Florida Ear & Balance Center, P.A.
Center of Excellence

James S. Atkins, Jr. M.D.
Board Certified Otolaryngology and Neurology

Dear patient:

We do everything possible to contact your insurance company to get accurate authorizations and benefits according to your plan. This allows us to give you accurate information regarding your out-of-pocket expenses for office visits, testing and surgical procedures that are medically necessary for your care.

Unfortunately, we have found it increasingly difficult to get a live person to get accurate information. Often the information that we're getting is from a website with poor accuracy. For this reason we encourage you to contact your insurance company to confirm the information that we receive.

We understand the frustration that occurs when inaccurate information is given to you by our office, especially when we tied up our office staff time trying to get the accurate information.

In the event that the information that we are given is inaccurate, you as the policyholder are responsible for the out-of-pocket expenses. If you have any questions regarding this policy please don't hesitate to ask the office staff.

James S. Atkins, M.D.

By signing, I acknowledge that I have read the letter above: X _____

Florida Ear and Balance Center, PA.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I _____ consent to the use of disclosure of my protected health information by Florida Ear and Balance Center, PA for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Florida Ear and Balance Center, PA. I understand that diagnosis or treatment of me by James S. Atkins, Jr. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Florida Ear and Balance Center, PA is not required to agree to the restrictions that I may request. However, if Florida Ear and Balance Center, PA agrees to a restriction that I request, the restriction is binding on Florida Ear and Balance Center, PA and James S. Atkins, Jr...

I have the right to revoke this consent, in writing, at any time, except to the extent that James S. Atkins, Jr. or Florida Ear and Balance Center, PA has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and creates or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Florida Ear and Balance Center, PA's Notice of Privacy Practices prior to signing this document. The Florida Ear and Balance Center, PA's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describe the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Florida Ear and Balance Center, PA. The Notice of Privacy Practices for Florida Ear and Balance Center, PA is also provided 410 Celebration Pl. Ste. 100 Celebration, Fl. 34747. This Notice of Privacy Practices also describes my rights and the Florida Ear and Balance Center, PA duties with respect to my protected health information.

Florida Ear and Balance Center, PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revises notice of privacy practices by accessing the Florida Ear and Balance Center, PA website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

Patient Name: _____ ____ DOB: _____ / _____ / _____

Date: _____ Age: _____

Reason for visit: _____

Have you had a hearing test within the last 6 months? _____ Where?_____

Please list any operations and date of the procedures:

Operation	Date

Social History

	YES	NO	DETAILS
Do you currently smoke?			
If not, have you previously?			
How often do you drink alcohol? What kind?			
Are you employed?			
Do you have a history of cancer?			
Are you routinely exposed to loud noises?			
Have you been exposed to loud noises in the past?			

Please select YES or NO to indicate if you have any of the following illnesses. If YES please explain

	YES	NO	EXPLAIN
Diabetes			
Hypertension			
Thyroid Problems			
Heart Disease/High cholesterol			
Respiratory Problems			
Bleeding Disorder			
Hepatitis			
Stomach or Intestinal Problems			
Allergy Problems / Therapy			
Kidney Problems			
Neurological Problems			
Immune Deficiency			
Other Medical Diagnosis			
History of IV antibiotic treatment			

If you were referred by a **DOCTOR** please list the doctor's name here : **_____**

What is the best number to reach you at should Dr. Atkins need to call_____

Family History

	YES	NO	RELATIVE
Hearing Problems			
Dizziness			
Neurological Disorder			
Diabetes			
Allergies			
Heart Problems			
Bleeding Disorder			
Cancer			
Anesthesia Problems			
Hypertension			

