FLORIDA EYE
Microsurgical Institute, Inc.

1717 Woolbright Road • Boynton Beach, FL 33426
(561) 737-5500 • FAX (561) 737-7055 • fleyedocs.com

WELCOME TO OUR OFFICE

Today's Date: ______________________ Soc. Sec. # ______________________

Patient's Name: ______________________ / ______________________
(First) (MI) (Last) (Preferred Name)

Marital Status: S M D W Date of Birth:_____/_____/______ Age: ______ Sex: F M

Address:____

City, State and Zip Code: ____

Home #: (_____) ______________ Cell #: (_____) ______________ E-mail: ______________

Spouse's Name: ______________________ Phone #: (________) ______________

Employer: Work #: (_____) ______________

Referred By: ______________________ Phone #: (________) ______________

Family Physician Name: ______________________ Phone #: (________) ______________

Insurance Information

Primary Insurance Name: ____

Insurance Policy Holder's Name: ______________________ Date of Birth:_____/_____/_____

Insurer's Social Security: ______________________ Ins ID#: ______________________

Secondary Insurance Name: ____

Insurance Policy Holder's Name: ______________________ Date of Birth:_____/_____/_____

Insurer's Social Security: ______________________ Ins ID#: ______________________

Emergency Contact

In case of emergency, please contact: ______________________ Phone #: (________) ______________

Relationship to you: ______________________ Address: ______________________

Name of family member NOT residing with you: ______________________ Phone #: (________) ______________

Relationship to you: ______________________ Address: ______________________

PLEASE NOTE: PAYMENT IS EXPECTED AT TIME OF SERVICE

- I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to Medicare or any other insurance company. I authorize payment of medical payments to Florida Eye Microsurgical Institute for any services rendered to me by any doctor of Florida Eye Microsurgical Institute.
- I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, co-pays, coinsurance and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of the service provided.
- I authorize use of this form on all my insurance submissions. I understand I am responsible for my bill. I permit a copy of this authorization to be used in place of the original.

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance payments. However, the patient is responsible for ALL fees, regardless of insurance coverage. If it is necessary to tum this service over to collections for non-payment after 90 days, then the patient is responsible for the bill, the interest, in addition to collection and attorney fees.

____ ______________________
Signature of Patient or Legal Guardian (Signature on file for payment authorization) Date

NOTE: ANY UNPAID BALANCES FROM PREVIOUS VISITS, OR NON ALLOWED CHARGES/NON-COVERED SERVICES MUST BE PAID IN FULL TODAY. I request that authorized Medigap benefits (If applicable) be made on my behalf to Florida Eye Microsurgical Institute. I authorize Florida Eye Microsurgical Institute to contact the State Insurance Commissioner on my behalf in which state my insurance company domiciles to collect their payment. SIGNING THIS FORM CERTIFIES YOUR AGREEMENT WITH ALL THE STATEMENTS ABOVE. If you disagree with any statement, please discuss with us before signing.

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PATIENT MEDICAL HISTORY

Please complete this form and bring it with you to your appointment. Add pages if you need space.

Patient Name ______________________________ Date of Birth ______________

1. Do you have now, or have you ever had:

PROBLEM	YES/ NO	DATE OF ONSET
Diabetes Mellitus	❑ Yes ❑ No	______
Treatment: ❑ Diet control ❑ Oral agents ❑ Insulin		
Name of Physician Treating diabetes ______		
Heart Attack	❑ Yes ❑ No	______
Chest Pain or Angina	❑ Yes ❑ No	______
High Blood Pressure	❑ Yes ❑ No	______
Stroke or “Shock”	❑ Yes ❑ No	______
Anemia	❑ Yes ❑ No	______
Hepatitis	❑ Yes ❑ No	______
Asthma	❑ Yes ❑ No	______
Emphysema	❑ Yes ❑ No	______
Bronchitis	❑ Yes ❑ No	______
Pneumonia	❑ Yes ❑ No	______
Tuberculosis	❑ Yes ❑ No	______
Liver Disease	❑ Yes ❑ No	______
Ulcer	❑ Yes ❑ No	______
Overactive Bladder	❑ Yes ❑ No	______
Prostate Treatment	❑ Yes ❑ No	______
Kidney Disease, Stones	❑ Yes ❑ No	______
Arthritis	❑ Yes ❑ No	______
Type: ❑ Osteo ❑ Rheumatoid		
Cancer or Tumor	❑ Yes ❑ No	______
Type, Location and Treatments: ______		
Thyroid Disease	❑ Yes ❑ No	______
❑ Underactive .... Treatment ______		
❑ Overactive .... Treatment ______		
Seizures	❑ Yes ❑ No	
Varicose Veins, Clots	❑ Yes ❑ No	______
Transfusions	❑ Yes ❑ No	______
Have you tested positive for AIDS or HIV	❑ Yes ❑ No	______
Other medical problems	❑ Yes ❑ No	______

