ALTAMONTE FAMILY PRACTICE

Patient Acct #:_____

(1) PATIENT INFORMATION: (Please Print)

First Name		Last Name		M.I.	Sex M / F
Date of Birth	Age	SS#		Race/Ethnicity	
Home Address	City	State	Zipcode	Marital Status S M W D	
Mailing Address	City	State	Zipcode	Preferred Language	
Cell #	Home #	Work #	Ext.	Email address:	
Employer Name	Occupation				
Employer's Address	City	State	Zipcode		
Spouse Info: Full Name	Cell #	Home #		Work #	
Who may we thank for referring you:					

(2) Financial Responsibility-Guarantor Information Is guarantor a patient here? Yes No

First Name	Last Name	M.I.	Date of Birth	SS#
Home Address	City	State	Zipcode	Sex: F M
Cell #	Home #	Work # & Ext:	Employer Name & Occupation	
Employer's Address	City	State	Zipcode	
Emergency Contact	Relationship	Cell #	Home #	Work #
Emergency Contact Address:	City	State	Zipcode	

(3) Primary Insurance Coverage Information		**(4) Secondary Insurance Coverage Information**	
Insurance Company Name		Insurance Company Name	
Address	Phone	Address	Phone
Subscriber	Relationship	Subscriber	Relationship
SS#	Date of Birth	SS#	Date of Birth
ID #	Group #	ID #	Group #

(5) Authorization and Release of Information

I hereby authorize Altamonte Family Practice to administer medical care as may be deemed advisable in the diagnosis and treatment of the patient. I further authorize Altamonte Family Practice to furnish to the patient's insurance company, Social Security Administration and Health Care Financing Administration, or any representative thereof, any and all information which may be requested regarding past or present condition or treatment. I authorize the insurance company or attorney or other parties to pay all medical and/or surgical expenses payable under the terms of the insurance contract directly to Altamonte Family Practice. In making this assignment, I also agree that any balance not covered will be paid by me, and that photocopies of this form may be used as valid in place of the original.

Patient Name	Guarantor Name	Patient/Guarantor Signature	Date

Altamonte Family Practice

Andrew E. Krupitsky, D.O., Marie Christensen, M.D.
Board Certified in Family Practice
Cynthia R. Bridges, ARNP, FNP-BC,
Paula Paton, ARNP, FNP-C, CCRN

MEDICAL HISTORY

NAME **AGE** **DATE**

LIST OF MEDICATIONS

FAMILY HISTORY

FATHER: Living or Deceased Age:
MOTHER: Living or Deceased Age:
SIBLINGS: Living or Deceased Age:
CHILDREN: Living or Deceased Age:

DRUG/FOOD ALLERGIES

FAMILY HISTORY

	Father	Mother	Siblings	Children
Heart disease				
High blood pressure				
Stroke				
Cancer				
Diabetes				
Bleeding disorder				
Thyroid disease				
Mental illness				

HOSPITALIZATION OR SURGERY

REASON	DATE

PAST MEDICAL HISTORY

___Allergies/Hay Fever ___Depression/Anxiety ___Hypertension
___Anemia ___Dizziness/Fainting ___Prostate disease
___Arthritis ___Diabetes ___Seizure disorder
___Back/Neck pain ___Gout ___Sexual/Menstrual dysfunction
___Bowel irregularity ___Headache/Migraines ___Shortness of breath
___Chest pain ___Heart palpitations ___Ulcer
___Chronic rashes ___High cholesterol ___Other _____

Date of Last Immunization

___Flu Vaccine
___Tetanus
___Pneumonia
___PPD
___Other_____

HABITS/RISK FACTORS (Complete those that apply)

Smoke now: Yes No Ever Smoked: Yes No
Packs Daily: _____ How Long: _____
Alcohol: Yes No Type:_____ Amount:_____
Street drugs: Yes No Type: _____
Contact with blood/body fluids at work: Yes No
Coffee: cups daily _____ Other caffeines: _____
Exercise: Yes No Type: _____ Amount: _____

