FPM

Date: _____

NEW PATIENT
David Braun, M.D.
Page 1

Patient Name *(Please Print)* _____ Date of Birth _____

Height _____ Weight _____

Who requested that you visit this office?

Doctor *(Name)* _____ ☐ Self Referral ☐ Attorney _____

Primary Care Physician _____

What is the main reason for your visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other *(Chief Complaint)* _____

What body part is involved?																			(Location)
Neck	☐		Shoulder	☐	Right Left	Elbow	☐	Right Left	Hand	☐	Right Left	Pelvis	☐	Right Left	Knee	☐	Right Left	Foot	☐	Right Left
Back	☐	Mid	Arm	☐	Right Left	Wrist	☐	Right Left	Finger	☐	Right Left	Hip	☐	Right Left	Ankle	☐	Right Left	Toe	☐	Right Left
	☐	Lower																		

How long has this problem been present? ☐ Days ☐ Weeks ☐ Months ☐ Other *(Explain)* _____

Check the box which best fits how your problem started. Then answer the one question below the box you checked.
Use as much space to the right as needed.

☐ **NO INJURY (Onset was:** ☐ Gradual or ☐ Sudden _____
Why do you think it started?

INJURY - (Not Auto or work) _____
Date _____ Where or how did it happen?

INJURY AT WORK _____
Date _____ Where or how did it happen?

INJURY RELATED-(BUT NO INJURY) _____
Date _____ Where or how did it happen?

AUTO ACCIDENT-Date/Details- _____
Date _____ Driver/Passenger taken to ER?

Please check the box below which best describes your problem.

The pain is ☐ Constant ☐ Comes and goes(intermittent) (Duration)

Severity of pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe (Severity)

What is the **quality** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other _____ (Quality)

Are these associated symptoms: ☐ Swelling ☐ Numbness ☐ Weakness ☐ Catching/Locking (Assoc Symp)

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged (Context)

Does your pain wake you from sleep? ☐ Yes ☐ No (Timing)

What makes your symptoms **worse**? ☐ Activity ☐ Exercise ☐ Work ☐ Other _____ (Modify)

Which make you feel better: ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other _____ (Modify)

What medications have you taken or been prescribed for this problem? _____ (Modify)

Check which treatments you have tried: Injection ☐ Yes ☐ No Brace ☐ Yes ☐ No Therapy ☐ Yes ☐ No Cane/Crutch ☐ Yes ☐ No (Modify)

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

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

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

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

_____

_____

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

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

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

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

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

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

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

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

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

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

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

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

Dr. David Braun	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

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

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

FLORIDA PHYSICAL MEDICINE LLC
POWER OF ATTORNEY & MEDICAL RELEASE- Dr David Braun

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RNEDERED, INCLUDING BUT NOT LIMITIED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint FLORIDA PHYSICAL MEDICINE LLC / Dr David Braun and any of its duly authorized agents and employees as and to be the undersigned's true an lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders are made payable for services which have been made by FLORIDA PHYSICAL MEDICINE LLC at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft of money order.

Furthermore, the undersigned allows FLORIDA PHYSICAL MEDICINE, LLC / Dr David Braun or any of his agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give and grant the said FLORIDA PHYISCIAL MEDICINE LLC / Dr David Braun as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to FLORIDA PHYSICAL MEDICINE LLC / Dr David Braun or any insurer providing coverage to me in connections with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

ASSIGNMENT OF BENEFITS

I _____hereby authorize my insurance company to make medical benefits payments otherwise payable to me for services rendered by Dr David Braun, but not to exceed the charges of those services, payable to and mailed directly to:

FLORIDA PHYSICAL MEDICINE
Dr. David Braun
2200 West Bay Dr., Largo, FL 33770
750 94th Ave. N. Ste. 202, St. Petersburg, FL 33702
625 6th Ave. S., Ste. 475, St. Petersburg, FL 33701
6500 66th Street North, Pinellas Park, FL 33781

Furthermore, I hereby IRREVOCABLY ASSIGN to FLORIDA PHYSCIAL MEDICINE, LLC / Dr David Braun the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by FLORIDA PHYSICAL MEDICINE, LLC / Dr David Braun. I also instruct the insurance carrier to request that, in the event the subject medical services and / or benefits are disputed for any reason, the amount of benefits being claimed by FLORIDA PHYSICAL MEDICINE, LLC / Dr David Braun are held in escrow and not disbursed until the dispute is resolved.

IN WITNESS WHEREOF the undersigned have hereunto set their hand, the _____ day of Month _____, 20_____.

_____ _____

PATIENT SIGNATURE PATIENT PRINTED NAME

Consent for Opioid Therapy

Dr. David Braun is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of _____.

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included:

_____

_____

_____

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain TM), pentazocine (TalwinTM), buprenorphine (Buprenex TM), and butorphanol (Stadol TM), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it cause harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following, runny nose, yawning, large pupils, goosed bumps, abdominal pain and cramping,

diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond will to opioids may cause my doctor to choose another form of treatment.

