A+ FAMILY HEALTH ADULT I.D. SHEET

Name: _____ **Birth Date:**_____ **Sex: M F**
Last First Middle Initial

Address:_____
Street City State Zip

Marital Status: (Circle One) S W D Sep. Mar:_____ **Spouse Name:**_____
Maiden Name

Race: American Indian / Alaskan Native / Asian/ African American/ Black Hispanic or Latino / Native Hawaiian or Pacific Islander / White / White Hispanic or Latino / Refuse

SS# _____-_____-_____ Advance Directives: (Circle One) YES NO Language Preference:_____

Tel Home:( )_____ **Work:( )**_____**Cell:( )**_____ **E-mail:**_____

How Did You Find Us: Newspaper Yellow Pages Hospital Friend Drive by Referred by_____ Other: _____

Employer:_____
Name Address Phone

Past Medical History: _____

List of Medications Patient is Taking Now? **Are You Allergic to any food or Medicine? YES NO** (If Yes Than List Below)

_____ _____

_____ _____

INSURED OR FINANCIALLY RESPONSIBLE PERSON

Insured: (Circle One) Self Other:_____
Name Relationship

_____ **( )**_____
Address Phone

_____-_____-_____ _____ **Employer:**_____
Social Security Number Date of Birth

_____ _____
Address **Phone**

INSURANCE INFORMATION

Self Pay: Yes No Medicare #:_____**Eff. Date:** _____

Medicaid #:_____ **Seq #:**_____ **Control #** _____ **Eff. Date:**_____

Other Insurance :_____
Name Address Phone

ID #:_____ **Group #:**_____ **Eff. Date:**_____

EMERGENCY CONTACT PERSON

Name/Address:_____ **Relationship:**_____

_____ **Home Phone:( )**_____

_____ **Work Phone:( )**_____

ASSIGNMENT OF INSURANCE BENEFITS.

I hereby authorize direct payment of medical / surgical benefits to **A+ FAMILY HEALTH** for services rendered by the doctors and staff. I understand that I am financially responsible for any balance / Amount not covered or paid by my insurance.

MEDICARE -- MEDICAID

I certify that the information given by me in applying for payments is correct. I request that payment of authorized benefits be made on my behalf. I will be responsible to pay any Amount / Balance not paid on my behalf.

CONSENT FOR TREATMENT

I_____, do hereby voluntarily consent to and/or authorize the performance of examinations, treatment, diagnostic procedures, blood tests and/or laboratory procedures, which the doctor(s) in attendance at the **A+ FAMILY HEALTH** Considers necessary and/or appropriate. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my condition. This consent will remain in effect for as long as the patient remains a client of **A+ FAMILY HEALTH.**

I acknowledge receipt of **A+ FAMILY HEALTH NOTICE OF PRIVACY PRACTICES and PATIENT CONSENT FORM.**
[Please complete on the back.] A photocopy of these assignments shall be valid as the original.

SIGNATURE:…….. PATIENT NAME:……...

AUTHORIZED PERSON:……..……. DATE:……
Print Name Relationship.

(Please fill the Back Side Also)

A+ FAMILY HEALTH.

Patients Name:_____

Authorization and Consent for The Use and/or Disclosure of Protected Health Information.

I have been given a copy of **A+ FAMILY HEALTH** Notice of Privacy Practices that provides more detailed information about how they may use and disclose my protected health information. I have the right to read this Notice of Privacy Practices before signing the consent.

The Physicians and employees of **A+ FAMILY HEALTH** will use and disclose your protected health information for the purposes of treatment, payment and health care operations unless you request a restriction as outlined in our Notice of Privacy Practices.

1. I authorize the use and/or disclosure of my protected health information to:
   _____

My authorization applies to the following information, only this information may be used and/or disclosed pursuant to this authorization: NAME & ADDRESS _____ PHONE # _____ SS # _____ BILLING INFO _____ MEDICAL RECORDS_____OTHER_____.

2. You can authorize additional persons or classes to receive your protected health information. Without
3. this authorization we are prohibited from divulging your health care information, even to your spouse
4. or other family members. If you wish to allow others access to your health care information please include their name and relationship in the following area:-

SPOUSE____ CHILDREN____ BROTHER/SISTER____ PARENT(S)____ OTHERS_____
Include Name(s)_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this authorization at any time as outlined in the Notice of Privacy Practices. If applicable this authorization expires upon _____

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from **A+ FAMILY HEALTH**, nor will it affect my eligibility for benefits.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed,(in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. § 164.524)

_____ _____

Signature Date

History & Physical

Name _____ / REVIEW OF SYMPTOMS

Date _____ SS# _____

Address _____

Occupation _____ Phone (Home) _____

(Work) _____ Date of Birth _____

Chief Complaint _____

Insurance# _____

Hospitalization or Surgery

Date	Reason	Date	Reason

Drug Allergies

Medications

Vaccine	Year of Last	Vaccine	Year of Last	Test/Exam	Year of Last	Test/Exam	Year of Last
Tetanus		Pneumonia		Rectal/Stool		Tuberculosis	
Flu		Other_____		Cholesterol		Other_____	