ADVANCE DIRECTIVES

Advanced Directive: Yes No (If yes, please provide copy)

OTHER:

WOMEN ONLY

Menstruation: First at age:_____
Flow is: light moderate heavy
____ days between period Period lasts: _____ days
Date of last period: _____
Pregnant: Yes No Planning: Yes No
Total # pregnancies _____ Full term: Yes No
Number living children: _____
Age of youngest:_____
Type of birth control:_____
Do you see a Gynecologist? Yes No
Who:_____
Date of last Pap Smear: _____
Date of last Breast Exam:_____
Date of last Mammogram: _____

249 Maitland Avenue, Suite 1000 • Altamonte Springs, Florida 32701
Phone 407-332-6366 • Fax 407-830-4300 • www.altamontefamilypractice.com

ALTAMONTE FAMILY PRACTICE

OUR FINANCIAL POLICY

Thank you for choosing Altamonte Family Practice as your medical care provider. We are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

- All patients must complete our information and insurance form before seeing the doctor.
- **Full payment is due at time of service**
- We accept cash, checks or VISA/MasterCard/Discover. **Returned checks are subject to a $40 service fee.**

HEALTH CARE INSURANCE PLAN OBLIGATION

Altamonte Family Practice maintains a list of the health care service plans with which it has contracted to provide services to patients. AFP has agreed to bill those insurance carriers for all services rendered. Authorization from your insurance company does not always guarantee payment. There may be times when services given by AFP is not covered by my insurance carrier; hence, I understand that I am still responsible for payment of these services. I also understand that lack of timely payment of patient responsibilities may result in monthly billing charge of $7.50 and if still not paid will be sent to our collection agency for legal action. An additional late payment fee of $25 will be added to the balance due. These administrative charges are not billed to any insurance nor are they covered by any insurance and I understand they are wholly my responsibility. The undersigned and/or patient shall remain responsible for all charges, applicable co-payments and deductibles.

_____
Initials

NON-PARTICIPATING INSURANCE

All fees are due in full at time of service. As a courtesy, we will prepare an insurance form for you to submit to your carrier for reimbursement.

PPO/HMO/MEDICARE/TRADITIONAL INSURANCE WAIVER REGARDING NON-COVERED SERVICES

Medicare, (under Section 1862 (a) (1) of the Medicare law), and some health insurance plans will only pay for services that it determines to be "reasonable and necessary"; If Medicare determines that a service is "not reasonable and necessary" under Medicare program standards; or your insurance determines that a service or services were unauthorized or not a covered benefit under your plan, Medicare and other insurance plans will deny payment for these services. We believe that, according to your insurance/Medicare plan, payment may be denied for the following service(s)/

- Routine physicals (no symptoms/complaints)
- Routine immunizations (Medicare covers flu shots)
- Lab tests for screening purposes (incl: X-Rays, EKG's, Dexascan)
- Prescription Drugs
- Durable Medical Supplies: i.e., back braces, crutches, splints, bandages
- Request for Medical Records
- Forms to be completed by physician or P.A. (i.e., FMLA, Disability, Employment, School)
- Urine Drug Screening

The undersigned and/or patient understand and agree to be personally and fully responsible for payment for all non-covered services.

_____
Initials

REFERRAL POLICY

All referrals are based on medical necessity. Requests for referrals will require patient evaluation by an Altamonte Family Practice provider. Non-emergent referrals require a minimum of 5 business days for processing.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and our charge reflects the quality of our care.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment at time of service. For unaccompanied minors, non-emergency treatment will be denied unless payment has been pre-authorized to an approved credit plan, VISA/MasterCard/Discover or payment by cash/check will be made at time of service. We are not a party to any divorce decree or other legal judgements that outlay responsibility for medical payments.

