Welcome!

We are thrilled that you chose us.

Our goal is simple: we want to keep you healthy. To do that, we follow a special approach to keep us on track:

- ✓ **We will see you in the office for four check-ups per year.**
- ✓ **Our schedule will always be open when you need to be seen – *Just Call Us!***
- ✓ **We are on call for your urgent care needs – both nights and weekends.**
- ✓ **We will conduct an annual wellness and comprehensive health review.**
- ✓ **We use a Screening Test Evaluation Program (STEP) for early detection of disease.**

Next Steps:

To help us prepare for your first visit, we will contact you ahead of time for any initial requirements. At your first visit, we will introduce you to our clinic and our team, show you to your exam room, then collect a few more details about you and your health. After that, you will meet with your provider. To help make the most of your first visit, please bring the following with you:

1. **ID Card**
2. **Insurance Card**
3. **All medications**
4. **Full Name(s) and Phone Number(s) for others we can contact in case of emergency**
5. **Full Name(s) of any others you give us permission to speak with about your health**
6. **Name and contact information for any other doctors you currently see**
7. **Name and Address of your pharmacy**

We are excited to start this journey to better health with you!

Your Partner In Better Health!

MEDICAL RECORDS RELEASE

RECORDS FAX#: 1-850-972-9891

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Records to be released from: _____ NO DISCS PLEASE

Fax #: _____ Phone #: _____

Patient Name: _____

DOB: _____ S. S. Number: - -

I authorize and request the disclosure of all protected information for the purpose of review and evaluation from the above-named doctor or healthcare provider to:

Requesting Provider: _____ Provider Phone: _____

Requested Information (if more than 25 pages please mail):

Dates from _____ to _____

- ☐ **All Records**
- ☐ **Office Visit Notes - last two only**
- ☐ **Cardiology Reports Only**
- ☐ **Consult Notes Only**
- ☐ **Office Notes Only**
- ☐ **Lab Reports Only**
- ☐ **Radiology Reports Only**
- ☐ **Hospital Records Only**
- ☐ **Other: _____**

_____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient. I understand that a copy of this authorization may be used with the same effectiveness as an original. I understand the information in my health record may include information relating to sexually transmitted disease and other reportable disease, AIDS/HIV. It may also include psychiatric or mental health services, and treatment for alcohol and drug abuse. By not selecting any of these options below, I understand sexually transmitted diseases, mental health, and drug abuse will not be disclosed.

I further authorize the release of following information which may be included in my medical records:

- ☐ **Alcohol/Substance Abuse Treatment**
- ☐ **Mental Health Information (Excluding Psychotherapy)**
- ☐ **Psychotherapy Notes**
- ☐ **STD/HIV/AIDS-related Information**
- ☐ **Genetic Testing**

HIPAA REQUIRED STATEMENTS: I understand the following (see CFR 164.508(c)(2)(i-iii)):

• I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance on this authorization.

• The information released in response to this authorization may be re-disclosed to other parties.

• My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____ _____

Name of Legally Authorized Representative for Patient **Relationship to Patient**

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

(Initial Here)____ RELEASE OF INFORMATION — I, the below named patient, do hereby authorize any physicians examining and/or treating me to release to any third party including payors such as an insurance company or governmental agencies, e.g. Blue Cross Blue Shield of Florida or Medicare, any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

(Initial Here)____ PHYSICIAN INSURANCE ASSIGNMENT — I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

(Initial Here)____ MEDICARE/MEDICAID — Patient's certification authorization to release information and payment requests. I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

(Initial Here)____ PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE — The assignment will remain in effect until revoked by me in writing.

(Initial Here)____ CONSENT FOR TREATMENT — I, the below named patient hereby give my consent for treatment to all physicians associated with Florida Medical Associates, LLC dba SaludVIP/VIPcare.

CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS — I, the below named patient, do hereby authorize Florida Medical Associates, LLC dba SaludVIP/VIPcare to discuss my medical condition with, or release my medical records to the below named person (s):

NAME: _____ Relationship: _____ Phone: _____

NAME: _____ Relationship: _____ Phone: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. By signing below, I understand it's my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed 60 days. All entities partnered with Florida Medical Associates, LLC dba SaludVIP/VIPcare are covered under this document.

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

_____ _____

Name of Legally Authorized Representative for Patient **Relationship to Patient**

HIPAA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have received Florida Medical Associates, LLC dba SaludVIP/VIPcare HIPAA Notice of Privacy Practices.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This notice will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by asking our Privacy Officer, Ram Moorthy. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.
Disclosure: We may disclose and/or share your health care information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.
Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.
Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.
Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers, and individuals performing similar activities.
Required by Law: We may use or disclose your health information when we are required to do so by law: court or administrative orders, subpoena, discovery request or other lawful process. We will use and disclose your information when requested by national security intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.
Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury and/or disability.
Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.
National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information, and that of an individual for whom you are a legal guardian. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page up to 25 pages, then 25 cents each page thereafter, and the staff time charged will be $50.00 per hour including the time required to locate and copy your health information. If you want the copies mailed if you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.
Amendment: You have the right to amend your health care information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.
Non-Routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back six (6) years starting on April 14. 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.
HOW TO CONTACT US: Privacy Officer: Ram Moorthy Practice Name: Florida Medical Associates, LLC dba SaludVIP/VIPcare PO Box 173126, Tampa FL 33672
Phone: 352-433-4477 Fax: 1-888-978-5669 Website: www.getvipcare.com

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

_____ _____

Name of Legally Authorized Representative for Patient **Relationship to Patient**

DEMOGRAPHICS FORM

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Preferred Language: _____

Emergency Contact Name: _____

Relationship to Patient: _____

Emergency Contact Address: _____

Emergency Contact Primary Phone: _____

Emergency Contact Cell Phone: _____

Current Pharmacy Name: _____

Current Pharmacy Location: _____

Current Pharmacy Phone: _____