2. Are you allergic to any medications or foods?

❑ Yes ❑ No

Please list ______________________

____

____

____

3. What eye medications are you currently using?

Name & Dosage ______________________

____

____

____

4. What other medications do you take regularly (including “social drugs”)?

Name, Dosage & Frequency

____

____

____

____

____

____

____

____

____

5. When did you last use aspirin in any form?

Name/Product ______________________

Date ______________________

CONTINUE →

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PATIENT MEDICAL HISTORY

6. When was your last professional eye exam and by whom?

Date ______________________

Name of Doctor ____

Type of doctor ❑ Ophthalmologist ❑ Optometrist

7. Have you had any previous eye surgery, laser surgery, including Lasik, or eye injuries? ❑ Yes ❑ No

Types/Dates ____

8. Do you wear Contact Lenses ❑ Yes ❑ No

9. What non-eye operations have you had?
Types/Dates ____

____

Date of Last general anesthesia __________________________

Complications? Explain __________________________________

____

10. Among you and your blood relatives, is there a history of any of the following?

PROBLEM	YOU	BLOOD RELATIVES
Glaucoma	❑ Yes ❑ No	❑ Yes ❑ No
Cataracts	❑ Yes ❑ No	❑ Yes ❑ No
Lazy Eye	❑ Yes ❑ No	❑ Yes ❑ No
Retinal Disease	❑ Yes ❑ No	❑ Yes ❑ No
Macular Disease	❑ Yes ❑ No	❑ Yes ❑ No
Night Blindness	❑ Yes ❑ No	❑ Yes ❑ No
Color Blindness	❑ Yes ❑ No	❑ Yes ❑ No
Unexplained Vision Loss	❑ Yes ❑ No	❑ Yes ❑ No
Bleeding Disorder	❑ Yes ❑ No	❑ Yes ❑ No
Diabetes Mellitus	❑ Yes ❑ No	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No	❑ Yes ❑ No
Heart Disease	❑ Yes ❑ No	❑ Yes ❑ No
Tumor or Cancer	❑ Yes ❑ No	❑ Yes ❑ No
Other (Please list)	❑ Yes ❑ No	❑ Yes ❑ No

11. Do you smoke?

❑Yes ❑ No
How many packs of cigarettes, cigars, pipes per day? ______________
If you smoked in the past, when did you stop and how long had you smoked? ____________________

12. Do you drink alcoholic beverages?

❑ Yes ❑ No
How many drinks (beers, wine glasses or ounces of liquor) per day? ____________________
Per average week? ____________
If you drank alcohol in the past, when did you stop and how long were you drinking? ____________________

13. In your line of work, hobby, or lifestyle, are your eyes exposed to chemical or air pollutants?

❑ Yes ❑ No
Name and frequency ____________

____

14. If applicable, are you pregnant?

❑ Yes ❑ No

15. Are there other health issues we should be aware of?

____

____

____

____

____

FINANCIAL POLICY

The following information is regarding your account at Florida Eye Microsurgical Institute. If you have questions or concerns about any of the information contained below, please discuss them with our staff. We look forward to providing you and your family with excellent service for all of your eye care needs.