- For your convenience, we offer on site diagnostic and lab services. These services are performed by organizations other than Altamonte Family Practice and may be billed separately by the service provider.
- Should collections become necessary, the patient will be responsible for all collection costs and attorney's fees.
- **Unless an appointment is canceled at least 24 hours in advance, our policy is to charge $35 for an office visit.**
- **In order to comply with strict DEA (Drug Enforcement Administration) guidelines, random urine drug screening may be required.**

_____
Initials

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ Date: _____
Signature of Patient/Responsible Party

X_____ Date: _____
Signature of Co-Responsible Party

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AUTHORIZATION TO RELEASE INFORMATION TO FAMILY &/OR FRIENDS & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NPP)

Our physician/patient relationship with you is held in strictest confidence. We will not discuss anything about your medical condition or care with anyone (including parent, spouse or child) without your written permission to do so.

Please complete this form listing the people you are authorizing us to communicate with about you. If no one, indicate "**No One**".

RE: _____
(Print patient name)

I acknowledge and agree that Altamonte Family Practice may disclose my Protected Health Information and medical record information to the following individuals:

_____ _____
Name Relationship

_____ _____
Name Relationship

This could be in **person, by telephone, fax or mail** and includes the following information:
(Please **INITIAL** each one that you are authorizing)

_____ Lab results/test results _____ General medical information
_____ Any and all medical or financial information in my records including HIV information, alcohol or drug abuse information, sexually transmitted disease information, or psychological information
_____ Other – please specify _____

This authorization allows us to provide information via fax or mail requested by you and those listed above.

With my signature, I acknowledge that I have been presented with the NPP and that I have authorized the above – initialed disclosures.

_____ _____
Signature Date

_____ _____
Witness Date

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NOTICE OF PRIVACY PRACTICES

Effective Date: **9/20/2013**

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 of Privacy Practices ('Notice'), please contact:
Privacy Officer: JOANNE GAYLE
Phone Number: 407-332-6366
249 Maitland Ave Ste 1000, Altamonte Springs, Fl 32701

Section A: Who Will Follow This Notice?

This Notice describes Altamonte Family Practice (hereafter referred to as 'Provider') Privacy Practices and that of: Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment and Healthcare Operations. These workforce members may include:

- All departments and units of the Provider
- Any member of a volunteer group
- All employees, staff and other Provider personnel
- Any entity providing services under the Provider's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for Treatment, Payment or Healthcare Operational purposes described in this Notice

Section B: Our Pledge Regarding Medical Information
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by the Provider, whether made by Provider personnel or your personal doctor.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You
The following categories describe different ways that we use and disclose medical information. For each category

of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the Provider, such as family members, clergy or others we use to provide services that are part of your care.
- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the Provider may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the Provider so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **Healthcare Operations.** We may use and disclose medical information about you for Provider operations. These uses and disclosures are necessary to run the Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Provider patients to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other Provider personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identity.
- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Provider.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health & Related Benefits and Services.** We may use and disclose medical information to tell you about health & related benefits or services that may be of interest to you.
- **Fundraising Activities.** If we intend to use your medical information for fund-raising purposes, we will inform you of such intent and that you have a right to opt out of receiving fundraising communications. We may use information about you to contact you in an effort to raise money for the Provider and its operations. We may disclose information to a foundation related to the Provider so that the foundation may contact you into raising money for the Provider. We only would release only contact information, such as your name, address and phone number and the dates you received treatment or services at the

Provider. If you do not want the Provider to contact you for fundraising efforts, you must notify us in writing and you will be given the opportunity to 'opt-out' of these communications.

