Taylor Dental Center

New Patient Registration

Basic Patient Information

Patient's SSN: ______________________

Patient Name ____
First Middle Last

Birth Date ______________________ Gender F ☐ M ☐

Street Address ____

City ______________________ State ________ Zip ________

Mailing Address ____

City ______________________ State ________ Zip ________

Home Phone ( ) ______________________ Work Phone ( ) ______________________

Cell Phone ( ) ______________________ Email Address ______________________

Patient's Relationship to Insured?

☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other: (specify) ______________________

Please present your insurance card to the front desk receptionist when returning this form

Billing Information/Responsible Party/Guarantor for Visit

Name of Guarantor or Insured ____
First Middle Last

Street Address ____

Mailing Address ____

City ______________________ State ________ Zip ________

Birth Date ______________________ Guarantor's SSN: ______________________

Gender F ☐ M ☐

Home Phone ( ) ______________________ Work Phone ( ) ______________________

Guarantor's Employer ____

Insurance Coverage - Primary

Name of Insurance Co. ____

Policy Number ______________________ Effective Date: ______________________

Group Name ______________________ Group # ____________ Expected Copay: ____________

Name of Insured ____
First Middle Last

Birth Date ______________ Phone ( ) ______________ Gender F ☐ M ☐

Address of Insured ____

City ______________________ State ________ Zip ________

Name of Insured's Employer ____

Employment status of Insured: ☐ Full-Time ☐ Part-Time ☐ None

Insurance Coverage - Secondary

Name of Insurance Co. ____

Policy Number ______________________ Effective Date: ______________________

Group Name ______________________ Group # ____________ Expected Copay: ____________

Name of Insured ____
First Middle Last

Birth Date ______________ Phone ( ) ______________ Gender F ☐ M ☐

Address of Insured ____

City ______________________ State ________ Zip ________

Employment status of Insured: ☐ Full-Time ☐ Part-Time ☐ None

Taylor Dental Center | **Patient Demographic & Financial Responsibility Acknowledgement**

Additional Patient Information

Marital Status Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Patient's Employment Status ☐ Full-Time ☐ Part-Time ☐ None

Student Status (If Applicable) ☐ Full-Time ☐ Part-Time ☐ None

Spouse's Employment Status ☐ Full-Time ☐ Part-Time ☐ None

Name of participating pharmacy that is offering discounted prescription medications:

O'Quinn Pharmacy **Do you prefer another Pharmacy? If so, which pharmacy?**

Language Best Served In ☐ English ☐ Spanish ☐ Other

Interpreter Service Needed ☐ Yes ☐ No **Homeless** ☐ Yes ☐ No

Over the last 2 years have you OR the person you depend upon: (Check if applicable)

☐ Been hired to do farm work or pick fruit? ☐ Done farm work on an annual or seasonal basis?

☐ Earned most of your income by doing farm work?

☐ Spent at least one night away from home to do farm work?

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ White ☐ Other Pacific Islander

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Patient's Driver's License # **Veteran** ☐ Yes ☐ No

How did you hear about us? ☐ Community Event ☐ Drive By ☐ Family ☐ Friend ☐ Health Fair ☐ Hospital ☐ TMH ☐ Newspaper ☐ Health Dept ☐ Phonebook ☐ Radio

Emergency Contact Information - Primary Contact

Name ______________________ **Relationship:** ______________________

☐ **Ck if Pt lives with Emer Contact** ☐ **Ck if Emer contact is Legal Guardian**

Home Phone ( ) ______________________ **Work Phone** ( ) ______________________

Street Address ____

City ______________________ **State** ________ **Zip** ____________

Mailing Address ____

City ______________________ **State** ________ **Zip** ____________

Consent and Financial Responsibility Agreement

I/We hereby grant Taylor Dental Center permission to treat myself and/or my child/ward for any illness or injury that I/we may encounter. I/We hereby authorize Taylor Dental Center to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment of medical benefits to Taylor Dental Center and further understand that should my account have to be referred to a collection agency that I am responsible for all fees and costs incurred therein. I/We hereby authorize Taylor Dental Center to act on my behalf in accessing hospital medical records when and if needed.