(Males Only) I am aware the chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Female Only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to deliver while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I have read this form or have it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this for voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

Patient Signature: _____ Date: _____

Witness to above: _____

Controlled Substances Therapy for Pain

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefits. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential of abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of , the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is: _____ Phone: _____
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with the dispensing pharmacist or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substance may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with the chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
9. Original containers of medications should be brought in to each office visit.
10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, et. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
12. Early refills will generally not be given.

13. Prescriptions may be issued early if the physician or patient will be out town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
17. It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.
18. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation.)
19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

_____ _____

Physician Signature Patient Signature

_____ _____

Date Patient Name (Printed)

FLORIDA PHYSICAL MEDICINE LLC
2200 West Bay Dr. Largo, FL 33770
6500 66th Street N., Pinellas Park, FL 33781
750 94th Avenue. N., Ste. 202, St. Petersburg, FL 33702
625 6th Avenue. S., Ste. 475, St. Petersburg, FL 33701
(T) 727-518-2977 (F) 727-518-0010

Fax to: _____

Attention: _____

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION

NAME OF INSURER: _____

ID NUMBER: _____

NAME OF INSURED: _____

DATE OF ACCIDENT: _____

I, _____, hereby authorize and direct MY INSURANCE COMPANY to send Florida Physical Medicine my coverage information and an accounting of payouts made under all claims submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date as those payouts occur.

Signature_____ **Date signed** _____

To Whom It May Concern,

Please be advised that I have been consulted by and have begun rendering medical treatment to the above referenced patient, with the patient's initial date of treatment occurring on _____.

In accordance with Florida Statutes 627.736 (5) (b), I will timely submit all claims to your address with mail documentation.

Truly,

Matthew Cusumano, D.O., Lora Brown, M.D., Adam Di Dio, M.D., David Braun, M.D. & Brad Young R.P.T.

Florida Physical Medicine
2200 West Bay Dr. Largo, FL 33770

After careful consideration, it is my decision to decline benefits available through my personal or group health insurance.

I understand that by doing so I am waiving any submission of bills from Florida Physical Medicine now, or at ay time in the future to Managed Care, Indemnity, or Private Network Health Carriers. I am aware that the reason for this is related to properly pre-approving care, timely filing limits of claims and other such industry standards and rules.

I am also fully aware that in the event of an unfavorable judgment of my personal injury matter I am personally responsible for all charges incurred in the office of Florida Physical Medicine.

If I have Medicare Insurance I request that payment of authorized Medicare benefits be made on my behalf to the rendering provider for any services furnished to me. If I have Medicare Insurance and this is a liability situation, I understand that the provider has a choice of billing the liability insurer, filing a lien against a patient's court settlement, or billing Medicare. I authorize any holder of medical information about me to release to the Centers of Medicare (CMS) and its agent any information needed to determine these benefits or the benefits payable for related services. I agree to pay any portion of my charges that my Medicare carrier determines is my responsibility.

Date: _____

Name: _____

Signature: _____

Florida Physical Medicine, LLC.
Phone: 727-518-2977 Fax: 727-518-0010

Letter of Protection and Authorization for Lien on Services

_____
Patient Name

_____
Date of Accident

In the event that I, _____ _____, recover money from a settlement of my claim relating to the accident dated above, I direct my attorney to withhold from my settlement sufficient funds to pay for all medical care provided by Florida Physical Medicine, LLC, FEIN# 54-2144380, up to the lesser of a.) the funds received from the recovery of the above named client/patient; or b.) the balance of the account, unless otherwise approved by the legal department.

My attorney will use his/her best efforts to request a confirmation of my account balance when the recovery is imminent.

If the net recovery of settlement to me is less than the total outstanding charges owed to all healthcare providers covered by a letter of protection or any other lien holder, excluding Medicare or Medicaid, Florida Physical Medicine, LLC. have priority to have its claim paid first after attorney costs and fees.

My attorney acknowledges independent responsibility to Florida Physical Medicine, LLC. for charges incurred for medical records, medical reports, conferences and witness fees.

In the event that I am not represented by an attorney, I authorize any and all lien holders to pay directly to Florida Physical Medicine all funds due on my account related to the above named accident.

If I, _____ _____, object to the amount of the bill, I agree that my attorney or any other lien holder to withhold an amount sufficient to pay my bill in a trust account. My attorney or any other lien holder will not thereafter pay any portion of the monies withheld, either to the doctor or to me, until a written agreement is made by all parties involved. The only exception would be upon an Order of Court of competent jurisdiction directing that such funds be paid to either me, Florida Physical Medicine, LLC.

By signing below, I have either read or have had explained to me the above written statements. By signing below, I authorize my representing attorney to protect my bills for treatment as outlined above. I also understand and agree that I am ultimately responsible to Florida Physical Medicine, LLC for the payment of all services rendered for my benefit.
(a copy will be accepted in place of original)

_____
Name of Representing Attorney

_____
Signature of Client/Patient Date

_____
Witness Signature Date

_____ Patient given a copy of LOP/Lien on Services

_____ Patient denied a copy of LOP/Lien on Services

OFFICE AND FINANCIAL POLICY

Welcome!

