Florida Dental Implants
& Oral Surgery

HEALTH HISTORY

PATIENT NAME: _____ **AGE:** _____

DATE OF BIRTH:_____ **GENDER:** ☐M ☐F **HEIGHT:** _____ **WEIGHT:** _____

ADDRESS: _____ **CITY:** _____ **ST:** _____ **ZIP:**_____

EMAIL:_____ **PHONE:** _____

GENERAL DENTIST: _____ **DENTIST PHONE:** _____

PRIMARY CARE PHYSICIAN/MD: _____ **PHYSICIAN PHONE:**_____

DATE OF LAST MEDICAL EXAM: _____ **CURRENT HEALTH:** GOOD | FAIR | POOR

Have you ever tested positive for COVID-19? ☐Yes ☐No If yes, when? _____ Vaccine? _____

PLEASE CHECK ALL THAT APPLY:

CARDIOVASCULAR

- ☐ Heart attack | Date: _____
- ☐ Heart Stent | Date: _____
- ☐ Chest pain/angina/pressure with activity
- ☐ Heart failure
- ☐ Heart surgery/Bypass | Date: _____
- ☐ Heart stent ☐In the last 6 months
- ☐ Implanted heart device
  ☐Pacemaker/LVAD ☐Defibrillator
- ☐ Artificial Heart Valve | Type: _____
- ☐ Transcatheter aortic valve replacement (TAVR) ☐Closed ☐Open
- ☐ Atrial Fibrillation
- ☐ Arrhythmia (Abnormal Heartbeat)
- ☐ Congenital Heart Disease
- ☐ Hypertension (High Blood Pressure)
- ☐ Murmur/Valve Noise
- ☐ Unable to climb 2 flights of stairs/walk 2 blocks due to chest pain/trouble breathing
- ☐ Pain in legs while walking
- ☐ Phlebitis or Blood Clots

CARDIOLOGIST _____

PHONE NUMBER _____

NEUROLOGICAL

- ☐ Stroke
- ☐ Aneurysm
- ☐ Seizure
- ☐ Paralysis
- ☐ Leg Pain
- ☐ Psychiatric Problems
- ☐ Epilepsy
- ☐ Spinal cord stimulator
- ☐ Fainted in the last year
- ☐ Parkinson's Disease
- ☐ Neuromuscular Disease

PULMONARY

- ☐ Oxygen at home
- ☐ Pulmonary Hypertension
- ☐ Trouble breathing at rest/Shortness of breath
- ☐ Asthma
- ☐ COPD
- ☐ Pneumonia (in last 2 mos)
- ☐ Tuberculosis
- ☐ Chronic cough
- ☐ Any other lung issues

PULMONOLOGIST_____

PHONE NUMBER _____

ALLERGIES

☐ Eggs ☐ Latex ☐ None

List all drug allergies: _____

_____

_____

MEDICATION

Have you **ever** taken:	YES	NO
Risedronate (Actonel®)	☐	☐
Ibandronate (Boniva®)	☐	☐
Alendronate (Fosamax®)	☐	☐
Pamidronate (Aredia®)	☐	☐
Zolendronate (Zometa®)	☐	☐
Zolendronate (Reclast®)	☐	☐
Denosumab (XGEVA®)	☐	☐
Bevacizumab (Avastin®)	☐	☐
Sunitnib (Sutent®)	☐	☐
Sorafenib (Nexavar®)	☐	☐
Denosumab (Prolia®)	☐	☐

How Long _____

Last Dose _____

PATIENT NAME: _____

GI/HEPATIC

- ☐ Hiatal Hernia
- ☐ Hepatitis ☐A ☐B ☐C
- ☐ Other Liver Disease

CANCER

- ☐ Melanoma
- ☐ Basal Cell
- ☐ Squamous Cell
- ☐ Radiation to head/neck
- ☐ Chemotherapy

If yes, last date of treatment:

_____

_____

_____

ORTHOPEDIC

- ☐ Artificial Replacement
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Osteoarthritis

