FLORIDA WELLNESS MEDICAL GROUP

101 N. Franklin St., Suite A ◆ Tampa, FL 33602
3424 W. Kennedy Blvd. ◆ Tampa, FL 33609
4104 W. Linebaugh Ave. ◆ Tampa, FL 33624
1820 Wellness Ln., Bldg. 4 ◆ Trinity, FL 34655
6751 Gall Blvd. ◆ Zephyrhills, FL 33542

Phone: 813.229.2225 ◆ 727.264.8888
Fax: 813.221.2225 ◆ 727.264.8817
Website: www.floridawell.com

NEW MVA / WC / ACCIDENT PATIENT REGISTRATION

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

SSN: _____ **Primary Doctor & Contact #:** _____

Current occupation: _____ **Email**: _____

Home phone: _____ Can we leave messages for you? (circle one) **Y N**

Work phone: _____ Can we leave messages for you? (circle one) **Y N**

Cell phone: _____ Can we leave messages for you? (circle one) **Y N**

Emergency Contact Name: _____ **Relationship to Patient**: _____

Emergency Contact Phone #(s): _____

We send out monthly newsletters containing useful information for our patients. Topics often include things you can do in your daily life to improve your personal wellness.

Would you like to receive our monthly email newsletter? (circle one) **Y N**

Are you the *subscriber* or *dependent* of your insurance policy? (check one) ❑ **Subscriber** ❑ **Dependent**

If you are a dependent, who is the subscriber? Name: _____ Date of Birth: _____

If you were in an accident please fill out the below sections:

What type of accident? (check one) ❑ **Motor Vehicle** ❑ **Workers' Comp** ❑ **Other:** _____

What was the date of your accident? _____ Do you have an attorney? (circle one) **Y N**

If YES, who is your attorney? _____ Firm:_____

Attorney's Phone:_____

YOUR insurance **company name**: _____

Accident **claim #**: _____

Adjuster name: _____

Adjuster contact info: _____

(FOR ADMINISTRATIVE USE ONLY:) **** VITALS ****
Height:_____ Weight:_____
Temp:_____ Pulse:_____
R Rate:_____ O_2:_____
BP:____/_____

INFORMED CONSENT

In consideration of the undertaking of treatment, I agree to the following:

1. **Personal Responsibility for Charges:** I understand that I am personally responsible for charges and/or balances not covered by insurance payments or settlements.

2. **Senior Adults:** Chiropractic care is covered under Medicare. It will reimburse for spinal manipulations. However, many ancillary services (e.g. therapies or x-rays) are not covered unless ordered by a primary care physician. If you would like these services, you must first been seen by a primary care physician and they must be ordered by that physician. If not, you will be responsible for a reasonable charge for these services.

3. **Release of Information:** I authorize Florida Wellness Medical Group ("FWMG") to discuss and release my office notes, x-rays, and other medical records to insurance companies, adjusters, other medical professionals involved in my care, attorneys I have named as being involved in my case, and those named here:

   _____

4. **Access to Protected Health Information:** I understand that I have a right to access my medical information and obtain copies of medical records for a reasonable fee in accordance with Florida law.

5. **Consent for Treatment:** I am seeking medical treatment from FWMG, and I voluntarily consent to receiving health care services for my minor child or myself provided by my doctor(s) or a designee. I understand such services may include and are not limited to: diagnostic tests, examinations, drugs, and medical or surgical treatments considered necessary to treat my health issue. I also understand that I may be released before all my medical problems are known or treated and it is my responsibility to make arrangements for follow-up care.

6. **Chance of Injury and Other Risks:** I understand that there is some risk with any procedure, medical, acupuncture, or chiropractic. I understand that, despite my efforts and the efforts of the health care providers at FWMG, my condition may not improve and, in some cases, may even get worse. Although there is some chance of soreness or stiffness after an initial chiropractic adjustment, or adverse reaction to an injection or administration of certain medications, the chance of serious injury is very small. However, in very rare cases, I understand that a person can experience vascular, musculoskeletal, or other types of injury as a result of medical treatment administered by a licensed professional, including injury to a disc, ribs or spine.

