PATIENT INFORMATION

DATE: _____ OFFICE CO-PAY VISIT AMOUNT: $ _____

NAME AND CONTACT INFORMATION

LAST: _____ FIRST: _____ MIDDLE: _____

STREET ADDRESS: _____ UNIT/APARTMENT: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ MOBILE PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

EMPLOYMENT

EMPLOYER NAME: _____ PHONE: _____

STREET ADDRESS: _____ UNIT/APARTMENT: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE/BILLING

SOCIAL SECURITY NUMBER: _____ – _____ – _____ DATE OF BIRTH: ____ / ____ / _____

PRIMARY INSURANCE: _____ POLICY #: _____

SECONDARY INSURANCE: _____ POLICY #: _____

GUARANTOR/RESPONSIBLE PARTY

NAME: _____

RELATIONSHIP TO PATIENT: _____

SOCIAL SECURITY NUMBER: _____ – _____ – _____ DATE OF BIRTH: ____ / ____ / _____

DEMOGRAPHICS

MARITAL STATUS:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

GENDER:
- ☐ Male
- ☐ Female

RACE (check all that apply):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other: _____

ETHNICITY (check one):
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

ADDRESS (IF DIFFERENT): _____

HOME PHONE: _____ MOBILE PHONE: _____ WORK PHONE: _____

EMPLOYER NAME: _____ PHONE: _____

MEDICAL

REFERRING PHYSICIAN: _____ PHONE: _____

REASON FOR TODAY'S VISIT: _____

KNOWN MEDICAL PROBLEMS: _____

_____

MEDICATION ALLERGIES: _____

PHARMACY NAME: _____ PHONE: _____

EMERGENCY CONTACT - Who should be notified in case of an emergency? Please provide a number other than your home phone.

NAME: _____ PHONE: _____ RELATIONSHIP: _____

I understand that I am responsible for all charges for services unless arrangements are made prior to services being provided. Payment is expected at time of service. I guarantee that the above information is correct. I will notify this office if any changes occur.

Please allow front desk staff to copy your insurance card(s) if you would like to have our office file your insurance as a courtesy. Our filing will in no way relinquish you of your responsibility for payment of these services should they not be paid by your insurance carrier in a timely and reasonable manner.

HEALTH HISTORY

WELCOME TO PALM AESTHETICS. PROVIDE THE FOLLOWING INFORMATION TO THE BEST OF YOUR ABILITY. **PLEASE COMPLETE FRONT AND BACK.**

DATE: _____ **PATIENT #:** _____

PATIENT NAME: _____ **DATE OF BIRTH:** ____ / ____ / _____

REASON FOR VISIT: _____

HISTORY OF PRESENT ILLNESS

LOCATION: _____ **QUALITY:** _____

SEVERITY: _____ **DURATION:** _____

TIMING: _____ **CONTEXT:** _____

ASSOCIATED SIGNS/SYMPTOMS: _____ **MODIFYING FACTORS:** _____

OTHER ASSOCIATED PROBLEMS: _____

WHAT MAKES THE PROBLEM WORSE OR BETTER? _____

PAST MEDICAL HISTORY

Circle "yes" or "no" to indicate if you have had any of the following diseases/conditions. Leave blank if uncertain.

AIDS or HIV	Yes No	Diabetes	Yes No	Low blood pressure	Yes No	Transfusions	Yes No
Anemia	Yes No	Diphtheria	Yes No	Measles	Yes No	Tuberculosis	Yes No
Arthritis	Yes No	Epilepsy	Yes No	Migraine headache	Yes No	Ulcer	Yes No
Asthma	Yes No	Glaucoma	Yes No	Mitral valve prolapse	Yes No	Venereal disease	Yes No
Back trouble	Yes No	Heart disease	Yes No	Mumps	Yes No	Whooping cough	Yes No
Bladder infection	Yes No	Hemorrhoids	Yes No	Pneumonia	Yes No		
Bleeding tendency	Yes No	Hepatitis	Yes No	Polio	Yes No	List any other diseases/conditions:	
Blood or plasma transfusion	Yes No	Hernia	Yes No	Rheumatic fever	Yes No	_____	
Bronchitis	Yes No	High blood pressure	Yes No	Scarlet fever	Yes No	_____	
Cancer	Yes No	Hives or eczema	Yes No	Small pox	Yes No	_____	
Chicken pox	Yes No	Infectious mono	Yes No	Stroke	Yes No		
Date of last chest x-ray: _____		Kidney disease	Yes No	Thyroid disease	Yes No		

