Patient Information

Date: _____Name: _____
Date of Birth:_____ Sex:_____Phone#:_____
Street Address: _____ City: _____Zip:_____
Social Security # _____Primary Language:_____
Ethnicity: Hispanic or Latino, Yes ___ No ___ Race: _____
●**Parent/Guardian Email Address**: _____

I, the parent/guardian of the above patient, give consent for Plant City Pediatrics to leave detailed phone messages and medical information regarding this child on if I am not available. _____Yes _____No

Father's or Guardian's Name: _____
Relationship if not father: _____ Date of Birth: _____
Street Address: _____ City: _____ Zip: _____
Social Security# _____ Employer: _____
Phone# _____ Work # _____

*Mother's or Guardian's Name:*_____
Relationship if not mother:_____Date of Birth: _____
Street Address:_____ City: _____Zip:_____
Social Security# _____ Employer: _____
Phone# _____ Work # _____

Primary Insurance: _____ Policy ID:_____
Policy Holder's Name: _____ DOB: _____

Secondary Insurance: _____ Policy ID:_____
Policy Holder's Name: _____ DOB: _____

Emergency contact not living with you: _____
Relationship: _____ Phone#: _____

Pharmacy Name: _____ Location: _____

●Will visits require special need services, such as services for the hearing impaired, during office visits?
_____If yes, please explain:_____

●**Person responsible for patient account:** _____

I, the parent/guardian of the above patient, give consent for the following individual(s) (18 years or older) to receive medical information, bring my child to their appointments, and make medical decisions at Plant City Pediatrics.

1)_____ Relationship to patient:_____
2)_____ Relationship to patient:_____
3)_____ Relationship to patient:_____

Parent/Guardian Signature*:* _____

Printed *Name:*_____

Plant City Pediatrics Practice Guidelines and Policies

Patient Name: _____ DOB: _____

Please read and initial each line:

_____**No-Shows**: We require 24 hour notice of cancellation as a courtesy to other patients seeking services. Continued NO-SHOW APPOINTMENTS WILL RESULT IN DISCHARGE FROM THE PRACTICE.

_____**Appointments**: Our office will schedule appointments as a courtesy for patients and in consideration of your time. We do not accept walk-in's. Minors must be accompanied by a parent or guardian. ***Only 2 adults may accompany the child during the exam.**

_____**Emergencies:** Our providers will make every effort to receive your calls and respond promptly to urgent issues. If you do not receive an immediate response, you will call 911, receive paramedic intervention, or seek the nearest emergency room. **The answering service will not** schedule or cancel appointments or refill medications. Please be available to answer your phone after paging a provider if you have an urgent need.

_____**Prescription Refills:** It is our office policy that you should be responsible to know when your medications must be refilled, at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy or by notifying our office 5 days in advance. We can not take weekend, walk-in or after hours refill request.

_____**E-Prescribing:** E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. By initialing, you are agreeing that Plant City Pediatrics can request, and use, your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment.

_____**Antibiotics and Phone Encounters:** Our providers do not treat new patients or illnesses over the telephone. Prescriptions are not called in after office hours. Antibiotics are not called in without an office visit to support the necessity.

_____**Vaccine Policy:** We require that all new patients follow the Advisory Committee on Immunization Practice (ACIP) Vaccine Schedule. This schedule will not be altered in any way.

_____**Information:** You agree to provide the correct name, correct address, cell or other phone number, email address, insurance information, Social Security number, driver's license or picture identification at the time of registration or as requested by the practice.

_____**Financial Responsibility:** By these initials and your signature below, you accept financial responsibility for all charges for services rendered. If a minor, or under guardianship, the parent or guardian accompanying the patient assumes this responsibility.

_____**Payment Methods:** We accept cash, check, and major credit cards.

_____**Well-Visits:** Are required at 1 week of age, 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, and annually after 3 years of age. Non-compliance with well visits will result in discharge from the practice.

_____**Form Fees:** Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice: $25 fee for forms and letters (FMLA, letters, disability forms, etc.).

_____**Physical and Vaccine Forms:** Our office will provide Physical and Vaccine Forms, as requested at well visits, free of charge. If forms are requested at another time, there is a $5.00 fee.

_____**Medical Records:** The medical chart is **the property of the practice.** However, copies of your pertinent medical information are available upon request. The practice charges a fee for a copy of the record according to those published annually by the State of Florida Comptroller's Office. This fee is available upon request. Records to other providers are provided free of charge.