Joints Affected: _____

_____

_____

- ☐ Fibromyalgia
- ☐ Rheumatoid

SOCIAL HISTORY

☐ Tobacco use
☐ Smokeless ☐ Smoking
How often? _____

☐ Marijuana
☐ Alcohol use
How often? _____

☐ Other illicit drugs
☐ Eating disorder

FEMALES

☐ Pregnant ☐ Trying to conceive
☐ Nursing

Last Menstrual Period: _____

TMJ

- ☐ Clicking of jaw joint
- ☐ Locking of the jaw
- ☐ Headaches

SLEEP APNEA

☐ Use of a CPAP

Do you sleep elevated with more than 1 pillow? ☐ YES ☐ NO
Do you **SNORE** loudly? ☐ YES ☐ NO
Often **TIRED**/Sleepy during the day? ☐ YES ☐ NO
Has anyone **OBSERVED** you stop breathing during sleep? ☐ YES ☐ NO

RENAL/ENDOCRINE

- ☐ Kidney Transplant
- ☐ Kidney Disease
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Graves
- ☐ Addisons
- ☐ Dialysis/Kidney Failure

Diabetes
☐ Type I ☐ Type II

Avg Blood Sugar Level:
_____ to _____
Insulin Pump ☐
Last AIC Level: _____

OTHER

- ☐ HIV
- ☐ Implanted Bladder
- ☐ Device
- ☐ Cochlear Implant
- ☐ Pain Pump
- ☐ Eye Disease
- ☐ Glaucoma
- ☐ Cataracts

Surgery Date: _____

- ☐ Macular Degeneration
- ☐ _____
- ☐ _____
- ☐ _____

GENERAL ANESTHESIA

YES	NO	
☐	☐	Have you or a blood relative ever had problems with general anesthesia, local anesthesia and or intravenous sedation? **PLEASE EXPLAIN** _____ _____
☐	☐	Have you ever been told you had a difficult intubation (placement of breathing tube)?
☐	☐	History of motion sickness/nausea/vomiting after surgery?
☐	☐	Are you sensitive to pain medication or sleeping pills?
☐	☐	Are you being treated for a chronic pain condition?
☐	☐	Difficulty walking? Do you use: ☐ Cane ☐ Walker ☐ Wheelchair

PATIENT NAME _____

PHARMACY NAME _____

LOCATION _____

PHONE _____

ALL Medications, Dosage, and Frequency ☐ **Check if you're not on any medications**

1.
2.
3.
4.
5.
6.
7.
8.

PAST SURGICAL HISTORY

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you wish to talk with the doctor privately about anything? _____

MUTUAL UNDERSTANDING

The statements on this form are true to the best of my knowledge.

_____

SIGNATURE - Patient or Legal Guardian (if minor) **PRINT NAME** - Patient or Legal Guardian **DATE**

(Office Use Only) Reviewed By: _____

Florida Dental Implants & Oral Surgery

FINANCIAL/INSURANCE

FINANCIAL

Payment is due at the time of service

I hereby authorize my insurance company to pay all benefits directly to Florida Dental Implants & Oral Surgery. I understand that execution of this agreement in no way relieves me of my financial responsibility.

SIGNATURE **PRINT NAME** **DATE**

By signing below, I understand that I am responsible for this account and agree to pay all unpaid balances, including a 1.5% service charge accrued monthly on all balances outstanding over 60 days.

SIGNATURE **PRINT NAME** **DATE**

INSURANCE

Patients Name_____ Name of Subscriber_____

Insurance Company_____

DOB of Subscriber_____ Employer of Subscriber_____

Group # or Social Security # of Subscriber_____

I acknowledge and understand that I will be provided an estimate obtained from my insurance company. I understand this information is **NOT A GUARANTEE OF PAYMENT.** Insurance companies pay based on "Reasonable & Customary" fee schedules, which often results in less payment than expected. I have been advised that Dr. Richards & Dr. Kirkpatrick are out of network providers for all dental/medical insurance companies. I acknowledge and understand that I will be billed and fully responsible for any amount due or balances on this account not covered by my insurance.

SIGNATURE **PRINT NAME** **DATE**

Florida Dental Implants & Oral Surgery

HIPAA

PATIENT HIPAA ACKNOWLEDGEMENT & DESIGNATION DISCLOSURE FORM

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

By signing below I acknowledge that I was provided a copy of the Notice of Privacy Practices(NPP), and that I have read(or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices(NPP) and agree to it's terms.