Please notify our office when you have a change of address, phone number or insurance information.

APPOINTMENTS AND CANCELLATIONS:

It is your responsibility to keep or cancel your appointment, whether or not we are able to contact you for confirmation.

24 hour advance notice is required when canceling an appointment. Failure to cancel with the appropriate advance notice will result in a $75.00 fee.

INSURANCE

We will gladly file your insurance claim for you and accept assignment of benefits. However, if the insurance company does not pay, it will be your responsibility to pay Florida Physical Medicine, LLC for all services rendered on your behalf.

PAYMENT ARRANGEMENTS:

Payment in full is due for services when rendered. We accept all major credit cards for your convenience.

Should your account be turned over to our collection agency for nonpayment, the patient is responsible for all collection/attorney fees incurred by Florida Physical Medicine, LLC.

Please read this policy carefully before signing. Our staff is available to you if you should have any questions or concerns regarding this policy. Your signature certifies that you understand and will comply with this policy.

Patient's Signature: _____ Date: ___/___/___

Florida Physical Medicine, LLC 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. Florida Physical Medicine is a HIPPA compliant facility.

This Practice is committee 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 care. This Notice details how your PHI may be used and disclose 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 being examined or treated.

We collect information from you and store it in a medical record as well as on the computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

No Consent Required

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

- Treatment- In order to provide you with the health care you require, the Practice will provide you 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 physical examination by this office.
- Payment- In order to get pain 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 be determined whether or not it will cover treatment expense.
- 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:

- De-identified Information- Information that does not identify you and, even without your name, cannot be used to identify you.
- Business Association- To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard you PHI. A business associate is an entity that assists the Practice in undertaking some essential information, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
- Personal Representative- To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
- 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.
- Communication Barriers- If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent an the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment in clearly inferred from the circumstances.
- Public Health Activities- Such activities include, for example, information collected y 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.
- Abuse, Neglect, or Domestic Violence- To a government authority if the Practice is required by law to make such a 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.
- 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 relating to the community's health care system.
- 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.
- 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.
- Coroner or Medical Examiner- The Practice may disclose yourPHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
- 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.
- 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 no identify you and, even without your name, cannot be used to identify you.

- 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 an 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.

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

Appointment Reminder/Birthday cards/Practice specials

- 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. card or postcard mailed to you at the address provided by you; and b. telephoning your home and/or work and leaving a message on your answering machine/voicemail or with the individual answering the phone.

Sign-In Log

- The Practice maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the individual's location with the Practice's office suit. 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 of your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, personal representative, or another person responsible for your care, of your location, general condition, or death. However, in both cases, the following conditions apply:

- 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 of the disclosure.
- 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:

- Obtain a paper copy of this notice from us, upon request. You may obtain a copy by asking our receptionist.
- Revoke any Authorization and/or Consent, in writing, at any time and to request a revocation, you must submit a written request to the Practice's Compliance Officer.
- Request restrictions on certain use and/or disclosure of your PHI as provided by the 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 COMPLIANCE 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.
- Inspect and receive a copy of the PHI that we maintain about you in our medical chart, for as long as we maintain this record. The record includes your medical and billing records aw well as any other records we use for making decisions about you, such as test results. We may charge you a fee for the costs of copying, mailing, or for other supplies used in fulfilling your request.
- If you with to inspect or receive a copy of your medical information, you must submit your request in writing to our COMPLIANCE OFFICER. You may mail your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off site, we are allowed up to 60 days to respond, but must inform you of this delay.
- You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to the COMPLIANCE OFFICER, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not support a reason for the request. We may also deny your request if the information was not created by us, or the person who created it, is no longer available to make the amendment, or if our physician's opinion is that the information is not accurate and complete.

Questions and Complaints

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below who is the COMPLIANCE OFFICER and Contact person appointed for this practice. The COMPLIANCE OFFICER is Amanda McDonald.

You may file a complaint with the COMPLIANCE OFFICER if you believe that your privacy rights have been violated relating to the 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 COMPLIANCE OFFICER. We will not retaliate against you in any way if you want to file a complaint.

Effective Date

This Notice is in effect as of April 14, 2003 for Florida Physical Medicine. Ammended date: 02/10/2016

FPM
A Multi-Disciplinary Clinic

Tips from our doctors, directly to your inbox.

At Florida Physical Medicine, we strive to provide quality care and expertise, whether you're in our office or looking for more information related to your injuries. Get all the information you need, right at your fingertips.

Please sign your name and email address below to receive:

- Injury Recovery Tips
- Road Safety Tips
- News from Florida Physical Medicine

We will not share your information with any third parties. You can opt-out at any time.

Name (Print)

Email Address

Disclaimer:
By signing this form, you agree to receive communication from Florida Physical Medicine. We may use your Personal Information to contact you with newsletters, marketing or promotional materials and other information that is related to the services we provide. Personal Information will not be sold or shared with any Third Party without prior consent.

If you would like to stop receiving communication from Florida Physical Medicine at any time, you can contact a member of our team or click the "Unsubscribe" link in any of our communications.

If you have any questions about this Disclaimer, please contact us.