_____**Insurance Copayments, Deductibles and Coinsurance:** Payment is expected at time of service. Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All co-payments, deductibles and coinsurance are to be paid at the time of service.

_____**Statement Policy:** Patient statements are sent each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company we are required to bill them for services rendered. The sending of a statement may be delayed until your insurance responds to a claim. You understand that such a delay does not alter our policy or patient financial responsibility and you will be liable for all service fees.

_____**Collection and Bank Fees:** Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense. The banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees.

_____**Notice of "Non-Covered Servies"** I am aware that some services performed by Plant City Pediatrics may be 'non-covered' by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

_____**Cell Phones: We require that cell phones be silenced when you enter the office area** and when your child is being examined. If the parent/guardian is on the phone, the provider will return when you are able to give them your attention during your child's visit.

_____**ADHD Patients:** We will refill ADHD medications after an initial visit by Neurology. Patients must be rechecked 1 month after a medication change and every 3 months to continue receiving refills. **We do not write prescriptions for psychiatric medications/antidepressants.**

_____**Patient Discharge:** The practice reserves the right to discharge a patient for any reason. Because of quality care considerations, the practice may discharge you for failure to comply with treatment plans. In addition, **we will discharge patients due to continued no-show appointments, disorderly conduct in the office, on the phone and with our staff.**

_____**Visit Charges: You may be seen for both a well visit and a problem/sick visit on the same day because you satisfy the requirements for both types of visits during one appointment. PLEASE BE ADVISED that your insurance company may apply some charges to patient responsibility. If you prefer to return for the problem/sick visit on another day please advise the provider.**

____**Permission for Treatment:** Permission is hereby granted for physicians, employees, or agents of Plant City pediatrics to render such medical and surgical treatment as deemed necessary.

_____**Telemedicine**: We have decided, as a group, not to participate in this type of patient healthcare. As a Primary Care Physician we are responsible for the management of our patient's healthcare. We understand that telemedicine may provide immediate service, but we question the accuracy of the diagnosis and treatment provided without examination. As the parent, you have the right to utilize telemedicine if your insurance company provides this service. However, we strongly encourage you to follow-up in our office within 1-2 days.

Parent/Guardian Name/Printed:_____

Parent/Guardian Signature:_____**Date:**_____

PLANT CITY PEDIATRICS
VACCINE POLICY SATEMENT

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives and we have complete confidence in the safety of vaccines. **We believe that all children, and young adults, should receive the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.**

We are confident that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers. The childhood immunization schedule is the result of years of scientific study and data by thousands of the brightest scientists and physicians.

We recognize that there has been controversy surrounding vaccination. In many ways, the vaccine campaign is a victim of its own success. It is because vaccines are so effective at preventing illness that some question whether they should still be given. Because of vaccines, many have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox. Such success can make us complacent about vaccinating, but such an attitude can lead to tragic results. Over the past several years, many people in Europe have chosen not to vaccinate their children with the MMR vaccine after a publication of an unfounded suspicion (later retracted) that the vaccine caused Autism. As a result of under immunization, there have been outbreaks of vaccine preventable illnesses such as measles and pertussis in the United States.

We are making you aware of these facts not to scare or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do our best to inform you of the benefits of vaccinating your child. Delaying, or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations and can put your child at risk for serious illness (or even death) from preventable illnesses. Therefore, Plant City Pediatrics does not alter the schedule.

If you should decide that you do not want to vaccinate your child, we respect your decision but will ask that you find another health care provider who shares your views.

Thank you for your time in reading this policy.

I, the parent/guardian, understand the policy and understand that if I choose not to follow the recommended schedule, my child/children will be discharged from Plant City Pediatrics.

Date: _____

Parent/Guardian: _____ Relationship: _____
Patient Name: _____ Date of Birth: _____

Pediatric Medical History Form

Your answers on this form will help your provider understand your child's medical history.

Date: _____

Child's Name: _____ Date of Birth: _____

Person Completing Form/Relationship _____

Medications:

Medication Dose How many times daily

_____

_____

_____

Allergies: □ Yes □ No

If yes, to what? _____

Immunization History:

To the best of my knowledge, my child is up to date on his/her immunizations □ Yes □ No

If no, why?_____

Birth History:

Please indicate any medical problems during pregnancy _____

Please list any medications taken during pregnancy _____

Any drug or alcohol use during the pregnancy □ No □ Yes _____

Delivered by □ Elective C-Section □ Emergent C-Section □ Forceps □Vacuum extraction
□ Normal Vaginal Delivery