I AGREE THAT MY INFORMATION MAY BE LEFT VIA: ☐ VOICEMAIL ☐ TEXT ☐ EMAIL

PRINT PATIENT'S NAME **DOB**

SIGNATURE **DATE**

DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE:

I agree that the practice may disclose details of my health information to a personal Representative of my choosing since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

REPRESENTATIVE AUTHORIZED FOR DISCLOSURE OF INFO

REPRESENTATIVE AUTHORIZED FOR DISCLOSURE OF INFO

SIGNATURE **DATE**

WITNESS **DATE**

Florida Dental Implants & Oral Surgery

IMAGE CONSENT/MEDICATIONS

PRINT PATIENT'S NAME

I consent that my photograph or likeness (the "IMAGES" and the entire text of, excerpts from, or a part of any letters, e-mails or other communications I have sent to Musser, Richards & Kirkpatrick, L. L.C., d/b/a/Florida Dental Implants and Oral Surgery (the "Practice"), or any of its dentists or other personnel (the "Communications"), may be used by the Practice under the following conditions.

The Images, negatives, prints or copies thereof and the Communications may be used for educational, medical, marketing and promotional purposes for the Practice and its services, and its dentists. They may be published and republished, either separately or in connection with each other, on websites, in magazines, newspaper or other periodicals, television or other marketing and promotional materials of the Practice, or used for any lawful purpose that the Practice may deem appropriate.

I specifically consent to my procedure and treatment by the Practice being videotaped and authorize the Practice to use all or portions of such video for advertising purposes, whether on television, websites or any media or for any other lawful purpose that the Practice may deem appropriate.

I understand that the Images may be modified or retouched in any way that the Practice, in its discretion, may consider desirable, and that portions or excerpts of the Communication for use by the Practice may be determined as the Practice deems appropriate.

I understand that the Images and Communications received by the Practice are and will remain the exclusive property of the Practice and I will have not right, title or interest in them whatsoever.

By consenting to the use of the Images and the Communications as set forth above, I understand that I will not receive payment from any party. I understand that refusal to consent to use the Images and the Communication will in no way affect the medical care I will receive.

☐ **ACCEPT**

☐ **DECLINE**

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

SIGNATURE OF WITNESS **DATE**

MEDICATION ACKNOWLEDGEMENT

I _____ acknowledge that certain medications prescribed to me by Florida Dental Implants & Oral Surgery may alter my state of mental awareness and decision making. I understand that I should refrain from operating machinery or any type of motorized vehicle, consuming alcohol, and defer from making family or business decisions until I am no longer consuming these medications for 24 hours.

SIGNATURE **DATE**

Florida Dental Implants & Oral Surgery

DENTAL HISTORY

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

Please describe your current dental health: **EXCELLENT** | **GOOD** | **FAIR** | **POOR**

How did you hear about New Teeth Now?

☐ Internet ☐ Seminar/Webinar ☐ TV What station?_____
☐ Radio ☐ Referring Doctor ☐ Other

Is this your first consultation regarding dental implants? **YES** | **NO**

Please explain what symptoms or tooth related concerns prompted this visit.

☐ Difficulty chewing
☐ Pain
☐ Infected teeth
☐ Facial swelling
☐ Missing teeth
☐ Lack of social interaction
☐ Dentures/Partials
☐ Bad Breath
☐ Embarrassment
☐ Failing dental work
☐ Broken teeth
☐ Failing dental implants
☐ Other

COMMENTS:

_____

_____

Have you ever been diagnosed with periodontal disease? **YES** | **NO**

If Yes, do you currently have loose teeth? **YES** | **NO**

Please specify what treatment you are most interested in.

☐ Full Mouth ☐ Lower
☐ Upper ☐ Singles

DENTURES

How long have you worn dentures?_____
What is your chief complaint?