______________________ ____

Date **Lifetime Signature of patient, parent or legal guardian**

North Florida Medical Centers, Inc.

PEDIATRIC HEALTH HISTORY

Date: ____________ ***Child's Name:*** ______________________________ ***Date of Birth:*** _____________

Child's Previous Primary Care Provider: ____

Present Health Concerns: ____

____

Current Medications: ____

____

Allergies/Reactions to Medicines or Vaccinations: ____

____

PREGNANCY & BIRTH

Is this child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Foster Care ☐Other ___________________

Please indicate any medical problems during pregnancy: ☐None ☐ Specify: _________________________

Birth Weight: _________ Delivery by: ☐ Vaginal Birth ☐ Caesarean ☐ Unknown

If cesarean, why? ____

Birthplace: ☐Hospital ☐Birthing Clinic ☐Home ☐Ambulance ☐Taxi/Car ☐Other (specify): _____________

Birth Hospital/Clinic Name: ___________________________ City & State: ____________________________

Please indicate any medical problems during the baby's newborn period: _______________________________

____

FEEDING

☐ Breast Fed ☐ Bottle Fed ☐ Formula or ☐ Milk type ____

SLEEP

Any sleep problems? ____

DEVELOPMENT

At what age did your child: Sit alone _______ Walk alone _______ Say words _______ Toilet train _______

Age at first menstrual period: _________ Sexually active? ☐ No ☐ Yes

Birth control? ☐ Yes (Type) __________________ ☐ No Condom Use? ☐ No ☐ Yes

DENTAL HISTORY

Is child seeing a Dentist regularly? ☐ No ☐ Yes Date of last visit: _________________

IMMUNIZATIONS/INFECTIOUS DISEASES

Are shots up to date? ☐ No ☐ Yes *(Please bring your child's immunization records to your appointment)*

Has your child had: ☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis

Date: ____________ Child's Name: ___________________________ Date of Birth: _______________

EXPOSURES/HABITS

Any concerns about Lead exposure? ☐ No ☐ Yes

Do any household members smoke? ☐ No ☐ Yes

PATIENT'S PAST MEDICAL HISTORY *(Please describe any major medical problems and dates)*

____

Hospitalizations/Operations (with dates): ____

Severe Injuries (with dates): ____

Chronic Illnesses: ☐ Asthma ☐ Allergies ☐ Migraines ☐ Genetic Conditions: _____________________

FAMILY HISTORY *(Please check-off any family history of the following):*

FAMILY HX	MOM	DAD	BRO.	SISTER
Alcoholism				
Asthma				
Birth defects				
Bleeding problems				
Blindness				
Bone disorders				
Cancer				
Chronic disabling disease				
Deafness before age 5				
Developmental disorders				
Diabetes mellitus				
Early deaths				
Genetic disease				
Heart disease				
Psychiatric disorders				
Seizures				

SOCIAL HISTORY

With whom does child live? ____

SCHOOL/BEHAVIOR HISTORY

Any concerns about school performance? ____

Any concerns about behavior? ____

Any other information you would like us to know?

____

____

North Florida Medical Centers, Inc.

NEW PATIENT HISTORY

Please fill out the following sections as completely and accurately as possible so that we may provide the best quality of care.