Number weeks of gestation _____ Birth Weight _____ Discharge Weight _____

Did the baby receive the Hepatitis B Vaccine □ Yes □ No If yes, date given _____

Did the baby receive the Vitamin K shot □ Yes □ No If yes, date given _____

Please indicate any medical problems during the newborn period _____

Name of hospital or place where child was born _____

Newborn Hearing Screening Passed □ Yes □ No If yes, date passed _____

Personal Medical History:

Please check if your child has had an of the following medical problems:

□ ADD/ADHD	□ Chicken Pox	□ Headaches	□ Liver disease/Hepatitis
□ Allergies	□ Concussion	□ Hearing Problems	□ Recurrent ear infection
□ Anemia	□ Diabetes	□ Heart Problems	□ Seizures
□ Asthma	□ Eczema	□ Congenital heart disease	□ Urinary tract infections
□ Bleeding disorder	□ Fracture	□ High blood pressure	□ Vesicoureteral reflux
□ Bronchiolitis	□ Handicaps/Disabilities	□ Kidney disease	□ Vision problems

Hospitalizations:

Has your child ever stayed overnight night in a hospital? □ No □ Yes

If yes, when and why? _____

Surgical History:

Please indicate any surgeries or procedures your child has had. Please include the year and surgery/procedure was performed. _____

_____

Patient GYN History if applicable:

Age of first period _____ years First day of last period _____Has not had menses yet _____

Family History:

Please indicate if your child has a family history (***parents, siblings, grandparents, to the child)*** of any of the following:

Diagnosis	Family Member	Diagnosis	Family Member
□ ADD/ADHD	_____	□ Hearing disability	_____
□ Alcohol/Drug use	_____	□ High cholesterol	_____
□ Allergies	_____	□ High blood pressure	_____
□ Birth defects	_____	□ HIV/AIDS	_____
□ Blood disorders	_____	□ Learning disability	_____
□ Cancer, type	_____	□ Mental illness	_____
□ Heart disease (heart attack, bypass, stents)	_____	□ Migraines	_____
□ Deafness/Hearing problem	_____	□ Scoliosis	_____
□ Depression	_____	□ Seizure disorder	_____
□ Developmental delay	_____	□ Speech problems	_____
□ Diabetes	_____	□ TB/Lung disease	_____
□ Genetic disorder	_____	□ Stroke	_____
□ Hepatitis/Liver disease	_____	□ Thyroid disease	_____
		□ Other	_____

Social History:

Who lives at home?

Name	Relationship	DOB

Is the child cared for by any one other than the parents? □ No □ Yes

If yes, by whom and how frequently? _____

Does anyone in your home smoke? □ No □ Yes

_____

Provider Signature: _____

Plant City Pediatrics
2370 Walden Woods Drive Suite A
Plant City, Florida 33563
Phone: 813-659-9800 Fax: 813-659-9807

Medical Record Request

Patient Name: DOB: Social Security Number:

Address: Telephone Number:
(____)

I hereby authorize: _____

To release information from the medical record of the above mentioned patient.
To:_____

For the following purpose or treatment: _____

If more than 20 pages, please <u>MAIL</u> records!

Type of Access Requested: _____ Copies of Record _____Inspection of Record

This authorization expires 90 days from the date signed below and covers only treatment for the dates or diagnosis specified above.

_____H&P ___Immunization Record ____Other
____Progress notes ___Consultation Reports ____Current Information
_____Labs ___**All Records, Changing Primary Physician**

I acknowledge, and hereby consent to such, that the release of information may contain Alcohol, drug abuse, psychiatric, HIV testing, HIV results, and AIDS information.
Initials_____

_____I, the undersigned, have read the above and authorized the staff of Plant City Pediatrics to disclose such information as herin contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information". Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the authorization except if the authorization is for (1) conducting research-related treatment, (2) obtaining information in connection with the eligibility for enrollment in a health plan, (3) determining an entity's obligation to pay a claim, or (4) creating health information to provide to a third party.