PREVIOUS HOSPITALIZATIONS/SERIOUS ILLNESSES/SURGERIES	WHEN?	HOSPITAL, CITY, STATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS (prescription and non-prescription) _____

_____

SOCIAL HISTORY

MARITAL STATUS:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

ALCOHOL USE:
- ☐ Never
- ☐ Rarely
- ☐ Monthly (# of drinks:____)
- ☐ Weekly (# of drinks:____)
- ☐ Daily (# of drinks:____)

TOBACCO USE:
- ☐ No (never)
- ☐ No (former), quit date:_____
- ☐ Yes (list amount and frequency)

_____

DRUGS:
- ☐ Never
- ☐ Yes (list type and frequency)

_____

_____

EXCESSIVE EXPOSURE TO:
- ☐ Fumes
- ☐ Dust
- ☐ Solvents
- ☐ Airborne particles
- ☐ Noise

FAMILY MEDICAL HISTORY

	AGE	DISEASES	CAUSE OF DEATH (IF DECEASED)
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
SIBLINGS	_____	_____	_____
	_____	_____	_____
SPOUSE	_____	_____	_____
CHILDREN	_____	_____	_____
	_____	_____	_____

HEALTH HISTORY

REVIEW OF SYMPTOMS (Please indicate any personal history below)

ALLERGIC/IMMUNOLOGIC
History of skin reaction or other adverse reaction to:
- Aspirin or other pain remedies ..... Yes No
- Iodine, Merthiolate or other antiseptic ..... Yes No
- Morphine, Demerol or other narcotics ..... Yes No
- Novocain or other anesthetics ..... Yes No
- Penicillin or other antibiotics ..... Yes No
- Tetanus antitoxin or other serums ..... Yes No
- Other drugs/medications: _____
  _____
  _____
- Known food allergies: _____
  _____
  _____
- Environmental allergies: _____
  _____
  _____

CARDIOVASCULAR
- Chest pain or angina pectoris ..... Yes No
- Heart trouble ..... Yes No
- Palpitation ..... Yes No
- Shortness of breath (walking or lying flat) ..... Yes No
- Swelling of feet, ankles or hands ..... Yes No

CONSTITUTIONAL SYMPTOMS
- Fatigue ..... Yes No
- Fever ..... Yes No
- Good general health lately ..... Yes No
- Headaches ..... Yes No
- Recent weight change ..... Yes No

EARS/NOSE/MOUTH/THROAT
- Bad breath or bad taste ..... Yes No
- Bleeding gums ..... Yes No
- Chronic sinus problem or rhinitis ..... Yes No
- Earaches or drainage ..... Yes No
- Hearing loss or ringing ..... Yes No
- Mouth sores ..... Yes No
- Nose Bleeds ..... Yes No
- Sore throat or voice change ..... Yes No
- Swollen glands in neck ..... Yes No

ENDOCRINE
- Change in hat or glove size ..... Yes No
- Excessive thirst or urination ..... Yes No
- Glandular or hormone problem ..... Yes No
- Heat or cold intolerance ..... Yes No
- Skin becoming dryer ..... Yes No

EYES
- Blurred or double vision ..... Yes No
- Eye disease or injury ..... Yes No
- Wear glasses/contact lenses ..... Yes No

GASTROINTESTINAL
- Date of last colonoscopy: _____
- Abdominal pain ..... Yes No
- Change in bowel movements ..... Yes No
- Frequent diarrhea ..... Yes No
- Loss of appetite ..... Yes No
- Nausea or vomiting ..... Yes No
- Painful bowel movements or constipation ... Yes No
- Rectal bleeding or blood in stool ..... Yes No