7. **ATTENTION FEMALE PATIENTS**: In the event that x-rays are needed, please advise the doctor at this time if you are or have reason to believe you may be pregnant.

8. **Cancellation / Change Policy:** To maintain office operations integrity and efficiency, all cancellations or changes to appointments made within 24-hours of the scheduled time are subject to a **$30 fee**.

PATIENT INITIALS: _____

ASSIGNMENT OF BENEFITS

PRIMARY Insurer: _____	**SECONDARY Insurer: _____**
Policy #: _____	**Policy #: _____**

I authorize the aforementioned insurer(s) to make medical benefit payments otherwise payable to me for services rendered by FLORIDA WELLNESS AND REHAB, PA d/b/a FLORIDA WELLNESS MEDICAL GROUP ("FWMG") but not to exceed the charges of those services, payable to and mailed directly to:

Florida Wellness & Rehab, P.A.
d/b/a Florida Wellness Medical Group
4104 West Linebaugh Ave.
Tampa, FL 33624

I hereby instruct the insurance carrier that in the event that the subject medical benefits are disputed and/or reduced for any reason, including medical reasonableness and/or necessity, that the amount of the unpaid benefits claimed by FWMG is to be set aside and not disbursed until the dispute is solved.

Furthermore, I hereby irrevocably assign to FWMG the right and benefits and any and all causes of action resulting from any reduction and/or nonpayment under any policy of insurance, indemnity agreement or any other collateral source as defined by Florida Statutes for any service and/or charges provided by FWMG.

TECHNOLOGY DISCLAIMER

At Florida Wellness Medical Group, we pride ourselves on maintaining evidence-based practices. We are constantly furthering our education to bring you the latest advances in healthcare technology.

These advances include in-house digital x-ray, diagnostic ultrasound, electrocardiograms, electrodiagnostic equipment for monitoring nerve damage, centrifuges and other equipment to process labs in-house, and allergy testing equipment, to name a few.

We have made substantial investment in software as well, including an electronic health records system with a patient portal so you may log in and view medical records at any time. We installed various radiology software programs which allow us to immediately access and analyze many of your digital x-rays, MRIs, and other images, greatly increasing our level of patient convenience and customized care.

We are proud to have invested in these technological advances and are sure our equipment is unrivaled outside of a hospital setting. We use research-based practice methods for all of our services to ensure the highest level of quality, patient-focused care.

While most of these services are covered by most medical insurance plans, sometimes these services may fall to patient responsibility. *If you have concerns due to deductibles, health savings accounts (HSAs) or health reimbursement accounts (HRAs), we encourage you to discuss these concerns with your health care provider.*

PATIENT INITIALS: _____

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Section 381.026, Florida Statutes, addresses the Patient's Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and well being of patients and to promote better communication between the patient and the health care provider. 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. A summary of your rights and responsibilities follows:

A patient has the right to:

- Be treated with courtesy and respect, with appreciation of his/her dignity and protection of privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare. .
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
- Express complaints regarding any violation of his or her rights.

A patient is responsible for:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His/her actions if he/she refuses treatment or does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

You may request a copy of the full text of this law from your health care provider or health care facility. It is also available online at: http://www.floridahealthfinder.gov/reports-guides/patient-bill-rights.aspx

PATIENT INITIALS: _____

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Patient Name (please print) Patient DATE OF BIRTH

_____ _____
Patient or Authorized Representative's PRINTED name Relationship to Patient

_____ _____
Signature Date Signed

FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____(name) _____(relationship)

_____(name) _____(relationship)

_____(name) _____(relationship)

PATIENT INITIALS: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Prior Practice Name and Location: _____

I authorize my health information to be disclosed to and used by **Florida Wellness Medical Group.**

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I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditions on signing this authorization.