Today's Date: ____________ *Name:* ______________________________ *Date of Birth:* ___________________

Previous Hospitalizations and Dates: ____

____

PAST MEDICAL HISTORY (*Do you have/had any of the following?)*:

- □ Alcohol dementia
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Bipolar
- □ Bladder cancer
- □ Bleeding disease
- □ Breast cancer
- □ Bronchopulmonary infections
- □ Cervical cancer
- □ Chest pain
- □ Congenital abnormalities
- □ Congestive heart failure
- □ Convulsions
- □ COPD
- □ Depression
- □ Diabetes melitus
- □ Esophageal cancer
- □ Heart (cardiac) disease
- □ Hepatitis (A)(B)(C) carrier
- □ Hepatitis exposure
- □ High blood pressure
- □ HIV/AIDS or exposure to
- □ Hyperlipidemia
- □ Hypertension
- □ Kidney cancer
- □ Kidney disease
- □ Laryngeal cancer
- □ Liver/stomach/bowel
- □ Lung cancer
- □ Migraine HA
- □ Obsessive Compulsive
- □ Parkinson's disease
- □ Prostate cancer
- □ Pulmonary embolism
- □ Rectal cancer
- □ Reflux/GERD
- □ Schizophrenia
- □ Sexually transmitted disease
- □ Sinusitis
- □ Skin cancer
- □ Skin disease
- □ Testicular cancer
- □ Thrombophlebitis
- □ Thyroid cancer
- □ Thyroid disease
- □ TIA or Stroke
- □ Tuberculosis (TB)

Other:

____

____

SURGICAL HISTORY

- □ Abdominal
- □ Angioplasty
- □ Aortic aneurysm repair
- □ Appendectomy
- □ Arthroscopy knee
- □ Back surgery
- □ Bladder
- □ Breast biopsy
- □ Cardiothoracic
- □ Carpal tunnel
- □ Cataract/lens implant
- □ Cholecystectomy
- □ Colostomy, partial
- □ Coronary artery bypass graft
- □ Delivery by C-section
- □ Ears, nose, throat
- □ Gastric, other
- □ Gastroplasty, bariatric
- □ Hernia
- □ Hip replacement
- □ Hysterectomy
- □ Intestinal bypass
- □ Joint replacement
- □ Kidney
- □ Laminectomy/ discectomy
- □ Lithotripsy
- □ Mastectomy
- □ Neurosurgery
- □ Oophorectomy
- □ Open lysis adhesions
- □ Orthopedic
- □ Prostate
- □ Skin/dermal
- □ Small bowel resection
- □ Thyroid
- □ Tonsillectomy
- □ Tubal ligation
- □ TURP
- □ Ulcer

□ Prior surgery **Other** - Explain:

____

____

____

SOCIAL HISTORY

Occupation: ____

Living situation: □ w/ spouse □ alone □ w/ parents □ w/ children/family □ in nursing home □ other

Sexually active? □ Yes □ No **Birth control?** □ Yes (Type) _____________ □ No **Condom Use?** □ Yes □ No

Habits: Sleep well? □ Yes □ No, reason ____

Practice preventive health? □ Yes □ No **Exercise:** □ Yes □ No If Yes, days/week ________________

Leisure activities: □ Yes □ No If Yes, what? ____

Travel history: Where? _________________________ Method of travel: _____________________________

Caffeine use: □ Coffee ____ cups/day □ Tea ____ cups/day □ Cola ____ cans/day

□ Chocolate ____ bars/day □ Over the counter 'stay-awake' pills

Today's Date: ____________ *Name:* ______________________________ *Date of Birth:* ___________________

Alcohol Use: ☐ Never ☐ Prior heavy use ☐ Social
☐ Beer ☐ Wine ☐ Hard liquor Per day/week __________
☐ Considered quitting ☐ Angry discussing it ☐ Feel guilty using ☐ Use to "get going" in AM
☐ Use for symptom relief

Tobacco Use: ☐ Previous smoker ☐ Cigarettes: packs per day _________ ☐ Never smoked
☐ Chew tobacco ☐ Dip tobacco Age started _____ Age stopped _____

Drug Use: ☐ Marijuana ☐ Cocaine ☐ Intravenous ☐ Other ___________ ☐ Never used ☐ No longer using

Diet: ☐ Taking meds to lose wt ☐ Taking vitamins ☐ Nutritious/Satisfying ☐ Needs improvement
☐ Recent change ☐ Vegetarian ☐ Other ____

Domestic Violence: Have you been physically or emotionally abused? ☐ Yes ☐ No
If **yes**, please briefly explain: ____

Any other information you would like us to know?