GENITOURINARY
- Blood in urine ..... Yes No
- Burning or painful urination ..... Yes No
- Change in force of strain when urinating ..... Yes No
- Frequent urination ..... Yes No
- Incontinence or dribbling ..... Yes No
- Kidney stones ..... Yes No

Male patients only:
- Testicular pain ..... Yes No

Female patients only:
- Date of last mammogram: _____
- Date of last Pap smear: _____
- Number of pregnancies: _____
- Number of miscarriages: _____

HEMATOLOGIC/LYMPHATIC
- Anemia ..... Yes No
- Bleeding or bruising tendency ..... Yes No
- Enlarged glands ..... Yes No
- Past transfusion ..... Yes No
- Phlebitis ..... Yes No
- Slow to heal after cuts ..... Yes No

INTEGUMENTARY (SKIN, BREAST)
- Breast discharge ..... Yes No
- Breast lump ..... Yes No
- Breast pain ..... Yes No
- Change in hair or nails ..... Yes No
- Change in skin color ..... Yes No
- Rash or itching ..... Yes No
- Varicose veins ..... Yes No

MUSCULOSKELETAL
- Back pain ..... Yes No
- Cold extremities ..... Yes No
- Difficulty in walking ..... Yes No
- Joint pain ..... Yes No
- Joint stiffness or swelling ..... Yes No
- Muscle pain or cramps ..... Yes No
- Weakness of muscles or joints ..... Yes No

NEUROLOGICAL
- Convulsions or seizures ..... Yes No
- Frequent or recurring headaches ..... Yes No
- Head injury ..... Yes No
- Light headed or dizzy ..... Yes No
- Numbness or tingling sensations ..... Yes No
- Paralysis ..... Yes No
- Tremors ..... Yes No

PSYCHIATRIC
- Depression ..... Yes No
- Insomnia ..... Yes No
- Memory loss or confusion ..... Yes No
- Nervousness ..... Yes No

RESPIRATORY
- Date of last flu shot: _____
- Persistent cough or throat clearing not associated with a known illness lasting more than three weeks ..... Yes No
- Shortness of breath ..... Yes No
- Spitting up blood ..... Yes No
- Wheezing ..... Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____
SIGNATURE OF PHYSICIAN DATE

PALM AESTHETICS
PLASTIC SURGERY CENTER

6310 Health Parkway, Suite 110 | Lakewood Ranch, FL 34202
PHONE (941) 822-8955 | **FAX** (941) 822-8684 | PalmAesthetics.com

PALM AESTHETICS
PLASTIC SURGERY CENTER

REQUEST FOR RELEASE OF MEDICAL RECORDS FOR TREATMENT PURPOSES

To Whom It May Concern:
The individual identified below is a patient of Palm Aesthetics Plastic Surgery Center and has consented to your release of his/her medical records to our practice for purposes of treatment. Accordingly, please provide the information as indicated below. Contact us with any questions: (941) 822-8955
Thank You
Palm Aesthetics

PATIENT - FULL LEGAL NAME (FIRST M.I. LAST) _____ DATE OF BIRTH (MM/DD/YYYY) _____

OBTAIN FROM	SEND OR FAX TO
PHYSICIAN/ORGANIZATION	PHYSICIAN/ORGANIZATION
ATTENTION	ATTENTION
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
PHONE	PHONE
FAX	FAX

INFORMATION TO BE RELEASED

I hereby consent to the release of the following information from/to the individual(s)/organization(s) as indicated above:

- ☐ All Dates
- ☐ Specific Dates: _____ through _____
- ☐ All Records
- ☐ Imaging/X-Ray
- ☐ Operative Note
- ☐ Discharge Summary
- ☐ Laboratory Report
- ☐ Progress Notes
- ☐ History & Physical
- ☐ Medication Records
- ☐ Other: _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____ TODAY'S DATE (MM/DD/YYYY) _____

If signed by Legal Representative:

RELATIONSHIP TO PATIENT/AUTHORITY TO SIGN _____ REASON PATIENT UNABLE TO SIGN _____

LEGAL REPRESENTATIVE'S ADDRESS _____ LEGAL REPRESENTATIVE'S PHONE NUMBER _____

Verbal Consent Received from Capable Patient if Unable to Sign: ☐ Yes

PALM AESTHETICS
PLASTIC SURGERY CENTER

Patient Communication Preference Form, Designation of Individuals Involved in Care/Treatment and Indication of Personal Representative