- Payment is due at the time services are rendered. This may include co-pays, deductibles, co-insurance, non-covered services, etc. For your convenience, we accept all major credit cards as well as debit cards, cash, and checks.
- It is your responsibility to know your insurance coverage and to provide our office with the most current and accurate information. While our staff is extremely knowledgeable about many insurance plans, we are not aware of every plan since they constantly change. We cannot be held liable for misquoted benefits, eligibility or estimates.
- A refraction is necessary to determine the performance of the visual system and is the first step of evaluating the health of the eye. Although a refraction is also used to determine the need for corrective eyeglasses or contact lenses, this practice performs refractions as an **essential** part of the medical eye examination. A refraction is also necessary to evaluate a patient for surgery and some eye conditions.
- Unfortunately, most insurance plans (including Medicare) DO NOT cover the cost of the refraction. In these cases, the patient will be responsible for the $50.00 refraction charge on the day of the appointment.
- If there is a problem with your glasses prescription or contact lenses you have 45 days from the original exam to get rechecked, after the 45 days you will be charged an office visit.
- If your insurance requires a referral, you are responsible for contacting your primary care physician/pediatrician to obtain said referral. It is also your responsibility to verify that valid referrals are on file for any follow up care.
- All “self pay” patients are required to pay in full at the time services are rendered.
- Our office does not accept insurance liens, workers compensation, or attorney liens. Payment is the patient’s responsibility and due in full at the time of service.
- All returned checks are subject to a $35.00 processing fee and will result in refusal to accept future payments by check.
- If the parents are divorced, the parent bringing the child for treatment is ultimately responsible for payment, regardless of the terms of any divorce decree or custody arrangement.
- All outstanding balances must be paid in full before scheduling surgery.
- All delinquent accounts may be sent to a collection agency and you will be charged an administrative fee of 30%. Once an account has been transferred to collections, you and your immediate family members will be discharged from the practice.
- Any account credit balance less than $5.00 will not be issued a refund check.
- Payment on all accounts billed is expected within 30 days. If payment is not received within 30 days, a monthly administrative fee may be added to your account to partially defray postage and other office costs generated by multiple billings.
- We charge a fee for any and all forms that require the doctor’s signature and review. This service will not be billed to your account or your insurance company. Payment is due before the form(s) will be released. A receipt will be provided at the time of payment.
- As a courtesy to all patients, we will try to notify you with a reminder call 24 hours prior to your visit. It is very important that you keep the practice updated with your most current information. We reserve the right to charge a fee for all NO SHOW or missed appointments that are not cancelled within 24 hours of your scheduled appointment. This amount will be required before your next scheduled appointment.
- By signing below, I agree to the above terms and I agree to pay any collection costs and/or reasonable attorney’s fees if a delinquent balance is placed with a collection agency and/or attorney for collection, or suit.

I understand that even if Florida Eye Microsurgical Institute is contracted with my health care plan, I am ultimately responsible for payment of both covered and non-covered services performed during the course of my treatment. I request payment of authorized benefits by my insurance plan be made on my behalf to Florida Eye Microsurgical Institute for services rendered and request that Florida Eye Microsurgical Institute submit claims for payment for those services on my behalf to my insurance carrier. I authorize release of medical information to the insurance carrier or its agents to allow for benefit or claim determination.

______________________________________ ______________

Patient Signature/Legal Guardian Signature Date

NON-COVERED SERVICES AND FEES

Welcome and thank you for choosing Florida Eye Microsurgical Institute for all your eye care needs. It is our goal to work with you to help you understand and maximize your medical insurance benefits.

As you know, we are committed to providing you with the very best eye care available. Unfortunately some health insurance companies do not always cover all the services that may be provided during your eye examination. **Routine Eye Exams** and **Refractions** are often not covered as a result, we may have to charge for these services, separate from any co-payment you might have.

Unfortunately, health insurance, whether medical or vision, has been made needlessly complex by the insurance industry. Our office strives to diligently stay abreast of the ever changing rules and regulations which we are contractually obligated to follow. In fact, there are over a thousand different insurance plans in the South Florida area and it is difficult to always know what is or is not covered by any particular plan. Our office therefore highly recommends that each of our patients find out exactly **what their individual insurance covers in advance** so that there will be no confusion on the day of your visit. Please note that our office does NOT accept vision insurance.