This authorization will expire without my express revocation, 180 days from the date hereof, unless otherwise specified. If I am a minor, on the date I become and adult according to state law. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on actions taken prior to receiving the revocation. A copy of this authorization or my signature thereon, may be utilized with the same effectiveness as an original.

The medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history. The type and amount of information to be disclosed is as follows (as applicable):

- ❑ Last TWO progress notes
- ❑ Complete vaccination record
- ❑ All laboratory results
- ❑ Latest colonoscopy and EGD with reports
- ❑ Most recent EKG
- ❑ Most recent stress test
- ❑ Last complete physical
- ❑ Complete listing of current medications.
- ❑ Any abnormal EKGs, stress tests, or other abnormal test results.
- ❑ **For women:** Include most recent pap smears, mammograms, breast ultrasound, breast MRI, and breast biopsy with diagnosis (if done).

I do hereby consent and acknowledge my agreement to the terms set forth in the INFORMED CONSENT, ASSIGNMENT OF BENEFITS, TECHNOLOGY DISCLAIMER, PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES, NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT, AUTHORIZATION TO DISCLOSE HEALTH INFORMATION, and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

TYPE / PRINT Patient's Name Patient's Date of Birth

_____ _____ _____

Signature of Patient / Authorized Personal Representative Relationship to Patient Date Signed

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

LETTER OF PROTECTION

THIS AGREEMENT is entered into and made effective as of the ___ day of _____, 201__ by and between FLORIDA WELLNESS AND REHAB PA, d/b/a FLORIDA WELLNESS MEDICAL GROUP ("Group") and _____ ("Patient").

Patient agrees to be personally liable and pay reasonable and customary fees for services rendered by Group regarding the incident that occurred on _____. Patient permits Group to bill his/her Personal Injury Protection ("PIP") policy for all medical related services.

If in such event that PIP insurance benefits are not sufficient to pay for the services Patient receives from Group, and a favorable trial verdict or settlement is reached, Patient instructs his/her representing Attorney to submit payment for any outstanding balance to the extent that adequate net proceeds are available to pay such fees, pursuant to *Florida Bar Rule 5-1.1 Trust Accounts Sections*:

(e) Notice of Receipt of Trust Funds; Delivery; Accounting; *Upon receiving funds or other property in which a client or third person has an interest, a lawyer shall promptly notify the client or third person. Except as stated in this rule or otherwise permitted by law or by agreement with the client, a lawyer shall promptly deliver to the client or third person any funds or other property that the client or third person is entitled to receive and, upon request by the client or third person, shall promptly render a full accounting regarding such property.*

(f) Disputed Ownership of Trust Funds. *When in the course of representation a lawyer is in possession of property in which 2 or more persons (1 of whom may be the lawyer) claim interests, the property shall be treated by the lawyer as trust property, but the portion belonging to the lawyer or law firm shall be withdrawn within a reasonable time after it becomes due unless the right of the lawyer or law firm to receive it is disputed, in which event the portion in dispute shall be kept separate by the lawyer until the dispute is resolved. The lawyer shall promptly distribute all portions of the property as to which the interests are not in dispute.*

In the event of a settlement offer from Patient or Attorney, Group agrees to reply with acceptance or refusal of the offer in writing within ten (10) business days from the date Patient or Attorney sends the settlement offer via postal mail or facsimile to correct address or facsimile phone number.

Patient agrees that, in the event he/she changes counsel, he/she will notify Group within 48 hours and that this agreement will remain effective between Group and Patient, regardless of who Patient selects for his/her counsel.

Please refer to the case of *The Florida Bar v. Eric Andres Pintaluga, Case No. SC13-1021* in regards to attorney and patient responsibilities. Patient understands it is his/her duty to inform Attorney of this contract with Group.