Current Symptoms

	YES	NO		YES	NO
Chills			Daytime sleepiness		
Fatigue			Sneezing fits		
Enviro Allergy			Facial weakness		
Post-Nasal Drip			Arm weakness		
Headache			Leg weakness		
Passing Out			Arm numbness		
Double Vision			Leg numbness		
Eye Pain / Pressure			Vision changes		
Watery / Itchy Eyes			Do you wear glasses?		
Ear Pain / Itch			Ear drainage		
Hearing Loss			Ear noises		
Dizziness			Lightheadedness		
Nasal congestion			Sinus pressure or pain		
Sense of smell problem			Problem snoring, Apnea		
Hoarseness of throat / voice			Throat pain		
Throat clearing problem			Throat dryness / Itching		
Cough			Coughing blood		
Wheezing			Shortness of breath		
Chest Pain			Palpitations		
Difficulty swallowing			Heartburn		
Frequent Urination			Blood in urine		
Swollen Glands			Sweating at night		
Bleeding Problems			Easy bruising		
Feeling warmer than others			Feeling cooler than others		
Joint Aches			Muscle aches		
Rash			Hives		
Itching of the skin			Skin changes		
Depression			Hair changes		
Weight Loss			Anxiety		
Weight Gain			Panic		

Florida Ear and Balance Center Patient Medication Record

Patient Name: _____ Date: _____

Drug Allergies: _____

Please list all medications both prescription and over the counter (include dosage, frequency, and purpose)

_____
_____
_____
_____
_____
_____
_____
_____
__

FOR OFFICE USE ONLY:

Date of visit	Medication Changes Y or N	If yes, please list changes	Reviewed by: (all providers initial here)

Meaningful Use Patient Form

Name _____ Date _____

☐ I am refusing to fill out this form _____

Signature of Patient

Email _____

PLEASE CIRCLE YOUR RESPONSE TO EACH

Ethnicity
Hispanic or Latino
Not Hispanic or Latino
Unknown

Smoking Status
Current every day smoker
Current some day smoker
Former Smoker
Never Smoker
Unknown

Race
American Indian or Alaska Native
Asian Indian
Asian Other
Black or African American
Chinese
Filipino
Guamanian
Hawaiian Native
Japanese
Korean
Multiple
Other
Pacific Islander – Other
Samoan
Unknown
Vietnamese
White

Preferred Language: _____

Preferred Pharmacy List

Pharmacy	Address	City	State	Zip

NOTICE OF PRIVACY PRACTICES

This Notice is effective on April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND

HOW YOU CAN GET ACCESS TO THIS INFORMATION.

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about health care we provide to you or payment for health care provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for all medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting area
- Have copies of the new Notice available upon request (you may always contact our Privacy Officer at *(321) 939-3000.*

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you
- Explain your rights with respect to medical information about you
- Describe how and where you may file a privacy-related complaint

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact our Privacy Officer at *(321) 939-3000.*

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

We use and disclose medical information about patients everyday. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide health care, obtain payment for that health care, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact our Privacy Officer at *(321) 939-3000.*

1. Treatment

We may use and disclose medical information about you to provide health care treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others.

***Example*:** Jane is a patient at the health department. The receptionist may use medical information about Jane when setting up an appointment. The nurse practitioner will likely use medical information about Jane when reviewing Jane's condition and ordering a blood test. The laboratory technician will likely use medical information about Jane when processing or reviewing her blood test results. If, after reviewing the results of the blood test, the nurse practitioner concludes that Jane should be referred to a specialist, the nurse may disclose medical information about Jane to the specialist to assist the specialist in providing appropriate care to Jane.

2. Payment

We may use and disclose medical information about you to obtain payment for health care services that you received. This means that, within the health department, we may use medical

information about you to arrange for payment (such as preparing bills and managing accounts). We also may disclose medical information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose medical information about you to an insurance plan before you receive certain health care services because, for example, we may want to know whether the insurance plan will pay for a particular service.

***Example*:** Jane is a patient at the health department and she has private insurance. During an appointment with a nurse practitioner, the nurse practitioner ordered a blood test. The health department billing clerk will use medical information about Jane when he prepares a bill for the services provided at the appointment and the blood test. Medical information about Jane will be disclosed to her insurance company when the billing clerk sends in the bill.

Example: The nurse practitioner referred Jane to a specialist. The specialist recommended several complicated and expensive tests. The specialist's billing clerk may contact Jane's insurance company before the specialist runs the tests to determine whether the plan would pay for the test.