☐ Ill-Fitting/Pain ☐ Gag reflex
☐ Difficulty chewing ☐ Other: _____

Shade or mark the area(s) of your mouth that are in pain in the diagram below:

Notes:

_____

_____

_____

SIGNATURE **PRINT NAME** **DATE**

NOTICE OF PRIVACY PRACTICES

NEW TEETH NOW/FLORIDA DENTAL IMPLANTS & ORAL SURGERY

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

For purposes of this Notice "us" "we" and "our" refers to FDIOS and "you" or "your" refers to our patients (or their legal representatives as determined by us in accordance with Florida informed consent law). When you receive health-care services from us, we will obtain access to your medical information (e.g., your health history). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

Florida law and the Health Insurance Portability & Accountability Act of 1996 (HIPAA) require us to maintain the confidentiality of all your health-care records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally("PHI" or Protected Health Information). HIPAA is a federal law that gives you significant new rights to understand and control how your health information is used. HIPAA and Florida law provide penalties for covered entities and records owners, respectively, that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPAA requires us to provide you with this Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for health-care services. If you have any questions about this Notice, please ask to speak to our privacy officer, Tom Kane at 863-665-8878.

Our doctors, clinical staff, Business Associates (outside contractors we hire), employees and other office personnel follow the policies and procedures set forth in this notice. If your regular doctor is unavailable to assist you (e.g. illness, on-call coverage, vacation, etc.), we may provide you with the name of another health-care provider outside our practice for you to consult with by telephone. If we do so, that provider will follow the policies and procedures set forth in this notice or those established for his or her practice, so long as they substantially conform to those for our practice.

OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law (§456.074, Fla. Stats., and HIPAA), we must have your signature on a written, dated Consent form and/ or an Authorization form (not an Acknowledgment form) before we will use and disclose your PHI for certain purposes as detailed in the rules below.

Documentation you will be asked to sign a Consent form and/or an Authorization form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our privacy officer. You may take back or revoke your Consent or Authorization at any time (unless we already have acted based on it) by submitting our revocation form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (e.g., if after we provide services to you, you revoke your Authorization or Consent in order to prevent us billing or collecting for those services, your revocation will have no effect because we relied on your Authorization or Consent to provide services before you revoked it).

General Rule if you do not sign our Consent form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone

(Excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. Under Florida law, we are unable to submit claims to payers under assignment of benefits without your signature on our Consent form. We will not condition treatment on your signing an Authorization, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the Consent or Revoke it.

Health-care Treatment, Payment and Operations Rule

With your signed Consent, we may use or disclose your PHI in order:

To provide you with or coordinate health-care treatment and services. For example, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other health-care providers, schedule lab work for you, etc.;

To bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations form your health plan or provide your X-rays because your health plan requires them for payment; or

To run our office, assess the quality of care our patients receive and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you by telephone, mail or otherwise remind you of scheduled appointments, we may leave messages with whomever answers your telephone or e-mail to contact us (but we will not give out detailed PHI), we may call you by name from the waiting room, we may ask you to put your name on a sign-in sheet, we may tell

you about or recommend health-related products and complementary or alternative treatments that may interest you, we may review your PHI to evaluate our staff's performance, or our privacy officer may review your records to assist you with complaints. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, please notify us in writing at our address listed above and we will not use or disclose your PHI for these purposes. Special Rules Notwithstanding anything else contained in this Notice, only in accordance with applicable law, and under strictly limited circumstances, we may use or disclose your PHI without your permission, Consent or Authorization for the following purposes:

When required under federal, state or local law;

When necessary in emergencies to prevent a serious threat to your health and safety or the health and safety of other persons;

When necessary for public health reasons (e.g., prevention or control of disease, injury or disability; reporting information such as adverse reactions to anesthesia; ineffective or dangerous medications or products; suspected abuse, neglect or exploitation of children, disabled adults or the elderly; or domestic violence);

For federal or state government health-care oversight activities (e.g., civil rights laws, fraud and abuse investigations, audits, investigations, inspections, licensure or permitting, government programs, etc.);

For judicial and administrative proceedings and law enforcement purposes (e.g., in response to a warrant, subpoena or court order; by providing PHI to coroners, medical examiners and funeral directors to locate missing persons, identify deceased persons or determine cause of death);

For workers' compensation purposes (e.g., we may disclose your PHI if you have claimed health benefits for a work related injury or illness);

For intelligence, counterintelligence or other national security purposes (e.g., Veterans Affairs, U.S. military command, other government authorities or foreign military authorities may require us to release PHI about you);

For organ and tissue donation (e.g., if you are an organ donor we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation);

For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality (e.g., if the researcher will have access to your PHI because involved in your clinical care, we will ask you to sign an Authorization);

To create a collection of information that is "de-identified" (e.g., it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you);

To family members, friends and others, but only if you verbally give permission; we give you an opportunity to object and you do not; we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (e.g., you bring someone with you into the operatory or exam room during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (e.g., to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (e.g., your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI, but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed.