What is a Routine Eye Exam?
A **routine eye examination** takes place when you come for an eye examination without any medical eye problem, and there are no symptoms except for visual changes that can be corrected by eyeglasses or contact lenses. The doctor screens the eyes for disease and finds no medical problems. Glasses and contact lens prescriptions may be updated.

Most medical insurance plans, including Medicare, do NOT cover **routine refractions** or **routine eye examinations**. Medicare requires that we charge separately for this portion of the examination, since it is not a covered service.

What is Refraction?
Refraction is the process of determining the performance of the visual system. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

A **refraction** is also very important for patients of all ages from infancy through adulthood; it identifies problems such as amblyopia (also known as lazy eye) and strabismus (also known as crossed eye) as well as helping determine why your child might have failed a vision screening at school or at the pediatrician or family practitioner's office. The **refraction** is critical in helping determine precisely how well you or your child can see. If you or your child's vision cannot be corrected with glasses, there may be another eye disease or issue present, and a **refraction** is the only way we can effectively determine this. Unfortunately most medical insurances **will not** pay for a **refraction**, although it is a fundamental part of a comprehensive eye examination. With that being said, please make sure you review your insurance policy carefully as some companies may provide reimbursement for this service. However, either way, you will have to pay for this service on the day of your or your child's exam.

Our office fee for a **refraction** is $50.00 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the **refraction**, we will reimburse you accordingly.

Co-payments
Almost all insurances now require a co-payment to see a specialist. Please check with your insurance company prior to your visit to verify the amount of your specialist co-payment. Some insurances also require an additional co-payment for diagnostic procedures. This may be a different amount from your visit co-payment. Co-payments are collected when you check-in. There is an additional service fee of $25 if you prefer to have us bill you for your co-payment.

Patient Acknowledgement
I have read the above information and understand that the **refraction** is a non-covered service. I accept full financial responsibility for the cost of the service and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the **refraction** fee.

______________________________ ______________
Patient Signature (Parent / Legal Guardian) Date

INFORMED CONSENT OF TREATMENT

Patient's Name/ID#: ____ DATE: _____________

I agree and consent to health care services offered and provided by Florida Eye Microsurgical Institute, a health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to perform.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of the above named individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Patient or Guardian Signature (Parent for Minor) ____________________________ Date __________

Relationship to Patient (if applicable):________________________

FOR OUR MEDICARE PATIENTS

After you are seen by the doctor, Florida Eye Microsurgical Institute will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear *in lieu* of your signature on all Medicare forms submitted for you by our office.

X ____

Signature or patient or guardian

PATIENT REQUEST FOR EMAIL COMMUNICATIONS

Communications over the internet and /or using the email system are not encrypted and are inherently unsecured. There is no assurance of confidentiality of information when communicated this way. Nevertheless, you may request that we communicate with you via email. To do so, you must complete this form.

Please be advised that:

This request applies only to the office of Florida Eye Microsurgical Institute or its physicians.

Florida Eye Microsurgical Institute will not communicate health information that is specially protected under state and federal law (for example HIV/AIDS information, substance abuse treatment, mental health information) via email even if we agree to communicate with you via email.

Please provide us with the email address to which communication should be addressed to:

____

Please initial each phrase:

____ I certify the email address provided on this request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.

____ I understand and acknowledge that communications over the internet and/or using the email system are not encrypted and are inherently insecure; that there is no assurance of confidentiality of information when communicated this way.

____ I understand that email communication in which I engage may be forwarded to other providers, including providers not associated with Florida Eye Microsurgical Institute for purposes of providing treatment to me or my child.

____ I agree to hold Florida Eye Microsurgical Institute and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

Signature of Patient or Legal Representative ________________________________ Date__________

Name of Patient or Legal Representative ________________________________

ACKNOWLEDGEMENT OF RECEIPT OF FLORIDA EYE MICROSURGICAL INSTITUTE'S NOTICE OF PRIVACY PRACTICES

HIPAA Approved Contacts

Last Name	First Name	Middle	Gender	Date of Birth	SSN	Relationship

Address	City	State	Zip Code	Home	Cell	Work

Last Name	First Name	Middle	Gender	Date of Birth	SSN	Relationship

Address	City	State	Zip Code	Home	Cell	Work

By signing below I acknowledge I have received a copy of the Florida Eye Microsurgical Institute Notice of Privacy Practices.