- **Authorizations Required.** We will not use your protected health information for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization; Specifically the following types of uses and disclosures of your medical information require an authorization; 1) disclosure of psychotherapy notes; 2) disclosures for marketing purposes; and 3) disclosures that constitute a sale of protected health information. Other uses and disclosures not described in the NPP will not be made unless an individual provides an authorization and that authorizations may be revoked prospectively at any time by written revocation.
- **Emergencies.** We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.
- **Communication Barriers.** We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.
- **Provider Directory.** We may include certain limited information about you in the Provider directory while you are a patient at the Provider. This information may include your name, location in the Provider, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in the Provider and generally know how you are doing.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object and ask us not to provide this information to specific individuals, in writing. 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.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Provider. We will almost always generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.
- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **E-mail Use.**
  E-mail will only be used for communications with you following this organization's current policies and practices and with your permission. The use of secured, encrypted e-mail is encouraged.

Section D: Special Situations

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - in response to a court order, subpoena, warrant, summons or similar process;
  - to identify or locate a suspect, fugitive, material witness, or missing person;
  - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the Provider; and
- in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Provider to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Access, Inspect and Copy.** You have the right to access, inspect and copy the medical information that may be used to make decisions about your care, with a few exceptions. Usually, this includes medical and billing records, but may not include psychotherapy notes.
- If we maintain your information electronically you may request a copy of your records via a mutually agreed upon electronic format. If we fail to agree upon an electronic format for delivery of electronic copies we will provide you with a paper copy for your records. If you request a copy of the information in either paper or electronic format, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- We may deny your request to inspect and copy medical information in certain very limited circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may request us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Provider. In addition, you must provide a reason that supports your request.

- We may deny your request for an amendment if; it is not in writing or does not include a reason to support the request or for other reasons. Typical reasons for denial of an amendment request include if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by or for the Provider;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically, if available). The first list you request within a 12 month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
  Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for payment or healthcare operations. We require that any requests for use or disclosure of medical information be made in writing. In some cases we will not we are not required to agree to these types of request, however if we do agree to them we will abide by these restrictions. We will always notify you of our decisions regarding restriction requests in writing. We will not comply with any requests to restrict use or access of your medical information for treatment purposes.
  You have the right to request, in writing, a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply, for example, disclosures to your spouse.
  You also have the right, which we may not refuse, to restrict use and disclosure of your medical information about a service or item for which you have paid completely out of pocket, for payment (i.e. your insurance company) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We are not required to accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service. We are not required to notify other healthcare providers of these types of restrictions, that is your responsibility.

- **Right to Receive Notice of a Breach.** We are required to notify you by first class mail or by e-mail (if we offered and you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

- **Right to 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. For example, you can ask that we only contact you at work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice on our website at www.altamontefamilypractice.com.

To exercise the above rights, please contact privacy officer to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are admitted to the Provider for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services;
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html
To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

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Section H: Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Section I: Organized Healthcare Arrangement (OHCA)

The Provider, the independent contractor members of its Medical Staff (including your physician), and other healthcare providers affiliated with the Provider have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations, enabling us to better address your healthcare needs. Providers participating in an Organized Healthcare Arrangement may share the same Notice of Privacy Practices.

Revised Date: April 20, 2013. Compliant with HIPAA Omnibus Privacy Rules

Original Effective Date: April 14, 2003

249 Maitland Avenue, Suite 1000 • Altamonte Springs, Florida 32701
Phone 407-332-6366 • Fax 407-830-4300 • www.altamontefamilypractice.com

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Authorization for Use or Disclosure of Protected Health Information ("PHI")

I _____ hereby authorize the use or disclosure of the
(Patient Name/Legal Representative/Parent/Legal Guardian Name)

Individually identifiable health information of _____ as described herein.
(Print Patient Name)

Person/organization authorized to use/disclose the information:	Person/organization authorized to receive the information:
Name/Organization:_____ Address: _____ City, State, Zip:_____ Phone _____Fax _____	**Altamonte Family Practice** **249 Maitland Ave Ste.1000** **Altamonte Springs, FL 32701**

For the purpose of ____Legal Request ___Moving out of Area ___New Local Physician
___ Other (please specify) _____.