INTENDING TO BE LEGALLY BOUND, the parties hereto have executed this Agreement as of the date first above-written.

GROUP	**PATIENT**
_____	_____
Signature	Signature
_____	_____
PRINTED Name	PRINTED Name
_____	_____
Title	Title ("SELF" or "Authorized Representative")
_____	_____
Date	Date

I, _____, am knowingly refusing to sign the Letter of Protection agreement above. By refusing to sign the agreement, I agree to be personally liable and pay reasonable and customary fees for services rendered by Florida Wellness and Rehab PA ("Group") regarding the incident that occurred on _____. I also agree to pay for any services rendered by Group at the time of service.

SIGNATURE: _____ DATE: _____ Relationship to Patient: _____

TERMS AND CONDITIONS FOR USING THE PATIENT PORTAL:

Welcome to the MediTouch patient portal ("MediTouch Portal"). The MediTouch Portal is a web-based portal that allows patients securely store their personal health care information and communicate and interact with their medical provider. The MediTouch Portal and related services are provided by HealthFusion, Inc. ("HealthFusion"). In order to use the MediTouch Portal, you must agree to our terms and conditions. By accepting our terms and conditions, you agree to our Terms of Use and to be legally bound by them. HealthFusion reserves the right to modify or change the Terms of Use at any time, which will be indicated by the date of the most recent change as set forth on the bottom of this document. You should, therefore, periodically visit YourHealthFile.com to review the current Terms of Use so you are aware of any such revisions to which you are bound. Your continued use of the MediTouch Portal indicates your acceptance of the modified Terms of Use.

Medical Disclaimer
Information provide by or on behalf HealthFusion via the MediTouch Portal is intended for general information purposes only, and you agree and acknowledge that HealthFusion is not providing the materials to you for the purposes of giving you medical advice. You should not rely on the materials in deciding on a treatment plan, drug usage, or any other medical advice regarding the materials. You should consult with a physician in connection with any and all treatment options that may be available to you.

The MediTouch Portal is not intended for urgent matters or for use in emergencies. Do not send communications through the MediTouch Portal that requires urgent attention. If you have an emergency, you should telephone your physician's office directly, go to the nearest emergency room, or call 911. Nothing contained in the MediTouch Portal is or should be considered, or used as a substitute for, individual medical advice, diagnosis or treatment. Medical providers represent and warrant that they are licensed pursuant to all applicable federal, state and local laws, ordinances, rules and regulations, and shall upon request provide proof of all licenses.

User Registration
As part of the registration process for an online subscription, you will be provided with a user I.D and a temporary password ("Access Codes"). You will be required to provide us with certain registration information, all of which must be accurate and updated. It shall be a breach of these Terms of Use to select or utilize a user name (i) of another person with intent to impersonate that person, (ii) in which another person has rights, if you do not have that person's authorization to use such name, or (iii) that HealthFusion in its sole discretion deems offensive.

You are solely responsible for maintaining the confidentiality of the Access Codes you use to access the MediTouch Portal, and agree that HealthFusion shall have no obligations with regard thereto. You will be required to enter a valid Access Code to access certain areas of the MediTouch Portal or to submit payment for services. It is your sole responsibility to monitor and control use of these Access Codes for all purposes. You accept all responsibility for the security of your Access Codes, and utilization of the MediTouch Portal via the Access Codes. You agree that you shall be solely liable for all authorized and unauthorized access using the Access Codes. Do not disclose your Access Codes to anyone not authorized to act on your behalf. HealthFusion is not be liable for any loss or damage arising from your failure to comply with this Section. Please notify insert e-mail of any potential unauthorized use(s) of your account, or breach of security.

Restrictions on Use
HealthFusion grants you a limited license to make personal use only of the MediTouch Portal and the associated services in accordance with these Terms of Use. This license expressly excludes, without limitation, any reproduction, duplication, sale, resale or other commercial use of the MediTouch Portal and the associated services, making any derivative of the MediTouch Portal or the associated services, the collection and use of user email addresses or other user information, including, without limitation, health information or any data extraction or data mining whatsoever.