____

____

FAMILY HISTORY

Please check (√) all that apply

FAMILY HX	MOM	DAD	BRO.	SISTER	SON	DAUG.
Alcoholism						
Anemia						
Arthritis						
Asthma						
Backache						
Birth defects						
Bleeding problems						
Cancer						
Chronic disabling Dx						
Deafness before age 5						
Diabetes Mellitus						
Early deaths						
Genetic disease						
Goiter (simple)						
Heart attack						
Heart disease						
Hypertension						
Kidney disease						
Mental illness (not MR)						
Migraine headache						
Multiple births						
Polyps GI						
Stroke syndrome						
Thyroid syndrome						
Other:						

Mother's age: ________

Mother deceased at age: ______

Father's age: ______

Father deceased at age: ______

Were you provided with an **Advance Directive?** ☐ Yes ☐ No

If Yes, Date Provided: _____________

Date Refused: _____________________

Drug Allergies:

____

____

____

____

Current Medications: ____

____

____

Consent to the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Operations

I, __________________________, understand that as a part of my health care, North Florida Medical Centers, Inc. (NFMC) receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that NFMC and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- Diagnose my medical/psychiatric/psychological condition.
- Plan my care and treatment.
- Communicate with other health professionals concerning my care.
- Document services for payment/reimbursement.
- Conduct routine health care operations, such as quality assurance and peer review.
- For research and similar purposes designed to improve the quality and to reduce the cost of health care.

I have been provided a ***Notice of Information Practices*** that fully explains the uses and disclosures that NFMC will make with respect to my individually identifiable health information. I understand that I have the right to review the *Notice* before signing this consent. NFMC has afforded me sufficient time to review this *Notice* and has answered any questions that I have to my satisfaction. I also understand that NFMC cannot use or disclose my individually identifiable health information other than as specified on the *Notice*. I also understand, however, that NFMC reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it posts a copy of the revised notice in a prominent space in the medical center(s).

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that if I do not consent, NFMC may refuse to provide me health care services unless applicable state or federal law requires NFMC to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that NFMC is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or NFMC notifies me that it is no longer going to honor the request.

I understand that I have the right to request restriction as to the method of communications to me. I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that NFMC has already taken action in reliance on my earlier effective consent.

I request the following restrictions on the use or disclosure of my individually identifiable health information: ____

____

I object to uses and disclosures as follows: ______________________________

____

____

Signature of Patient or Legal Representative ______________________ Signature of Witness ______________________

Date ______________________ ______________________

For Office Use Only: ____

____

____

North Florida Medical Centers, Inc.
Notice of Information 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.

Understanding Your Health Record Information

Each time you visit a hospital, a physician, or another health care provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as the following:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care that you received.
- Means by which you or a third-party payer can verify that you actually received the services billed for.
- Tool in medical education.
- Source of information for public health officials charged with improving the health of the regions they serve.
- Tool to assess the appropriateness and quality of care that you received.
- Tool to improve the quality of health care and achieve better patient outcomes.

Understanding what is in your health records and how your health information is used helps you to--

- Ensure its accuracy and completeness.
- Understand who, what, where, why, and how others may access your health information.
- Make informed decisions about authorizing disclosure to others.
- Better understand the health information rights detailed below.

Your Rights under the Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed it, you have the following rights with regard to the information contained therein:

- Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. "Health care operations" consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under the following sections of the federal privacy regulations: § 164.502(a)(2)(i) (disclosures to you), 164.510(a) (for facility directories, but note that you have the right to object to such uses), or 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction. If we do, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means, and if the method of communication is reasonable, we must

grant the alternate communication request. You may request restriction or alternate communications on the consent form for treatment, payment, and health care operations.