Medical History

❑ Ringing In Ear_____
❑ Ear Infections - *Frequent* _____
❑ Dizziness/Fainting _____
❑ Hair Loss _____
❑ Failing Vision _____
❑ Eye Infections _____
❑ Nose Bleeds_____
❑ Sinus Trouble _____
❑ Sore Throats - *Frequent* _____
❑ Hayfever/Allergies _____
❑ Pneumonia _____
❑ Bronchitis/Chronic Cough_____
❑ Asthma/Wheezing _____
❑ Chest Pain _____
❑ Hair Loss _____
❑ High Blood Pressure _____
❑ Heart Murmur _____
❑ Swollen Ankles _____
❑ Leg Pain - *Walking*_____
❑ Varicose Veins/Phlebitis _____
❑ Loss of Appetite _____
❑ Difficulty Swallowing _____
❑ Indigestion or Heartburn _____
❑ Persistent Nausea/Vomiting _____

❑ Peptic Ulcers _____
❑ Abdominal Pain - *Chronic*_____
❑ Gall Bladder Trouble _____
❑ Jaundice/Hepatitis _____
❑ Change in Bowel Habits _____
❑ Diarrhea ❑ Constipation _____
❑ Diverticulosis ❑ Crohn's/Colitis ____
❑ Bloody or Tarry Stools _____
❑ Hemorrhoids _____
❑ Hernia _____
❑ Urine Infections - *Frequent* _____
❑ Blood In Urine _____
Urination-❑ Overnight > than twice
❑ Painful ❑ Loss of Control
❑ Decrease in Force/Flow
❑ Kidney Stones _____
❑ Venereal Disease_____
❑ Urethral Discharge _____
❑ Chronic Fatigue _____
❑ Weight Loss - *Recent*_____
❑ Anemia ❑ Bruise Easily _____
❑ Cancer _____
❑ Diabetes _____
❑ Thyroid Disease _____

❑ Convulsions/Seizures _____
❑ Stroke _____
❑ Tremor/Hands Shaking _____
❑ Muscle Weakness _____
❑ Numbness/Tingling Sensations _____
❑ Headaches - *Frequent* _____
❑ Arthritis/Rheumatism_____
❑ Osteoporosis _____
❑ Back Pain - *Recurrent* _____
❑ Bone Fracture/Joint injury _____
❑ Gout _____
❑ Foot Pain ❑ Cold Numb Feet _____
❑ Rashes ❑ Hives _____
❑ Psoriasis ❑ Eczema_____
❑ Nervousness ❑ Depression_____
❑ Memory Loss _____
❑ Moodiness - *Excessive* _____
❑ Phobias _____
❑ Mental Illness_____
❑ Lactose Intolerance _____
❑ Prostate Disease _____
❑ Sexual/Menstrual Dysfunction ____
❑ Frequent Infections _____
❑ Diphtheria _____

❑ Tetanus _____
❑ Chicken Pox ❑ Polio ❑ Mumps ❑ Measles ❑ Rubella ❑ Rheumatic Fever ❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
❑ Other _____
❑ Other _____

Females - *Please Complete*
Pregnant? ❑ Yes ❑ No
Planning Pregnancy? ❑ Yes ❑ No
Menstrual Flow:
❑ Regular ❑ Irregular ❑ Pain/Cramps
____Days of Flow ____Length of Cycle
Date-1st day of last period_____
❑ Pain/Bleeding during or after sex
Number of:
____Pregnancies ____Abortions
____Miscarriages ____Live Births
Birth Control Method_____
B.C. Pill (Name) _____
❑ Flushing/Menopause
Date of Last PAP Test _____
❑ Normal ❑ Abnormal
Date of Last Mammogram _____
Normal ❑ Abnormal

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Hair Loss	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
High Blood Pressure	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Migraine	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Other_____						

Habits

❑ Alcohol: Type _____
Amount _____
❑ Diet: Salt Intake _____
Fat Intake _____
Other _____

❑ Sleep: Difficulty Falling Asleep _____
Continuity Disturbances _____
Early Morning Awakening _____
Daytime Drowsiness _____
Other_____

❑ Smoke: Packs Daily _____
How Long _____
Interested in Stopping?_____
❑ Exercise Routine: _____
_____

❑ Coffee: Cups Daily_____
Other Caffeine _____
_____

History & Physical

Name _____ / REVIEW OF SYMPTOMS _____

Date _____

Vital Signs Ht. Wt. BP Supine BP Sitting Pulse Resp Rate Temp

Office Tests Urinalysis- Color S. Gr pH Prot Gluc Keto Bili Blood Nitrite Urob **Micro**

Vision Distant (Uncorr) (R) (L) Distant (Corr) (R) (L) Near (Uncorr) (R) (L) Near (Corr) (R) (L) Color Vision Tono Metry (R) (L)

Hbg Stool O.B.