Fees
Most services on the YourHealthFile patient portal are provided for free, any fees for using this portal will require your explicit consent.
HealthFusion charges fees for access to portions of the MediTouch Portal. You agree to pay the amounts set forth on the online subscription form ("Fees") for your subscription. You shall pay all Fees incurred through your account at the rates in effect for the billing period in which such Fees are incurred. You shall pay all applicable sales and use taxes, if applicable, relating to your use of the MediTouch Portal. ***If you decide to enroll in any subscription or membership,*** HealthFusion will automatically renew your subscription or membership at the end of each term and bill the then-current renewal fee to the credit card we have on file for your account. You may update the credit card on file by updating your account online.

In addition to the Fees, medical providers using the MediTouch Portal may charge you fees for certain services ("Medical Provider Fees"). ***The Medical Provider Fees, if any, are set by each medical provider and are applicable to such medical provider's patients***. If you select any services that have an associated Medical Provider Fee, you will be required to authorize the payment of such amounts, plus any applicable HealthFusion transaction fee as stated in the authorization. All payments shall be paid for at the time of request and shall be billed to the credit card on file. If you wish use a different credit card, you will have to update your user profile with such additional payment information. Medical provider hereby authorizes HealthFusion to collect such Medical Provider Fees on medical provider's behalf and to disperse such funds to medical provider on a monthly basis, less any costs and expenses, including an administrative fee. HealthFusion is not responsible for refunds or credits of Medical Provider Fees. Any such requests shall be between you and the applicable medical provider.

Ownership
The MediTouch Portal and the MediTouch Portal, including but not limited to its contents and design are the property of HealthFusion, its subsidiaries, affiliates, vendor and/or licensors. The MediTouch Portal is protected by United States and international copyright, trademark and patent laws. Any rights not expressly granted herein are reserved. The contents of the MediTouch Portal, including without limitation the text, images, audio, and video, and any materials accessed through or made available for use or download through the MediTouch Portal are copyrighted and may not be copied, distributed, modified, reproduced, published or used, in whole or in part, without the prior written consent of HealthFusion,

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For purposes of these Terms of Use, any use of these materials on any other Web site is prohibited. You do not acquire ownership rights to any content, document or other materials viewed through the MediTouch Portal. The posting of information or materials on the MediTouch Portal does not constitute a waiver of any right in such information and materials. All software used on the MediTouch Portal is the property of HealthFusion or its software suppliers and protected by United States and international copyright laws.

Personal Health Information
You may upload, store, access and grant your medical provider access to your personal health information, including copies of documents, records, images, and any other information submitted by you. You are responsible for uploading your personal health information. HealthFusion shall have no responsibility for the quality of X-rays or other personal medical images archived on the MediTouch Portal.

You hereby grant HealthFusion and its related parties the right to access, transmit, receive, monitor, retrieve, store, maintain, and use your personal health information and any other information you provide in connection with the establishment and maintenance of your account, to provide services and operate the MediTouch Portal, including but not limited to, converting documents received from you or on your behalf to an appropriate electronic format and maintaining your account.

Confidentiality
HealthFusion respects your privacy and seeks to maintain the confidentiality of your medical information and communications in accordance with HIPAA, State regulations and our Privacy Policy, which is incorporated herein by reference. By agreeing to the Terms of Use you indicate that you have read, understood and accept our Privacy Policy. Except as otherwise stated, HealthFusion does not own or make any claim to own any communications between you and the applicable medical provider. We will not disclose, transfer or cause to be disclosed or transferred to a third party any of your personal health information without your prior written consent or authorization, or as otherwise required by law.