Minimum Necessary Rule Our staff will not use or access your PHI unless it is necessary to do their jobs (e.g., doctors uninvolved in your care will not access your PHI; ancillary clinical staff caring for you will not access your billing information; billing staff will not access your PHI except as needed to complete the claim form for the latest visit;

Janitorial staff will not access your PHI). Also, we disclose to others outside our staff only as much of your PHI as is necessary to accomplish the recipient's lawful purposes. For example, we may use and disclose the entire contents of your medical record:

To you (and your legal representatives as stated above) and anyone else you list on a Consent or Authorization to receive a copy of your records; To health-care providers for treatment purposes (e.g. making diagnosis and treatment decisions or agreeing with prior recommendations in the medical record); To the U.S. Department of Health and Human Services (e.g., in connection with a HIPAA complaint); To others as required under federal or Florida law; To our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPAA (e.g., clerks who copy records need access to your entire medical record).

In accordance with the law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requester's purpose. Our privacy officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For non-routine requests or disclosures, the Plan's Privacy Officer will make a minimum necessary determination based on, but not limited to, the following factors: The amount of information being disclosed; The number of individuals or entities to whom the information is being disclosed; The importance of the use or disclosure; The likelihood of further disclosure;

Whether the same result could be achieved with de-identified information;

The technology available to protect confidentiality of the information; and

The cost to implement administrative, technical and security procedures to protect confidentiality.

If we believe that a request from others for disclosure of your entire medical record is unnecessary, we will ask the requester to document why this is needed, retain that documentation and make it available to you upon request. Incidental Disclosure Rule We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it (e.g., we require employees to talk softly when discussing PHI with you, we use computer passwords and change them periodically [e.g., when an employee leaves us], we allow access to areas where PHI is stored or filed only when we are present to supervise and prevent unauthorized access).

Business Associate Rule Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure. Nothing in our Business Associate agreement will allow our Business Associate to violate this re-disclosure Prohibition. Super-confidential Information Rule If we have PHI about you regarding HIV testing, alcohol or substance abuse diagnose is and treatment, or psychotherapy and mental health records (super-confidential information under the law), we will not disclose it under the General or Health-care Treatment, Payment and Operations Rules (see above) without you first signing and properly completing our Consent form (i.e., you specifically must initial the type of super-confidential information we are allowed to disclose). If you do not specifically authorize disclosure by initialing the super-confidential information, we will not disclose it unless authorized under the Special Rules (see above) (e.g., we are required by law to disclose it). If we disclose super-confidential information (either because you have initialed the Consent form or the Special Rules authorize us to do so), we will comply with state and federal law that requires us to warn the recipient in writing that re-disclosure is prohibited.

Changes to Privacy Policies Rule We reserve the right to change our privacy practices (by changing the terms of this Notice) at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past (i.e., to PHI about you that we had before the changes took effect). If we make changes, we will post the changed Notice, along with its effective date, in our office. Also, upon request, you will be given a copy of our current Notice.

Authorization Rule We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on a specifically worded, written Authorization form (not a Consent or an Acknowledgement).

If we need your Authorization, we must obtain it on our Authorization form, which is separate from any Consent or Acknowledgment we may have obtained from you. We will not condition treatment on whether you sign the Authorization (or not).

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

If you got this Notice via e-mail or web-site, you have the right to get, at any time, a paper copy by asking our privacy officer. Also, you have the following additional rights regarding PHI we maintain about you:

To Inspect and Copy You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to our privacy officer on our Request to Inspect, Copy or Summarize form.