I give permission for Florida Eye Microsurgical Institute to discuss/release protected health information with the above approved contacts. Changes may be made to this list at any time in person or in a written document.

Signature: ______________________________ Signature Date: ______________

Parent/Guardian Signature: ______________________________ Signature Date: ______________

FLORIDA EYE MICROSURGICAL INSTITUTE 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.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of Florida Eye Microsurgical Institute to protect the privacy of your medical information.

We use the term "medical information" in this notice to mean your protected health information, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care series and other information related to your health care that we maintain about you.

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact us at 561-737-5500. We are required by law to:

*Maintain the confidentiality of your medical information in accordance with applicable federal and/or state law;

*Comply with the terms of this notice until it is replaced with a new notice; and

*Give you this notice of our legal duties and privacy practices with respect to medical information we maintain about you.

We reserve the right to change the terms of this notice at any time. We also reserve the right to make the changes apply to your medical information we already have. Before we make a material change to this notice, we will promptly post a new notice in a clear and prominent area at each of our facilities and on our website. You can also request a copy of the new notice from any of our registration staff at each facility or via our website www.fleyedocs.com.

How May We Use or Disclose Your Medical Information?
We may use and disclose your medical information without your authorization for treatment, payment, and health care operations as explained below:

For Treatment: We may use and disclose your medical information to the physicians, nurses, and other health care personnel located at each of our facilities who provide, coordinate or manage your health care and any related services. For example, our doctors and nurses may use and disclose your medical information with each other to provide treatment to you. We may also disclose your medical information to another health care provider who is not located at one of our facilities, at his request, for your treatment by him. For example, your medical information may be provided to a doctor to whom you have been referred so that he may diagnose or treat you.

For Payment: We may use and disclose your medical information in order to bill and collect payment for the treatment and services provided to you. For instance, we may provide portions of your medical information to your health insurance plan to get paid for the health care services we provided to you. We may also disclose your medical information to your health insurance plan to permit it to make a determination of eligibility or coverage for insurance benefits, to review the services we provided to you for medical necessity, and to perform utilization review activities. We may also disclose medical information about you to the responsible party of your account. If you are listed as a dependent on another person's insurance policy, financial information regarding medical care provided may be mailed to that responsible party. In addition, if you do not timely pay us for the health care services we provided to you, we may also disclose limited medical information to a collection agency. We may also disclose your medical information to other health care providers, health plans or health care clearinghouses for their payment activities. For example, we may provide your medical information to an ambulance/transportation company that provided services to you.

For Health Care Operations: We may use and disclose your medical information in order to support our business activities, such as quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for our other business activities. For example, we may use your medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose your medical information to medical school students who see patients at our facilities. In addition, we may use and disclose your medical information to other health care providers, health plans or health care clearinghouses for their limited health care operations, such as quality assessment activities, licensing and other health care compliance activities.

Business Associates: We may disclose your medical information to our business associates that assist us in our delivery of health care and related services, such as billing companies, lawyers, accountants and others. Before we disclose your medical information to our business associates, we will have a written contract with each of them that will require each of them to agree to maintain the privacy of your medical information.

Below are other reasons we may use and disclose your medical information without your consent or authorization:

Uses and Disclosures Required by Law: We may use or disclose your medical information as required by law, but must limit such use or disclosure to relevant information and otherwise comply with applicable legal requirements. We must also disclose your medical information to the Secretary of Health and Human Services to determine our compliance with federal privacy laws.

Public Health Activities: We may use or disclose your medical information to public health authorities authorized to receive or collect information for public health purposes, such as for preventing or controlling disease and certain regulatory activities of the Food and Drug Administration.

Abuse, Neglect, or Domestic Violence: We may use or disclose your medical information in some instances if we reasonably believe that you are a victim of abuse, neglect, or domestic violence.