Accuracy; Integrity of Information
Although HealthFusion attempts to ensure the integrity and accurateness of the MediTouch Portal, it makes no guarantees whatsoever as to the correctness or accuracy of the MediTouch Portal. It is possible that the MediTouch Portal could include typographical errors, inaccuracies or other errors, and that unauthorized additions, deletions and alterations could be made to the MediTouch Portal by third parties. In the event that an inaccuracy arises, please inform HealthFusion so that it can be corrected. Information contained on the MediTouch Portal may be changed or updated without notice.

Links; Third Party Sites
The MediTouch Portal may contain links or references to Web sites operated by other parties which might have information on health topics of interest to you. These links and references are provided for your general information and education only, and should NOT be relied upon for personal diagnosis or treatment. HealthFusion makes no representations whatsoever about any other Web site that you may access through MediTouch. When you access a non-HealthFusion site, please understand that it is independent from HealthFusion, and that HealthFusion has no control over the content on that Web site. In addition, a hyperlink to a non-HealthFusion Web site does not mean that HealthFusion endorses or accepts any responsibility for the content, or the use, of the linked site. It is up to you to take precautions to ensure that whatever you select for your use or download is free of such items as viruses, worms, Trojan horses, and other items of a destructive nature. If you decide to access any of the third party sites linked to the MediTouch Portal, you do this entirely at your own risk. HealthFusion has no control over the security or privacy practices of these external Web sites. Use of other sites is strictly at your own risk. You are responsible for viewing and abiding by the terms and conditions of use and the privacy statements of the other Web sites.

Advertising
The MediTouch Portal may contain advertisement and/or sponsorship. The advertisers and/or sponsors that provide these advertisements and sponsorship are solely responsible for insuring that the materials submitted for inclusion on the MediTouch Portal are accurate and comply with all applicable laws. HealthFusion is not responsible for the acts or omissions of any advertiser or sponsor.

Termination
HealthFusion reserves the right, in its sole discretion and without liability to you, to change, suspend, or terminate your access to all or part of the MediTouch Portal, or discontinue any aspect of the MediTouch Portal, with or without cause, and with or without notice. You may terminate your online subscription at any time by sending email to: insert e-mail. If HealthFusion terminates your use of the MediTouch Portal or your online subscription, you shall not be entitled to a refund of any Fees. HealthFusion will not store, maintain, deliver or provide access to your personal health information after the termination of your subscription. Your right to access your personal health information via the MediTouch Portal shall terminate upon your termination of or failure to renew your subscription to the MediTouch Portal.

Disclaimer of Warranties
HEALTHFUSION AND ITS RELATED ENTITIES MAKES, AND YOU SHALL RECEIVE, NO WARRANTIES, EXPRESS OR IMPLIED, INCLUDING ANY IMPLIED WARRANTY OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, NON-INFRINGEMENT OR TITLE. HEALTHFUSION AND ITS RELATED ENTITIES DO NOT WARRANT OR REPRESENT THAT MESSAGES SENT THOUGHT THE MEDITOUCH PORTAL WILL BE READ OR RESPONDED TO BY YOUR MEDICAL PROVIDER, OR IN A TIMELY MANNER. HEALTHFUSION AND ITS RELATED ENTITIES MAKES NO REPRESENTATION AS TO THE RELIABILITY, ACCURACY, TIMELINESS, COMPLETENESS OR SUITABILITY OF THE MEDITOUCH PORTAL OR ANY SERVICES MADE AVAILABLE THROUGH THE MEDITOUCH PORTAL.

CERTAIN STATE LAWS DO NOT ALLOW LIMITATIONS ON IMPLIED WARRANTIES. SOME OR ALL OF THE ABOVE DISCLAIMERS MAY NOT APPLY TO YOU, AND YOU MAY HAVE ADDITIONAL RIGHTS.