Date: _____Printed Name:_____

Parent or Guardian's Signature:_____

Witness Signature: _____

FOR OFFICE USE ONLY:
Date Received:_____Processed By:_____

Date:_____ Patient Name: _____
Date of Birth:_____ Age:_____

Lead Poisoning Risk Assessment

Does your child live in or regularly visit (once a week or more) any house built before 1978?	Y N U
Does your child live or regularly visit any house or building that has vinyl mini-blinds, lead pipes, pipes with lead solder joints, or had metal pipes replaced or repaired within the last 5 years?	Y N U
Does your child have a mother, sibling or play mate, who has, or did have, lead poisoning?	Y N U
Does your child frequently come into contact with an adult whose job or hobby involves exposure to lead? Some examples are employment in building renovation, an auto battery factory, auto or radiator repair shop, highway bridge sandblasting or painting, welding metal structures, wire cable cutting or hobbies such as refinishing furniture, casting bullets, making stained glass, toy soldiers, dive weights or fishing weights?	Y N U
Does your child eat food that has been stored in metal cans, from leaded crystal, ceramic or pewter dishes, or have contact with cosmetics, candies, spices, and home or fold remedies not made or sold in the United States? Have you ever seen your child eat dirt?	Y N U
Does your child play in loose soil, near a busy road or near any industrial sites such as a battery recycling plant, junk yard or lead smelter?	Y N U
Has your child lived in a foster care home or in a country other than the U.S.?	Y N U

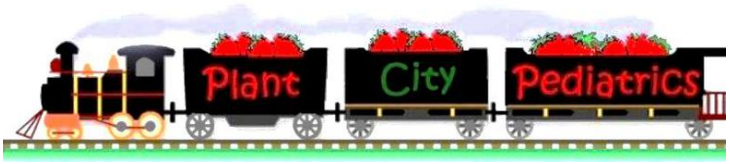
**Indicate response by circling "Y" for yes, "N" for no, or "U" for unknown. Sign name and relationship at the bottom of the page. A yes or unknown response to any question indicates the child is at risk for lead poisoning. The child should receive blood lead testing and appropriate follow-up. See Risk Assessment, Screening, and Follow-up of Children for Elevated Blood Lead Levels.

Tuberculosis Risk Assessment Questionnaire

Has your child had contact with a parent, relative or other caretaker with either active tuberculosis, abnormal chest x-ray suggestive of tuberculosis, or history of a positive PPD skin test?	Y N U
Are any parents, relatives or caretakers of your child from a region with high incidence of tuberculosis (i.e., Latin America, Asia, Africa and Eastern Europe)?	Y N U
Has your child been exposed to any adult who is HIV positive, homeless, a drug user, a migrant worker, indigent, resident from a nursing home, prisoner or other institution?	Y N U
Has your child ever been institutionalized? (i.e., imprisoned, detention home, foster care, mental hospital or orphanage).	Y N U
Does your child have cancer, diabetes, renal failure, malnutrition or an immunosuppressive condition?	Y N U

Parent/Guardian Signature:_____
Relationship to Patient:_____

Physician/Provider Signature:_____



NOTICE OF PRIVACY PRACTICES
For
PROTECTED HEALTH INFORMATION
(HIPAA)

2370 Walden Woods Dr., Suite A
Plant City, FL 33563

http://www.plantcitypediatrics.com/

Effective Date: March 23, 2013
Updated November 19, 2019

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

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your care is created. Typically, this record contains medical information such as your symptoms, examination, test results, diagnoses, treatment and/or treatment plan and billing-related information. This information is considered Protected Health Information (PHI).

This Notice is intended to advise you about the ways we may use and disclose medical information about you. It also describes your rights and certain obligations with regard to your medical information and applies to all of the records of your care generated by your healthcare provider(s) for our organization.

Our Responsibilities
Our Organization is required to maintain the privacy of your health information and to provide you with a description of our legal duties and Privacy Practices regarding your health information that we collect and maintain.
We are required by law to abide by the terms of this Notice and notify you if changes are made. We reserve the right to make changes to the Notice and make the new provisions effective for all protected health information we maintain. Copies of our Notice are available in our main reception area(s) and on our website.

How We May Use and Disclose Your Medical Information

Our practice may use a patient sign-in sheet that is visible to other patients; this is acceptable under the Privacy Rule.

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other healthcare professionals such as physicians, nurses, technicians, clinical laboratories, imaging centers, medical students, or other personnel who are involved in your care.

We may communicate your information using various methods, orally, written, facsimile and electronic communications. We may contact you to remind you of your appointment by telephone, reminder card, or email unless requested otherwise. Our office may contain open areas whereas conversations may be overheard, we will make every attempt to minimize the exposure of your PHI and if requested; we will relocate to a private room.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. Examples may include contacting your insurance company for referrals, verification, or pre-approval of covered services.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessments, employee review activities, licensing, legal advice, accounting support, information systems support, and conducting or arranging for other business activities such as lab or radiology interfaces within the EHR, and through a Health Information Exchange (HIE) program. We may use or disclose, as needed, your health information within a medical group to support your care.

