FLORIDA WELLNESS MEDICAL GROUP

101 N. Franklin St., Suite A ◆ Tampa, FL 33602
4104 W. Linebaugh Ave. ◆ Tampa, FL 33624
1820 Wellness Ln., Bldg. 4 ◆ Trinity, FL 34655
6751 Gall Blvd., Unit 104 ◆ Zephyrhills, FL 33542
3945 58th St. N. ◆ St. Petersburg, FL 33709
Phone: 813.229.2225 ◆ 727.264.8888
Fax: 813.221.2225 ◆ 727.264.8817
Website: ◆ www.floridawell.com

NEW PATIENT REGISTRATION

Name: _____ **Date of Birth:** _____ **SSN:**_____-_____-_____

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

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

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

Employer/ Occupation: _____ **Email**: _____
Email is not HIPPA Compliant. Do you give consent to email you health records to your email address? (circle one) **Y N)**

Emergency Contact: _____ **Phone#**_____ **Relationship to Patient**:_____

Primary Doctor:_____ **Phone #:** _____

Insurance Carrier: _____ **Policy #** _____

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:_____

Optional:

How did you hear about our clinic? _____

Facebook/Instagram Web Search Saw an Ad _____ Sign Driving by Other: _____

Sex: Male Female Non Binary **Marital Status:** Single Married Widowed Divorced

Employment Status: Employed FT Student PT Student Unemployed Retired Other:_____

Race: American Indian/ Alaskan Native Asian Black/African Hispanic/Latino Middle Eastern/ North African White
Native Hawaiian/ Pacific Islander Unknown Decline to Answer

Ethnicity: Hispanic or Latino Non Hispanic or Latino Unknown Other: _____

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. **Patient Bill of Rights and Responsibilities:** I acknowledge that I was provided a copy of the Patients Bill of Rights and Responsibilities and that I have read them or declined the opportunity to read them and understand them.
3. **COVID-19:** I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive treatment from all the providers at this facility..
4. **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. **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. List below the names and relationship of people to whom you authorize the Practice to release PHI.

   _____(name) _____(relationship)

   _____(name) _____(relationship)
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. By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

   _____ ____/____/____ _____
   Patient or Authorized Person's Signature Date Witness Initials
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**.

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

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

ASSIGNMENT OF BENEFITS

PRIMARY Insurer: _____	**SEONDARY Insurer:_____**
Policy #:_____	**Policy #: _____**

I authorize the aforementioned insurer 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.

For Medicare Patients: Chiropractic care is covered under Medicare. It will reimburse for spinal manipulations. New patient exams are not covered by Medicare when billed by a chiropractor and must be paid at the time of service. 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 be seen by primary care physician and they must be ordered by that physician. If not, you will be responsible for a reasonable charge for these services.

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT SIGNATURE: _____ DATE: _____

New Patient Medical History Form

Patient Name:_____ DOB:_____ Date:_____

ALLERGIES:

Allergy:	Allergic Reaction:

MEDICATIONS:

Medication Name: (Please list all)	Dose: (mg, pill, ect.)	Times Per Day

HEALTH MAINTENANCE SCREENING TEST HISTORY:

	Date:	Facility/ Provider:	Results:
Cholesterol			Abnormal Result? Y N
Colonoscopy/Sigmoid			Abnormal Result? Y N
Mammogram			Abnormal Result? Y N
Pap Smear			Abnormal Result? Y N
Bone Density			Abnormal Result? Y N

VACCINATION HISTORY:

Last Tetanus Booster or Tdap:	Last Pneumovax (Pneumonia):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine (Shingles)	

PERSONAL MEDICAL HISTORY:

Disease/Condition			
Alcoholism/ Drug Abuse			
Asthma			
Cancer /Type:			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes/ Type:			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (Hypertension)			
High Cholesterol			
Hypothyroidism/ Thyroid Disease			
Renal (Kidney) Disease			
Migraine Headaches			
Stroke			
Other:			

SURGERIES:

Type: (Specify Left/Right)	Date:	Location/Facility

WOMENS HEALTH HISTORY:

Date of last menstrual Cycle:	Total number of Pregnancies:
Age of First Menstruation:	Number of Live Births:
Age of Menopause:	Pregnancy Complications:

FAMILY MEDICAL HISTORY:

Check All Apply	Alcohol/Drug Abuse	Asthma	Cancer/ Type	Emphysema/COPD	Depression	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Diesease	Stroke	Thyroid Disease	Migraines	Other:
Mother																
Father																
Brother																
Sister																
Mother's Mother																
Mother's Father																
Father's Mother																
Father's Father																
Other																

SOCIAL HISTORY:

Occupation(Prior):	**Circle one:** Retired Unemployed LOA Disabled
Employer:	Years of Education:
If Employed, do you work the night shift: Y N N/A	
Marital Status (Check One): Single Partner Married Divorced Widowed Other:	
Do you have children? Y N	How many?

OTHER HEALTH HISTORY

Tobacco Use: Smoke Cigarettes: Y N (If you never smoked, Please move to Alcohol/Drug Use) **Current**: Packs a day: ____ For # of years:____ **Past:** Quit date:_____ Packs a day:___ # of Years _____
Alcohol/ Drug Use: Do you drink Alcohol? Y N Beer Wine Liquor # of Drinks a week:_____ Do you use Marijuana or recreation drugs? Y N Have you ever used needles to inject drugs? Y N Have you ever taken someone else's drugs? Y N
Sexual Activity: Sexually involved currently? Y N If no sexual history, pelase continue to exercise)

Sexual partner(s) is/ are/ have been: Male Female Birth control method: None Condom Pill/Ring/Inj/IUD Vasectomy
Exercise: Do you Exercise regularly? Y N (If you answer No , please move to sleep) What kind of exercise? Duration: How long (min): _____ How often:_____
Sleep: How many hours, on the average do you sleep at night or day? _____
Diet: How would you rate your diet? Good Fair Poor Would you like to advance you diet? Y N
Safety: Do you use a bike helmet? Y N Do you use seat belts consistently? Y N Working smoke detector in home? Y N If you have guns at home, are they locked up? Y N Is violence at home a concern for you? Y N Have you completed an Advanced Directive for Health Care (ADHC), Living Will, or physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/ SPECIALISTS:

Specialist	Name	Last Visit
Cardiology		
Gastroenterologist		
OB/GYN		
Neurology		
Pulmonary		
Other:		
Other:		

ADDITIONAL INFORMATION:

Have you traveled outside the country in the last 30 days. Y N If yes, where?
Have you served in the military? Y N If yes, how long and what branch? _____ Were you deployed? Y N If yes, where? _____

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 AUTHORIZATION TO DISCLOSE HEALTH INFORMATION. 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

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

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, Yanira Unger, 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 **Yanira Unger.**
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**.