Welcome to

Chipola Medical Associates

Date: _____

Name: Last_____First_____Middle_____

Street address: _____

City: _____State: _____Zip: _____

Primary Contact Number: _____Cell/Work Number: _____

Email Address: _____@_____

Social Security Number: _____-_____-_____ Birth date: _____/_____/_____

Gender: _____ Ethnicity: _____ Marital Status: _____

Employer: _____ Occupation: _____

Business Address: _____

Spouse's Name: _____ Spouse's Date of Birth: ____/____/_____

Emergency Contact &Phone Number: _____

Pharmacy Name: _____

Primary Insurance Carrier: _____

Member Number: _____ Group Number: _____

Subscriber's Name: _____Subscriber's Social Security Number: _____

Secondary Insurance Carrier: _____

Member Number: _____ Group Number: _____

I consent for Chipola Medical Associates to have access to any prescription history: pharmacy, medical provider, or other outside health association has processed if it is available.

I, the Undersigned, certify that I (or my dependents) have insurance coverage as listed above and assign directly to Dr. Joe Gay and staff, all insurance benefits if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

My signature below is also my consent to receive medical treatment by Dr. Gay and staff at Chipola Medical Associates.

Patient Signature_____ Relationship: _____ Date: _____

HIPAA Permission

My healthcare and patient account information may be shared with the following individuals:

1. _____
2. _____
3. _____
4. _____

You are welcome to change your permission list at any time.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

PRIVACY

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices. Your signature below acknowledges that you have received the privacy practice information and understand them.

Print Name: _____

Signature: _____ Date: _____

Electronically Communicating with Chipola Medical Associates

You acknowledge that you will not email us any protected health information using unsecure email. You agree that the only safe way to transmit protected health information is through your password-secured Chipola Medical Associates patient portal account.

Print Name: _____

Signature: _____ Date: _____

HIPAA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, and/or payment of health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians or the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information. This must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____

Signature: _____

Date: _____

Notice of Information Practice

Understanding Your Health Record Information

Each time that 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, diagnosis, 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 are 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 charges 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 the records, 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. The right to request restriction does not extend to uses or disclosures permitted or required under the following sections of the federal privacy regulations: ~I64.502(a)(2)(i) (disclosures to you), ~I64.510(a) (for facility directories, but note that you have the right to object to such uses), or ~164.512(uses and disclosure 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, except in the situation explained below. 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. If, however, you request restriction on a disclosure to health plan for purposes of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.

- Obtain a copy of this notice of information practices. Although we have posted a copy in prominent locations throughout the facility and on our website, 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 a right of access to the following:

    - Psychotherapy notes. Such notes consists 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”), 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 healthcare 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 report into your 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 until a date that the federal Department of Health and Human services will set after January 1, 2011. After that date, we will have to provide an accounting to you upon request for uses and disclosures 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(k)(2) 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 if 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.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost based fee.

- 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.

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 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 the office manager at 850-526-3434.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALY IDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS THAT YOU HAVE GIVEN US.

Examples of Disclosures for Treatment, Payment, and Health Care Operations

- *If you give us consent, we will use your health information for payment*. Example: We may send a bill to you or 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 you health information for health care 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.
- *If you given us consent, we will use your health information for treatment.* Example: A physician, a physicians 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 given treatment orders and document what he or she expects other members of the healthcare team to do to treat you. Those other members will then document the actions that 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 healthcare professionals, or a subsequent healthcare provider copies of your records to assist them in treating you once we are no longer treating you.
- *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. After February 17,2010, business associates must comply with the same federal security and privacy rules as we do.

- *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, 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 case 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 relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

- *Workers Compensation:* We may disclose health information to extent authorized by and to the extent necessary to comply with laws relating to workers compensation or disability.

- *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 members of our work force or business associates believe 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 health authorities, such as the department of health.

- *The federation 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 standard.

  Effective date: [date]

  Signature:

  Title:

  Name of covered entity:

Individual 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, Chipola Medical Associates 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, diagnosis treatment, treatment plans, and billing and health insurance. I understand that Chipola Medical Associated 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 (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel).

I have received a *Notice of Information Practices* that fully explains the uses and disclosures that Chipola Medical Associates 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. Chipola Medical Associates has afforded me sufficient time to review this *Notice* and has answered any questions that I have to my satisfaction. I also, understand that Chipola Medical Associates cannot use or disclose my individually identifiable health information other than as specified on the *Notice.* I also understand, however, that Chipola Medical Associates reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised noticed to the address that I have provided.

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 it does agree, it must honor the restriction unless I request that it stop doing so or Chipola Medical Associates notifies me that it is no longer going to honor the request.

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

I understand that I have the right to request restriction as to the method of communications to me. For example, I might request that all medical bills be mailed to a certain post office box. For example, I might request that all medical bills be mailed to a certain post office box rather than my home. I further understand that Chipola Medical Associates must honor this request if the *method of communication* is reasonable. Chipola Medical Associate may not ask me why I want the alternative method of communication.