Limitation of Liability
HEALTHFUSION, ITS RELATED ENTITIES AND/OR LICENSORS AND OTHER THIRD PARTIES MENTIONED ON THE MEDITOUCH PORTAL ARE NEITHER RESPONSIBLE NOR LIABLE FOR ANY INJURIES (INCLUDING FOR WRONGFUL DEATH), DIRECT, INDIRECT, INCIDENTAL, CONSEQUENTIAL, SPECIAL, EXEMPLARY, PUNITIVE, OR OTHER DAMAGES WHATSOEVER (INCLUDING, WITHOUT LIMITATION, THOSE RESULTING FROM LOST PROFITS, LOST DATA, OR BUSINESS INTERRUPTION) ARISING OUT OF OR RELATING IN ANY WAY TO THE MEDITOUCH PORTAL, USE OF OR INABILITY TO USE THE MEDITOUCH PORTAL, MEDITOUCH-RELATED SERVICE, CONTENT OR INFORMATION CONTAINED WITHIN THE MEDITOUCH PORTAL, MEDICAL ADVICE, DIAGNOSIS, TREATMENT, THE PERFORMANCE OR POSSESSION OF THE MEDITOUCH PORTAL, ANY HYPERLINKED WEB SITE, ANY DEFECT IN THE MEDITOUCH PORTAL OR ITS CONTENTS, AND/OR ANY BREACH OF THESE TERMS OF USE. THIS LIMITATION APPLIES (A) WHETHER THE ALLEGED CLAIMS OR DAMAGES ARE BASED ON WARRANTY, CONTRACT, TORT, OR ANY OTHER LEGAL THEORY AND (B) REGARDLESS OF WHETHER OR NOT HEALTHFUSION HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

YOUR SOLE REMEDY FOR DISSATISFACTION WITH THE MEDITOUCH PORTAL, MEDITOUCH-RELATED SERVICES, AND/OR HYPERLINKED WEB SITES IS TO STOP USING THE MEDITOUCH PORTAL AND/OR THOSE SERVICES. CERTAIN STATE LAWS DO NOT ALLOW LIMITATIONS ON IMPLIED WARRANTIES. SOME OR ALL OF THE ABOVE DISCLAIMERS, EXCLUSIONS, OR LIMITATIONS MAY NOT APPLY TO YOU, AND YOU MIGHT HAVE ADDITIONAL RIGHTS. IF THE EXCLUSION OF WARRANTY OR LIMITATION OF LIABILITY IS HELD INAPPLICABLE OR UNENFORCEABLE FOR ANY REASON, THEN HEALTHFUSION, AND ITS SUBSIDIARIES, AFFILIATES, VENDORS AND/OR LICENSORS AND OTHER THIRD PARTIES MENTIONED ON THE MEDITOUCH PORTAL MAXIMUM LIABILITY FOR ANY TYPE OF DAMAGES SHALL NOT EXCEED THE AMOUNT OF ANY SUBSCRIPTION OR MEMBERSHIP FEE WHICH YOU MAY HAVE PAID FOR THE MEDITOUCH PORTAL.

Indemnity
You agree to indemnify and hold HealthFusion, its related entities, vendors, licensors and other partners harmless from any loss, liability, injury (including injuries resulting in death), claim, or demand, including reasonable attorneys' fees and costs, of any kind due to, arising out of, or relating to your use of the MediTouch Portal or its content, including also your use of the MediTouch Portal to provide a link to another site or to upload content or other information to the MediTouch Portal, or your breach of the Terms of Use.