Health Oversight Activities: We may use or disclose your medical information to a health oversight agency for health oversight activities authorized by law, including, for example, inspections and licensure of health care facilities.

Judicial and Administrative Proceedings: We may use or disclose your medical information under certain conditions to comply with legal proceedings, such as a subpoena or order by a court or administrative tribunal.

Law Enforcement Purposes: We may use or disclose your medical information for law enforcement purposes to law enforcement officials, such as for identification of suspects or where a crime has been committed on our premises.

Decedents: We may use or disclose medical information about decedents to coroners, medical examiners, and funeral directors.

Organ, Eye, Tissue Donation: We may use or disclose your medical information to notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.

Research: In limited circumstances, we may use and disclose your medical information to conduct medical research.

Serious Safety Threat: We may use or disclose your medical information where we believe it is necessary to prevent or lessen a serious threat to the safety of a person or the public.

Special Government Functions: We may use or disclose your health information under some circumstances for specialized government functions, including those related to the armed forces, national security, and intelligence.

Workers' Compensation: We may use or disclose your medical information as authorized by and to the extent necessary to comply with laws related to workers' compensation and similar programs.

Scheduling Appointments, Appointment Reminders and Health Related Benefits or Services: We may use and disclose your medical information to schedule appointments, give you appointment reminders, and give you information about treatment alternatives or other health care related services or benefits we offer.

Fundraising: We may use and disclose your demographic information and the dates that you received treatment, as necessary, to contact you for fundraising activities supported by us.

To Your Personal Representatives: We may disclose your medical information to your personal representatives that are appointed by you or authorized by applicable law.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. We may release such information for purposes that include (1) providing you with health care; (2) protecting your health and safety or the health and safety of others; or (3) protecting the safety and security of the correctional institution.

Potential Impact of State Law: In some situations, the federal privacy laws do not preempt (or take precedence over) state privacy laws that give you greater privacy protections. As a result, the privacy laws of a particular state might impose a privacy standard under which we will be required to operate. For example, Florida law may provide greater privacy protections to medical information related to artificial insemination records, sexually-transmitted diseases, and certain mental health records.

Uses and Disclosures for which You Have An Opportunity to Agree or Object:

Facilities/Patient Directories: We may include your name, location in our facility, general condition, and religious affiliation in our patient directory at your location for use by clergy and visitors who ask for you by name Unless you object in whole or in part. The opportunity for you to agree or object may be given retroactively in emergency situations.

Individuals Involved in Your Care: We may disclose your medical information to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity for you to agree or object may be given retroactively in emergency situations.

Your Authorization Is Needed for Other Uses and Disclosures: We will not use or disclose your medical information for any other purpose unless you give us written authorization to do so. If you give us written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information that we maintain, unless we have taken action in reliance on your authorization.

What Rights Do You Have Regarding Your Medical Information?

The Right to Request Additional Restrictions on Uses and Disclosures of Your medical Information. You have the right to ask what we put additional restrictions on how we use and disclose your medical information. We do not have to agree to your request.

The Right to Inspect and Copy Your Medical Information. You have the right to inspect and copy your medical information that we may use to make decisions about you. In limited circumstances, we do not have to agree to your request.

The Right to Amend or Correct. If you feel that your medical information is incorrect or incomplete, you have the right to ask us to correct or amend the information. We will require that you submit the request in writing and explain your reasons for asking for an amendment. In some cases, we do not have to agree to your request.

The Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters by a different means or at a different location than what we are currently doing. In limited circumstances, we do not have to agree to your request.

Paper Copy of this Notice. You have the right to request and receive a paper copy of this notice if you received it by email or on the Internet.

The Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures that we and our business associates made for certain purposes for the last six (6) years (except for disclosures made before April 14, 2003). If you want to exercise any of these rights described in this notice, please contact our Contact Office (below). We will give you the necessary information and forms for you to complete and return to us. In some cases, we may charge you a nominal fee to carry out your request.

How to Complain About Our Privacy Practices: If you think we may have violated your privacy rights, you may file a complaint with our Contact Office (below). You also may send a written complaint to the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices.

Our Contact Office: To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact us at the following Contact Office: (561) 737-5500.