I object to the uses and disclosures as follows:

I understand that I must revoke this consent in writing but that the revocation will not be effective to the extent that Chipola Medical Associates has already taken action in reliance on my earlier effective consent.

Signature of Patient or Legal Representative

Signature of Witness

Date

Introduction

Chipola Medical Associates provides patients the opportunity to communicate with their physicians, other health care providers, and administrative services by email. Transmitting confidential patient information by email, however, has a number of risks, both general and specific, that patients should consider using email.

Risk Factors

- Among the general email risks are the following:
    - Email can be immediately broadcast worldwide and be received b many intended and unintended recipients
    - Recipients can forward email messages to other recipients without the original sender's permission or knowledge.
    - Users can easily misaddress an email
    - Email is easier to falsify than handwritten or signed documents.
    - Backup copies of email may exist even after the sender or recipient has deleted his or her copy.
- Among specific patient email risks are the following:
    - Email containing information pertaining to a patient's diagnosis and/or treatment must be included in the patient's medical record. Thus, all individuals who have access to the medical record will have access to the email messages.
    - Employees do not have an expectation of privacy in email that they send or receive at their place of employment thus, patients who send or receive emails from their place of employment risk having their employer read their email.
    - If employers, or others, such as insurance companies read an employee's email and learn of medical treatment, particularly mental health, sexually transmitted diseases, or alcohol and drug abuse information, they may discriminate against the employee/patient.
    - For example, they may fire the employee, not promote the employee, deny insurance coverage, and the like. In addition, the employee could suffer from social stigma from the disclosure of such information.
    - Patients have no way of anticipating how soon Chipola Medical Associates and its employees and agent will respond to a particular email message. Although Chipola Medical Associates and its employees and its agents will endeavor read and respond to email promptly, Chipola Medical Associates cannot guarantee that any particular email message will be read and responded to within any particular period of time.

- Physicians, nurses, and other health care workers rarely have time during rounds, surgeries, consultations, appointments, staff meetings, meetings away from the facility, and meetings with patients and their families to continually monitor whether they have received an email. Thus, patients should not use email in medical emergency.

Conditions for the Use of Email

- It is the policy of Chipola Medical Associates that Chipola Medical Associates will make all email messages sent or received that concern the diagnosis or treatment of a patient part of that patient's medical record and will treat such email messages with the same degree of confidentiality as afforded other portions of the medical record. Chipola Medical Associates cannot, however, guarantee the security and confidentiality of email communication.

  - All emails to or from the patient concerning diagnosis and/or treatment will be made a part if the patient's medical record. As a part of the medical record, other individuals, such as other physicians, nurses, physical therapists, patients account personnel, and the like, and other entities, such as other health care providers and insurers, will have access to email messages contained in medical records.

  - Chipola Medical Associates may forward email messages within the facility as necessary for diagnosis, treatment, and reimbursement. Chipola medical Associates will not, however, forward the email outside the facility without the consent of the patient of as required by law.

  - If the patient sends an email to Chipola Medical Associates, one of its physicians, another health care provider, or an administrative department, Chipola Medical Associates will endeavor to read the email promptly and respond promptly, if warranted. However, Chipola Medical Associates can provide no assurance that the recipient of a particular email will read the message promptly. Because Chipola Medical Associates cannot assure patients that recipients will read email messages promptly, patients must not use email in a medical emergency.

  - If a patient's email requires or invites a response, and the recipient does not respond within a reasonable time, the patient is responsible for following up to determine whether the intended recipient received the email and when the recipient will respond.

  - Because some medical information is so sensitive that authorized disclosure can be very damaging, patients should not use email for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; mental health or developmental disability; or alcohol and drug abuse.

- Because employees do not have a right of privacy in their employer's email system, patients should not use their employer's email system to transmit or receive confidential medical information.
- Chipola Medical Associates cannot guarantee that electronic communications will be private. Chipola Medical Associates will take reasonable steps to protect the confidentiality or patient email, but Chipola Medical Associates is not liable for improper disclosure of confidential information not caused by Chipola Medical Associates' gross negligence or wanton misconduct.
- If the patient consents to the use of email, the patient is responsible for informing Chipola Medical Associates of any types of information that the patient does not want to be sent by email other than those set out above.
- Patient is responsible for protecting patient's password or other means of access to email sent or received from Chipola Medical Associates to protect confidentially. Chipola Medical Associates is not liable for breaches of confidentiality caused by patient.
- Any further use of email by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing. You may withdraw consent to the use of email at any time by email or written communication to Chipola Medical Associates, attention: Director of Health Information.

I have read the above risk factors and conditions for the use of email, and I hereby consent to the use of email for communications to and from Chipola Medical Associates regarding my medical treatment.

_____ _____

Signature of Patient Date of Signature

_____

Printed Name of Patient

_____

Signature of Witness

_____

Printed Name of Witness