Physical Exam

	Norm	Abnorm.	
Head & Neck			
Carotid Bruits	❑	❑	
Ears	❑	❑	
Eye Muscles	❑	❑	
Fundi	❑	❑	
Head, Scalp	❑	❑	
Lids-Sclera-Conj.	❑	❑	
Neck Glands	❑	❑	
Nose/Sinuses	❑	❑	
Pharynx	❑	❑	
Pupils	❑	❑	
Teeth/Gums	❑	❑	
Thyroid	❑	❑	
Chest			
Axillary Nodes	❑	❑	
Breasts & Nipples	❑	❑	
Chest-Lungs	❑	❑	
Heart-Apex (Location)			
Heart Sound	❑	❑	
Murmurs/Thrills	❑	❑	
Abdomen			
Abdominal Bruits	❑	❑	
Abdominal Masses	❑	❑	
Abdominal Tend	❑	❑	
Hernial Rings	❑	❑	
Inguinal Nodes	❑	❑	
Liver/Spleen	❑	❑	

	Norm	Abnorm.	
Genit. Urine			
Vulva/Vagina	❑	❑	
Adnexae	❑	❑	
Cervix	❑	❑	
Uterus	❑	❑	
Utero/Rectocoele	❑	❑	
Pap Test (done)	Yes ❑	No ❑	
Genitalia - (male)	❑	❑	
- Prostate	❑	❑	
Ano-Rect			
Ano-Rectal	❑	❑	
Sigmoidoscopy			
Derm			
Skin Lesions	❑	❑	
Nail Beds - Fingers	❑	❑	
- Toes	❑	❑	
Extremities			
Pulses-Femoral	St ❑ Wk ❑ Ab ❑		
Popliteal	St ❑ Wk ❑ Ab ❑		
Post Tibial	St ❑ Wk ❑ Ab ❑		
Dorsalis Pedis	St ❑ Wk ❑ Ab ❑		
V. Veins ❑ ❑ Edema	❑	❑	
Cyanosis ❑ ❑ Clubbing	❑	❑	

	Norm	Abnorm.	
Joints			
Ankles/Feet	❑	❑	
Back	❑	❑	
Elbows	❑	❑	
Fingers	❑	❑	
Hips	❑	❑	
Knees	❑	❑	
Neck	❑	❑	
Shoulders	❑	❑	
Wrists	❑	❑	
Neurological Exam			
Babinski	❑	❑	
Cranial Nerves	❑	❑	
Gait	❑	❑	
Motor	❑	❑	
Muscle Atrophy	❑	❑	
Paralysis	❑	❑	
Position	❑	❑	
Rigidity	❑	❑	
Romberg	❑	❑	
Sensory	❑	❑	
Tendon Reflexes	❑	❑	
Tremor	❑	❑	
Vibration	❑	❑	

Tests Ordered

❑ Air Contrast: Obstruction Series ____ ❑ Chest X-ray ____ ❑ Flexisigmoidoscopy ____ ❑ TB Test ____

❑ Barium Enema ____ ❑ Colonoscopy ____ ❑ Kidney X-ray ____ ❑ UGI Series ____

❑ Blood Tests ____ ❑ Electrocardiogram ____ ❑ Liver Biopsy ____ ❑ Other ____

❑ CBC ____ ❑ ERCP ____ ❑ Mammogram ____

Notes

Payment Policy

Thank you for choosing **A+ FAMILY HEALTH** as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

A+ FAMILY HEALTH

NOTICE OF PRIVACY PRACTICES

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.**

Uses and Disclosures

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 Practice 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.

How We May Use and Disclose Medical Information About You.

The following describes examples of the way we may use and disclose medical information:

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 or reminder card unless requested otherwise.

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 preapproval 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 and 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. 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 and 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 of psychotherapy notes; PHI for marketing purposes unless we speak with you and disclosures that constitute a sale of PHI. If you provide an authorization to use or disclose medical information about you, 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 take back any disclosures we have already made with your authorization.

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.
Marketing and 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

If you are not present, able to agree or object to the use or disclosure (such as in an emergency situation), 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 copy of portable media (CD, USB) 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 and health care operations. 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.

To exercise any of your rights, please submit your request in writing to the practice's privacy officer indicated below.

For More Information or to Report a Problem
If you have questions and would like additional information please contact the Privacy Officer. 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: **ALNUR MASANI**
Address: 5010 Mile Stretch Drive
City / State / Zip: Holiday, FL. 34690
Telephone Number: (727) 943 9080
Fax Number: (727) 937 8411.

Effective Date: February 1, 2016.