell us what information you want to limit our use, disclosure, or both, and to who you want the limits to apply (for example, disclosure to your spouse).

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. 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. Even if You have agreed to receive the Notice electronically, you are still entitled to a Paper copy of this Notice.

To exercise the above rights, please complete request in writing and send to:

Medical Records

579 N.W. Lake Whitney Place, Suite 105, Port St. Lucie, FL, 34986

Section F: 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, in this Practice, a copy of the current Notice. The Notice will contain on the first page the effective date.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with this Practice, contact the individual identified on the first page of this notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.