- Obtain a copy of this notice of information practices. Although we have posted a copy in a prominent location throughout the facility, you have a right to a hard copy upon request.
- Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
    - Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
    - Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
    - Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. § 263a, to the extent that giving you access would be prohibited by law.
    - Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.

  In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:
    - A licensed healthcare professional, such as your attending physician, has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.
    - PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
    - The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.

  For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review.
  If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.
- Request amendment/correction of your health information. We do not have to grant the request if the following conditions exist:
    - We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.
    - The records are not available to you as discussed immediately above.
    - The record is accurate and complete.

If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

- Obtain an accounting of nonroutine uses and disclosures, those other than for treatment, payment, and health care operations. We do not need to provide an accounting for the following disclosures:
  - To you for disclosures of protected health information to you.
  - For the facility directory or to persons involved in your care or for other notification purposes as provided in § 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care, of the your location, general condition, or death).
  - For national security or intelligence purposes under § 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
  - To correctional institutions or law enforcement officials under § 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
  - That occurred before April 14, 2003.

  We must provide the accounting within 60 days. The accounting must include the following information:
  - Date of each disclosure.
  - Name and address of the organization or person who received the protected health information.
  - Brief description of the information disclosed.
  - Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.
- Revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.
- Submit a complaint to NFMC and to HHS if you believe your privacy rights have been violated. You may contact NFMC's Privacy Officer at (850) 385-4494 to file a complaint. NFMC will not retaliate against individuals for filing a complaint.
- Disputes not resolved by the complaint procedure shall be resolved by binding arbitration in Tallahassee, Florida, under rules of The American Arbitration Association with each party to pay its own attorney fees.

Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this notice.
- Train our personnel concerning privacy and confidentiality.

- Implement a sanction policy to discipline those who breach privacy/ confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm of) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

How to Get More Information or to Report a Problem

If you have questions and/or would like additional information, you may contact Privacy Officer or the Chief Executive Officer at 850-385-4494.

Examples of Disclosures for Treatment, Payment, and Health Operations

• *If you give us consent, we will use your health information for treatment.*

Example: A physician, a physician's assistant, a therapist or a counselor, a nurse, or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the health care team to do to treat you. Those other members will then document the actions they took and their observations. In that way, the primary caregiver will know how you are responding to treatment. We will also provide your physician, other health care professionals, or a subsequent health care provider copies of your records to assist them in treating you once we are no longer treating you.

• *If you give us consent, we will use your health information for payment.*

Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

• *If you give us consent, we will use your health information for health operations.*

Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

• *Business associates:* We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) that we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates to appropriately safeguard your information.

• *Directory:* Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

• *Notification:* We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, your location, and general condition.

• *Communication with family:* Unless you object, health professionals, using their best judgment, may disclose to a family member, another relative, a close personal friend, or any other person that you identify health information relevant to that person's involvement in your care or payment related to your care.

• *Research:* We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

- *Funeral directors:* We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.
- *Marketing/continuity of care:* We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- *Fundraising:* We may contact you as a part of a fundraising effort. You have the right to request not to receive subsequent fundraising materials.
- *Food and Drug Administration ("FDA"):* We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or postmarketing surveillance information to enable product recalls, repairs, or replacement.
- *Workers compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- *Public health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- *Correctional institution:* If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
- *Law enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- *Health oversight agencies and public health authorities:* If a member of our work force or a business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the department of health.
- *The federal Department of Health and Human Services ("DHHS"):* Under the privacy standards, we must disclose your health information to DHHS as necessary to determine our compliance with those standards.

Effective date: April 14, 2003

Joel Montgomery, CEO
North Florida Medical Centers, Inc.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL POST THE NEW NOTICE IN THE MEDICAL CENTER.

RECEIPT OF PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

I, ____(Print name) have received a copy of the Patient

Bill of Rights and Responsibilities and have read them or had them read to me.