We may also provide other healthcare professionals who contribute to your care with copies of various reports and information to assist him/her and ensure that they have appropriate information regarding your condition/treatment plan and diagnosis.

Business Associates, BA: Provide services for our organization through written contracts and/or service agreements. Examples of these services include billing, collection, and software support. We may disclose your health information to a BA so they can perform the services we have asked them to do such as billing your third-party payer for services rendered. The BA is also required by law to protect and safeguard your health information which is clearly defined through our Business Associate Agreement and written contracts/service agreements.

Breach Notification: In the event that there has been a breach of unsecured protected health information (PHI) identified on behalf of our organization or a BA you will be notified within 60 days of the breach unless our state law is more stringent, then we will abide by our state law. In addition to your individual notification we may be required to meet further reporting requirements set forth by state and federal agencies.

Uses and Disclosures That May Be Made *With* Your Consent, Authorization or Opportunity to Object: We will not use or disclose information without your written authorization, except as described in this Notice or as required by applicable laws. Written authorization is required for most uses and disclosures for medical research, the use of psychotherapy notes, and certain disclosures of sensitive health information. This may include the performance or results from a test or treatment of HIV, HIV related conditions, or drug/alcohol programs and treatment. If our practice participates in medical research and all patient identifiers have been removed we are not required under the Privacy Rule to obtain an authorization from you. If you do provide an authorization to use or disclose medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to retrieve any disclosures we have already made with your authorization.

Immunizations: The Privacy Rule permits the disclosure of immunization directly to a school that is required by law with the oral or written agreement of a parent or guardian.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate with you via newsletters, mailings or other means regarding treatment options and information on health-related benefits or services; to remind you that you have an appointment; or other community-based initiatives or activities to include limited marketing or fundraising initiatives in which our facility is participating. You have the right to opt out at any time if you are not interested in receiving these communications, please contact our Privacy Officer.
Fundraising initiatives; if applicable are limited and may require a separate authorization.

Uses and Disclosures That May Be Made *Without* Your Authorization or Opportunity to Object: We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability

If you are not present, able to agree or object to the use or disclosure (such as in an emergency situation or a communication barrier), then your healthcare provider may, using professional judgment will determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

State-Specific Requirements: Many states have reporting requirements which may include population-based activities relating to improving health or reducing health care costs, cancer registries, birth defect registries and others.

Your Health Information Rights
Although your health record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy: You and/or your personal representative have the right to inspect, review and receive a copy of your medical information. Electronic copies are available and may include various electronic means such as a patient portal or other reasonable accommodations requested. We may deny your request to inspect and copy in limited circumstances to include release of psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If you are denied access to medical information, you may request that the denial be reviewed.

Requests to copy and/or a review must be submitted in writing to our practice. There will be a fee charged for all applicable copying and producing a copy of portable media up to the maximum amount as prescribed by governing law.

Amend: If you feel that the medical information we have is incomplete or incorrect, you may ask us to amend the information by submitting a request in writing.
We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of your medical information; the list will not include disclosures to carry out treatment, payment, health care operations, or disclosures authorized by you. This request must be in writing and a time period, but may not be longer than six (6) years or before April 14, 2003. Our Practice will provide the first accounting to you in any 12-month period without charge, upon receipt of your written request. The cost for subsequent requests for an accounting within the 12-month period will be up to the maximum amount prescribed by governing law.

Request Restrictions: You have the right to request a restriction or limitation of your medical information we use or disclose about you for treatment, payment or health care operations.
Restrictions from your health plan (insurance company): You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket.

Other Restrictions, Limiting Information: You also have the right to request and limit any medical information we disclose about you to someone who may be involved in your care or the payment of your care, such as a family member or friend. We ask that you submit these requests in writing.
We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternate phone number or address. We ask that you submit these requests in writing.

For More Information or to Report a Problem
If you have questions or want to exercise any of your rights, please submit your request in writing to the practice's privacy officer indicated below.
If you believe that your (or someone else's) privacy rights may have been violated, you may file a complaint with the Privacy Officer at the contact number below or with the Secretary of Health and Human Services. All complaints must be submitted in writing within 180 days of when you knew that the act or omission occurred and there will be no retaliation for filing a complaint.

Privacy Officer: Mary Kifer
Address: 2370 Walden Woods Dr., Suite A
Plant City, FL 33563
813.659.9800 Phone

Notice of Privacy Practices Acknowledgement

____I acknowledge that I have received a copy of the Notice of Privacy Practices.

Print Name:_____ Date:_____

Signature:_____