Original records will not leave the premises, will be available for inspection only during our regular business hours, and only if our privacy officer is present at all times. You may ask us to give you the copies in a format other than photocopies (and we will do so unless we determine that it is impracticable) or ask us to prepare a summary in lieu of the copies. We may charge you a fee not to exceed Florida law to recover our costs (including postage, supplies and staff time as applicable, but excluding staff time for search and retrieval) to duplicate or summarize your PHI. We will not condition release of the copies or summary on payment of your outstanding balance for professional services (if you have one), but we may condition release of the copies or summary on payment of the copying fees. We will respond to requests in a timely manner, without delay for legal review, in less than thirty days if submitted in writing on our form or otherwise, and in ten business days or less if malpractice litigation or pre-suit production is involved.

We may deny your request in certain limited circumstances (e.g., we do not have the PHI; it came from a confidential source, etc). If we deny your request, you may ask for a review of that decision. If required by law, we will select a licensed health-care professional (other than the person who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed health-care professional who is not affiliated with us, we will ensure a Business Associate agreement is executed that prevents re-disclosure of your PHI without your consent by the outside professional.

To Request Amendment / Correction If another doctor involved in your care tells us in writing to change your PHI, we will do so as expeditiously as possible upon receipt of the changes and will send you written confirmation that we have made the changes. If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it (so long as we have it) by submitting a Request for Amendment / Correction form to our privacy officer. We normally will act on your request within 60 days from receipt, but we may extend our response time (within the 60-day period) no more than once and by no more than 30 days, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within five business days, make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language, and send the changes within 5 business days to persons you ask us to and persons we know may rely on incorrect or incomplete PHI to your detriment (or already have). We may deny your request under certain circumstances (e.g., it is not in writing, it does not give a reason why you want the change, we did not create the PHI you want changed (and the entity that did can be contacted), it was compiled for use in litigation, or we determine it is accurate and complete). If we deny your request, we will (in

writing within 5 business days) tell you: why and how to file a complaint with us if you disagree, that you may submit a written disagreement with our denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosures of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Services.

To an Accounting of Disclosures You may ask us for a list of those who got your PHI from us by submitting a Request for Accounting of Disclosures form to us. The list will not cover some disclosures (e.g. PHI given to you, given to your legal representative, given to others for treatment, payment or health-care-operations purposes). Your request must state in what form you want the list (e.g., paper or electronically) and the time period you want us to cover, which may be up to no more than the last six years (excluding dates before April 14, 2003). If you ask us for this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you want to withdraw or modify your request to avoid the cost.

To Request Restrictions You may ask us to limit how your PHI is used and disclosed (i.e. in addition to our rules as set forth in this Notice) by submitting a written Request for Restrictions on Use / Disclosure form to us (e.g., you may not want us to disclose your surgery to family members or friends involved in paying for our services or providing your homecare). If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations. Also, in some circumstances we may be unable to grant your request (e.g., we are required by law to use or disclose your PHI in a manner that you want restricted; you signed an Authorization form, which you may revoke, that allows us to use or disclose your PHI in the manner you want restricted; in an emergency).

To Request Alternative Communications You may ask us to communicate with you in a different way or at a different place by submitting a written Request for Alternative Communication form to us. We will not ask you why and we will accommodate all reasonable requests (including, e.g., to send appointment reminders in closed envelopes rather than by postcards, to send your PHI to a post office box instead of your home address, to communicate with you at a telephone number other than your home number). You must tell us the alternative means or location you want us to use and explain to our satisfaction how payments to us will be made if we communicate with you as you request.

To complain or Get More Information we will follow our rules as set forth in this Notice. If you want more information or if you believe your privacy rights have been violated (e.g., you disagree with a decision of ours about inspection / copying, amendment / correction, accounting of disclosures, restrictions or alternative communications), we want to make it right. We never will penalize you for filing a complaint. To do so, please file a formal, written complaint within 180 days with:

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Ave., S.W.

Washington, D.C. 20201

(877) 696-6775 (toll free)

Or, submit a written Complaint form to us at the following address:

FDIOS

Attn: Dianne Stickler, Privacy Officer

2150 Harden Blvd

Lakeland, FL 33803

863-665-8878 (Phone)

863-665-1064 (Fax)

You may get your complaint form by calling our privacy officer. These privacy practices will be effective April 14, 2003, and will remain in effect until we replace them as specified above.