____

Signature of Patient Date

____

Signature of staff member Date

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from the North Florida Medical Centers, Inc. A summary of your rights and responsibilities follows:

NORTH FLORIDA MEDICAL CENTERS, Inc.

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

MISSION: To provide quality health care to all people in a cost-effective and caring manner.

AS A PATIENT, YOU HAVE THE RIGHT TO:

1. Be treated with courtesy and respect, with appreciation of your individual dignity, and with protection of your need for privacy.
2. Prompt and reasonable response to questions and requests.
3. Know who is providing medical services and who is responsible for your care.
4. Know what patient support services are available, including whether an interpreter is available if you do not speak English.
5. Know what rules and regulations apply to your conduct.
6. Be given, by the health care provider, information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
7. Refuse any treatment, except as otherwise provided by law.
8. To be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.
9. (If you are a patient eligible for Medicare), to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
10. To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
11. Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
12. Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
13. Treatment for any emergency medical condition that should deteriorate from failure to provide treatment.
14. Know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research.
15. Express grievances regarding any violation of your rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility that served you and to the appropriate state licensing agency.

AS A PATIENT, YOU HAVE THE RESPONSIBILITY TO:

1. Provide to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.
2. Reporting unexpected changes in your condition to the health care provider.
3. Reporting to the health care provider whether you comprehend a contemplated course of action and what is expected of you.
4. Following the treatment plan recommended by the health care provider.
5. Keeping appointments and, when you are unable to do so for any reason, notifying the health care provider or health care facility.
6. Be responsible for your actions if you refuse treatment or do not follow the health care provider's instructions.
7. Assuring that the financial obligations of your health care are fulfilled as promptly as possible.
8. Following health care facility rules and regulations affecting patient care and conduct.

Individual Authorization

Request for Medical Records

I hereby knowingly authorize ______________________________ & ______________________

Health center sending health information *Phone Number*

to release the following information to: ____

Name of Individual or Entity that is receiving the health information

Initial all appropriate boxes that describe the information to be released:

____ General Medical Record (**Last 2 years**) ____ Progress Notes _____ Prenatal Records

____ History and Physical Results ____ Immunizations _____ Billing Records

____ Diagnostic Test Results - Specify Test(s): ______________________________________

____ Other (specify) ____

Purpose(s) of Release: ☐ Changing Primary Care Physician ☐ Personal Use ☐ Legal purpose

☐ Continuity of Care ☐ Other (specify) ____

I understand this authorization will expire in six (6) months if no date is specified:________________________

I understand that the information in my health record may include information relating to:

- **Sexually transmitted disease (Patient's Initial)___________**
- **AIDS or HIV (Patient's Initial)______________**
- **Behavioral, mental health or psychiatric conditions (Patient's Initial)____________**
- **Drug or alcohol abuse, drug-related and/or alcohol-related treatment (Patient's Initials)__________**

I AGREE TO SUCH RELEASE OF THE ITEMS INITIALED ABOVE.

I understand that I have the right to revoke this authorization in writing at any time. I understand that I must give my written revocation to the Health center which is sending the records. I understand the revocation will not apply to information already released in response to this authorization.

I understand that the information used or disclosed because of this form may be subject to redisclosure by the receiving entity and may no longer be protected by the privacy regulations. I also understand that I am under no obligation to sign this authorization and my ability to obtain treatment will not depend in any way on whether I sign this authorization.

Print Name of Patient	Date of Birth	Social Security Number
Signature of Patient/Guardian	Date	☐ Mail Health Information OR
Signature of Witness	Date	☐ Pick up or ☐ Fax #__________________

If this authorization is signed by a guardian or personal representative of the patient, a description of the representative's authority: ____

PLEASE NOTE: *For patient copies, the first ten pages are at no cost; all pages after the tenth page are $1.00 each for the next 25 pages and then 25 cents per page thereafter. A copy of this authorization must be given to the patient.*