COLUMBIA MEDICAL CENTERS

DATE _____ **NAME** _____ **DOB** _____

SS# _____ **AGE** _____

SEX M F **MARITAL STATUS :** Married Divorced Single Widowed

RACE: _____ **PREFERRED LANGUAGE:** _____

HOME PHONE: _____ **WORK PHONE:** _____

EMAIL : _____

HOME ADDRESS: _____

CITY: _____ **STATE :** _____ **ZIP:** _____

MAILING ADDRESS: _____

CITY: _____ **STATE :** _____ **ZIP:** _____

CHECK IF RETIRED: ( ) **EMPLOYER NAME:** _____

OCCUPATION: _____ **ADDRESS:** _____

EMERGENCY NOTIFICATION (Nearest Relative)

NAME: _____ **RELATIONSHIP TO PATIENT:** _____

HOME PHONE: _____ **WORK PHONE:** _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE: _____

NAME OF SECONDARY INSURANCE: _____

ID # _____**Responsible Party:** _____ **Patient relationship**_____

*** Referred to our office by:** _____

*****We are required to electronically prescribe certain medications. Please provide your preferred pharmacy information**

Name: _____ **Phone Number:** _____

ADVANCE DIRECTIVES _____ **YES** _____ **NO** **ADVANCE DIRECTIVE DATE:** _____
If yes, Please provide our office with a copy for your chart.

I authorize payment of medical benefits to Columbia Medical Centers for services rendered.

PATIENT SIGNATURE **DATE**

3907 Jog Road - Greenacres, FL 33467 Phone: 561-432-3455 Fax: 561-432-8755

COLUMBIA
MEDICAL CENTERS

Patient Acknowledgements

I hereby acknowledge that I am aware that Columbia Medical Centers will at times have other doctors On call.

I hereby authorize Columbia Medical Centers to release any medical Information to Insurance companies, Attorneys, or other related companies to get settlement of medical bills owed too this physician's office.

I hereby authorize and assign payment to Columbia Medical Centers for all insurance medical benefits. I also understand my responsibility of payment for any and all charges not payable under this assignment.

For Medicare patients: I hereby authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Columbia Medical Centers.

PAYMENT IS EXPECTED IN FULL AT THE TIME SERVICES ARE RENDERED

I understand and agree that, regardless of insurance status, I am fully responsible for the balance on my account for any professional services rendered, including any fee incurred for collection of debt.

I certify that the information I have provided is true and correct to the best of my knowledge.

I understand that diagnosis or treatment of me by Columbia Medical Centers may be conditioned Upon my consent as evidenced by my signature on this document.

I agree to provide 24 hours advance notice should I need to cancel or reschedule an appointment. I understand and agree that a $25 fee will be charged for any broken appointment for which I do not provide 24 hours advance notice.

_____ _____

Signature of Patient or Patient's Guardian / Rep Date

_____

Printed Name of Person Signing Above

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COLUMBIA MEDICAL CENTERS

PATIENT RECORD DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- Ok to leave message with detailed information
- Leave message with call back number only
- Ok to fax to this number _____
- Ok to mail to my home address
- Ok to mail to my work/office address
- Work Telephone _____
- Other _____

IF YOU WOULD LIKE TO AUTHORIZE OUR OFFICE TO SHARE YOUR HEALTH CARE INFORMATION WITH SOMEONE, PLEASE COMPLETE THE FOLLOWING:

I, _____, authorize my physician and / or his Representatives to discuss my health care with the following: (please print)

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ _____

Patient Signature Date

3907 Jog Road - Greenacres, FL 33467 Phone: 561-432-3455 Fax: 561-4328755

COLUMBIA MEDICAL CENTERS

CONSENT FOR TREATMENT

I, _____, hereby authorize
Columbia Medial Centers of Greenacres, FL, the attending physician, or the
Physician designated by him and other center employees; to examine and treat me.
I also authorize such treatment and procedures, as deemed necessary by the physician,
Including but not limited to, the taking of X-rays, medications, blood samples,
Urine samples and other therapies as deemed necessary.
I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment.

I hereby certify that I understand the above authorization.

_____
PATIENT SIGNATURE

_____
DATE

_____
PATIENT OR PERSON AUTHORIZING CONSENT

_____
RELATIONSHIP TO PATIENT

3907 Jog Road – Greenacres, FL 33467 Phone: 561-432-3455 fax: 561-432-8755

COLUMBIA MEDICAL CENTERS

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give my permission to: _____

To release a copy of my medical records to:

Columbia Medical Centers
3907 Jog Road
Greenacres, FL 33467

I hereby release the facility from any liability which may arise as a as a result of the use of the information contained in the records released.

Name of Patient:_____ Birthdate:_____

Signature of patient:_____ Date:_____

Signature of guardian:_____ Date:_____

Signature of witness:_____ Date:_____

TO RECEIVING AGENCY: PROHIBITION OF REDISCLOSURE

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED. ANY FURTHER DISCLOSURE IS STRICTLY PROHIBITED UNLESS THE PATIENT PROVIDES SPECIFIC WRITTEN CONSENT FOR THE SUBSEQUENT DISCLOSURE OF THIS INFORMATION.

COLUMBIA MEDICAL CENTERS

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient's Name: _____

Date of Birth: _____

I understand that as part of my health care, Columbia Medical Centers originates and maintain paper and/ or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

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

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised
Notice of Privacy Practices upon request.

I have had the opportunity to receive and review the Notice of Privacy Practices of Columbia Medical Group.

_____ _____
Signature of Patient or Patients Guardian/Rep Date

3907 Jog Road – Greenacres, FL 33467 Phone: (561)432-3455 Fax: (561)432-8755

COLUMBIA MEDICAL CENTERS
HIPAA 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.

If you have any questions about this notice, please contact our Privacy Officer.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the way we may use and disclose health information that identifies you (Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for Health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS;

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclosed any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 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 Health 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.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information 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 Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency 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 Health 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 also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if 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) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES.

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Columbia Medical Centers. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have 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 our office. To request an amendment, you must make your request , in writing, to Columbia Medical Centers.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Columbia Medical Centers.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Columbia Medical Centers. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

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 by mail or at work. To request confidential communications, you must make your request, in writing, to Columbia Medical Centers. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

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 this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.columbiamedicalcenters.com
To obtain a paper copy of this notice, a request, in writing, must go to Columbia Medical Centers.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. ***You will not be penalized for filing a complaint.***