3. Healthcare Operations

We may use and disclose medical information about you in performing a variety of business activities that we call "health care operations." These "health care operations" activities allow us to, for example, improve the quality of care we provide and reduce health care costs. For example, we may use or disclose medical information about you in performing the following activities:

- Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you.
- Providing training programs for students, trainees, health care providers or non-health care professionals to help them practice or improve their skills.
- Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities in a particular field or specialty.
- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
- Improving health care and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.
- Cooperating with outside organizations that assess the quality of the care others and we provide, including government agencies and private organizations.
- Planning for our organization's future operations.
- Resolving grievances within our organization.
- Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.

- Working with others (such as lawyers, accountants and other providers) who assist us to comply with this Notice and other applicable laws.

Example: Jane was diagnosed with diabetes. The health department used Jane's medical information – as well as medical information from all of the other health department patients diagnosed with diabetes – to develop an educational program to help patients recognize the early symptoms of diabetes. (Note: The educational program would not identify any specific patients without their permission).

Example: Jane complained that she did not receive appropriate health care. The health department reviewed Jane's record to evaluate the quality of the care provided to Jane. The health department also discussed Jane's care with an attorney.

4. Persons Involved in Your Care

We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. For more information on the privacy of minors' information, contact our Privacy Officer at *(321) 939-3000*.

We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

Example: Jane's husband regularly comes to the health department with Jane for her appointments and he helps her with her medication. When the nurse practitioner is discussing a new medication with Jane, Jane invites her husband to come into the private room. The nurse practitioner discusses the new medication with Jane and Jane's husband.

5. Required by Law

We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

6. National Priority Uses and Disclosures

When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the "national priority" activities recognized by law. For more information on these types of disclosures, contact our Privacy Officer at (321) 939-3000.

- **Threat to health or safety:** We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
- **Public health activities:** We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.
- **Abuse, neglect or domestic violence:** We may disclose medical information about you to a government authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect or domestic violence.
- **Health oversight activities:** We may disclose medical information about you to a health oversight agency – which is basically an agency responsible for overseeing the health care system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
- **Court proceedings:** We may disclose medical information about you to a court or an officer of the court (such as an attorney). For example, we would disclose medical information about you to a court if a judge orders us to do so.
- **Law enforcement:** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes. For example, we may

disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.

- **Coroners and others:** We may disclose medical information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye and tissue transplants.
- **Workers' compensation:** We may disclose medical information about you in order to comply with workers' compensation laws.
- **Research organizations:** We may use or disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
- **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans' activities and national security and intelligence activities. We may also use or disclose medical information about you to a correctional institution in some circumstances.

7. Authorization

Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Privacy Officer. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

YOU HAVE RIGHTS WITH RESPECT TO MEDICAL INFORMATION ABOUT YOU

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer at *(321) 939-3000.*

1. Right to a Copy of This Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Officer.

2. Right of Access to Inspect and Copy

You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain in certain groups of records. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing. You may write us a letter requesting access or fill out an Access Request Form. Access Request Forms are available from our Privacy Officer.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the information, we will charge you a fee to cover the costs of the copy. *$10.00.*

We may be able to provide you with a summary or explanation of the information. Contact our Privacy Officer for more information on these services and any possible additional fees.

3. Right to Have Medical Information Amended

You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information. You may either write us a letter requesting an amendment or fill out an Amendment Request Form. Amendment Request Forms are available from our Privacy Officer.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement

explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. Right to an Accounting of Disclosures We Have Made

You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an **Accounting Request Form**, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Officer.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or health care operations. It will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting. Fee of $20.00

5. Right to Request Restrictions on Uses and Disclosures

You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and health care operations.

We are <u>not</u> required to agree to your request.

If we do agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

6. Right to Request an Alternative Method of Contact

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an **Alternative Contact Request Form**. Alternative Contact Request Forms are available from our Privacy Officer.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a complaint either with us or with the federal government.

We will <u>not</u> take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with the health department, you may bring your complaint to the department or you may mail it to the following address:

Florida Ear and Balance Center, PA
410 Celebration Place, Suite 100
Celebration, FL 34747
(321) 939-3000

To file a complaint with the federal government, you may send your complaint to the following address:

(321) 939-3000