This authorization will expire on the following date, event or condition: _____.
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information. I further understand that Altamonte Family Practice may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Date(s) of Service: From _____To: _____

Place your **INITIALS** by each specific item: (if applicable)
___ Complete Record (charges will apply) ___ Radiology only ___ All diagnostic test results
___ Lab only ___ Office notes ___Other (specify) _____.

In addition, place your **INITIALS** by each specific item: (if applicable)
___Mental Health ___Drug and /or Alcohol ___HIV Testing/Results ___STD/Communicable Diseases

_____ _____ _____
Patient/Legal Representative or Parent/Legal Guardian ***Signature Required*** Date of Birth Date of Authorization

OFFICIAL USE ONLY: _____
Name of Person Releasing Information Date

Altamonte Family Practice

Andrew E. Krupitsky, D.O.
Marie Christensen, MD
Board Certified in Family Practice
Cynthia R. Bridges, ARNP, FNP-BC
Paula Paton, ARNP, FNP-C, CCRN

Re: Physical/Health Maintenance/Well Woman exam with E/M visits

Dear Patient,

Thank you for choosing our practice for your medical needs. We value our relationship with you and want to serve as your personal medical home.

If at the time of your visit for a Physical/Health Maintenance/Well Woman exam a medical issue is encountered or a pre-existing problem is addressed and is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then a separate office code will be reported and billed to your insurance.

The primary motivation of our office in this situation is to avoid inconveniencing our patients who present with acute problems at a preventive care visit. Rather than asking you to return on another date to divide the services, we will perform both, and submit a claim for both visits to your insurance carrier.

We want to make you aware that depending on your insurance there is a possibility that you will be responsible for an additional copay/deductible/co-insurance. We will not know at the time of service. We will collect for your responsibility for the Physical/Health Maintenance/Well Woman exam and submit the E/M service to your insurance.

If you have any questions or any concerns do not hesitate to ask our staff.

Sincerely,

Billing Department

Account #_____

Patient Print Name:_____ Guarantor Print Name:_____

Patient/Guarantor Signature:_____ Date:_____

Altamonte Family Practice

Andrew E. Krupitsky, D.O., Marie Christensen, MD
Board Certified in Family Practice
Cynthia R. Bridges, ARNP, FNP-BC
Paula Paton, ARNP,FNP-C, CCRN

Dear Patient,

Altamonte Family Practice's mottos is "Quality through Excellence," a concept which embodies our ongoing efforts to provide only the highest quality, patient oriented medical care. In recent times, many regulations promulgated by both federal/state and insurance organizations have interfered with the patient – doctor relationship. While this is an unacceptable change, we have all been forced to cope with this situation. Unfortunately, this had led to many unexpected problems, ranging from confusion with availability or affordability of prescription medications to outright denial of medicines deemed necessary for improved patient benefit.

To allow for continued excellent medical care in the face of these problems, Altamonte Family Practice will be instituting a new approach to assist with continuity of care. Effective March 1, 2009, certain requests such as unplanned prescription refill requests will be evaluated by a medical assistant and then by Dr. Krupitsky, Dr. Christensen, Cynthia Bridges, and Paula Paton. It has become necessary to charge a small fee to deal with this challenge. If you have insurance, we will bill your insurance company with the appropriate coding for reimbursement. Please keep in mind that should your insurance deny these charges, you may be responsible for the balance. Self-pay patients will be expected to pay at time of request.

If a prescription refill is unexpectedly needed, then a partial refill to last until your next office visit will be accomplished. We ask that you allow 48-72 hours for medical questions or prescription refills to be answered. Patients needing a full prescription refill will need to schedule an appointment.

Thank you for your consideration and understanding.

Sincerely,

Andrew E. Krupitsky, D.O.

Patient Name (Print): _____ Patient Signature: _____

Witness: _____ Patient Acct #_____ Date: _____

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