Choice of Law; Venue
The MediTouch Portal is controlled by HealthFusion from its offices within the state of California, of the United States of America. It can be accessed from all fifty states, as well as from other countries around the world. Each of these places has laws that may differ from those of California. By accessing the MediTouch Portal, both you and HealthFusion agree that the statutes and laws of the state of California will apply to all matters related to these Terms of Use and the use of the MediTouch Portal, without regard to conflicts of laws or principles thereof. Each party also agrees and hereby submits to the exclusive personal jurisdiction and venue of the state and federal courts sitting in San Diego County, California, and waives any jurisdictional, venue or inconvenient form of objections to such courts. HealthFusion makes no representation that materials on the MediTouch Portal are appropriate or available for use in other locations. Those who choose to access the MediTouch Portal from other locations do so on their own initiative and are responsible for compliance with local laws. Any cause of action brought by you against us or our related entities must be instituted within one (1) year after the cause of action arises or be deemed forever waived and barred. You agree that monetary damages may not provide a sufficient remedy to HealthFusion for violations of these Terms of Use and you consent to injunctive or other equitable relief for such violations. HealthFusion may release user information about you if required by law or subpoena.

International Use
By choosing to access the MediTouch Portal from any location other than the United States, you accept full responsibility for compliance with all local laws that are applicable. HealthFusion makes no representation that materials on the MediTouch Portal are appropriate or available for use in locations outside the United States, and accessing them from territories where their contents are illegal is prohibited. You may not use, export or re-export any materials from the MediTouch Portal in violation of any applicable laws or regulations, including, but not limited to, any United States export laws and regulations.

Severability
In the event that any of the Terms of Use are held by a court or other tribunal of competent jurisdiction to be unenforceable, such provisions shall be limited or eliminated to the minimum extent necessary so that these Terms of Use shall otherwise remain in full force and effect.

Entire Agreement
These Terms of Use constitute the entire agreement between HealthFusion and you pertaining to the subject matter hereof. Certain provisions of these Terms of Use may be superseded by expressly designated legal notices or terms located on particular pages within the MediTouch Portal.

_____ _____

TYPE / PRINT your name **Your relationship to Patient**

_____ _____

Signature of Patient (or Authorized Personal Representative) **Date**

FLORIDA WELLNESS & REHAB, PA d/b/a FLORIDA WELLNESS MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

1. **Treatment** - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.
2. **Payment** - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
3. **Health Care Operations** - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

1. **De-identified Information** - Information that does not identify you and cannot be used to identify you.
2. **Business Associate** - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
3. **Personal Representative** - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
4. **Emergency Situations** –
    a. for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
    b. to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
5. **Communication Barriers** - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.
6. **Public Health Activities** - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.
7. **Abuse, Neglect or Domestic Violence** - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

8. **Health Oversight Activities** - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

9. **Judicial and Administrative Proceeding** - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

10. **Law Enforcement Purposes** - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

11. **Coroner or Medical Examiner** - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

12. **Organ, Eye or Tissue Donation** - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

13. **Research** - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

14. **Avert a Threat to Health or Safety** - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

15. **Workers' Compensation** - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

16. **Disclosure of Immunizations** - to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER
The Practice may, from time to time, 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. The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

DIRECTORY/SIGN-IN LOG
The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS
The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

1. If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

2. If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION
Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS
You have the right to:

1. Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

2. Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the

Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

3. Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
4. Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.
5. Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.
6. Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy).
7. Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.
8. Receive notice of any breach of confidentiality of your PHI by the Practice.
9. Prohibit report of any test, examination or treatment to anyone else for which you pay in cash or by credit card.
10. Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov or to the Florida Attorney General, Office of the Attorney General, PL-01 The Capitol, Tallahassee, FL 32399-1050, 850 414-3300 if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.
11. Request copies of your PHI in electronic format.

To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, **Michael Eby**, at **813.229.2225** or via email at **info@floridawell.com**.

PRACTICE'S REQUIREMENTS
The Practice:

1. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
2. Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes:
   Section 381.004 relating to HIV testing, Chapter 384 relating to sexually transmitted diseases and Section 456.057 relating to patient records ownership, control and disclosure.
3. Is required to abide by the terms of this Privacy Notice.
4. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
5. Will distribute any revised Privacy Notice to you prior to implementation.
6. Will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS
You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below whom is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer is **Michael Eby**.
You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE
This Notice is in effect as of **09/03/2013**.