PATIENT - FULL LEGAL NAME (FIRST M.I. LAST) _____ DATE OF BIRTH (MM/DD/YYYY) _____

PATIENT COMMUNICATION(S) PREFERENCE REQUEST

I request and authorize Palm Aesthetics ("Palm") to communicate with me regarding my health care treatment and payment (including, but not limited to information such as appointment reminders, billing information, and lab/X-Ray results) as indicated below:

- ☐ Fax
- ☐ Message on Answering Machine/Voicemail
- ☐ Pick-up Forms on My Behalf
- ☐ Secure Encrypted E-mail
- ☐ Secure Encrypted Text Message
- ☐ Standard US Postal Mail

Please provide the following information for the manner(s) selected above:

PHONE (HOME) _____ PHONE (CELL) _____

ADDRESS, CITY, STATE, ZIP _____

E-MAIL _____

DESIGNATION OF INDIVIDUAL(S) INVOVLED IN YOUR CARE/TREATMENT

As a patient, you may designate one or more individuals with whom we may share Protected Health Information/Personal Identifying Information (PHI/PII) about you related to their involvement in your care/treatment or payment for your care/treatment. PHI/PII includes information about your current medical condition and diagnosis, treatment and prognosis, and billing and payments. Such individual(s) might be a spouse, relative, domestic partner, or friend. You can remove or add individuals at any time, including during treatment.

I authorize Palm to share PHI/PII about me with the individuals below related to their involvement in my care/treatment or payment for my care/treatment (attach additional pages if needed):

NAME (FIRST M.I. LAST) _____

RELATIONSHIP TO PATIENT _____

ADDRESS, CITY, STATE, ZIP _____

E-MAIL _____

PHONE NUMBER _____

NAME (FIRST M.I. LAST)

RELATIONSHIP TO PATIENT

ADDRESS, CITY, STATE, ZIP

E-MAIL

PHONE NUMBER

NAME (FIRST M.I. LAST)

RELATIONSHIP TO PATIENT

ADDRESS, CITY, STATE, ZIP

E-MAIL

PHONE NUMBER

INDICATION OF LEGAL REPRESENTATIVE

You may also indicate your Legal Representative below. A Legal Representative is a person who has authority under applicable law to act on your behalf in making decisions related to health care if you become incapacitated or unable to make decisions on your own, for example, a "health care agent" or "attorney in fact" under a Durable Power of Attorney for Health Care. We will treat such person the same as we would treat you with respect to PHI/PII relevant to such personal representation. We may ask for documentation to verify that a Legal Representative has appropriate legal authority to act for you before disclosing PHI/PII about you.

Please Initial One:

_____ I **do not wish** to indicate my Legal Representative. I understand that the Palm healthcare team may identify a Legal Representative for me in certain circumstances in accordance with applicable law, for example if I become incapacitated or am unable to make decisions on my own and designating a Legal Representative will expedite or enhance my care as a patient.

_____ I **do wish** to indicate my Legal Representative as the following person for purpose of making decisions related to health care:

LEGAL REPRESENTATIVE - FULL LEGAL NAME (FIRST M.I. LAST)

SIGNATURE

By signing this form, I authorize Palm to disclose information about me as indicated above. I understand that I may change the information provided in this form at any time by submitting changes in writing to Palm. I understand that changes will not be effective related to information previously disclosed, but will be effective going forward.

This authorization will expire (**SELECT ONE**):

☐ on the _____ day of _____, 20_____, or

☐ upon the occurrence of the following event or condition: _____; provided, however, that if no event or condition is listed, it will expire ten (10) years from the date I sign below.

I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to Palm at 6310 Health Park Way, Suite 110, Lakewood Ranch, FL 34202.

I understand that any such revocation will not apply to information that has already been released in response to or in reliance upon this Authorization.

I understand that I may refuse to sign this Authorization and that my refusal will not affect my health care treatment, payment, health plan enrollment, or eligibility for benefits.

I understand that I will be a given a copy of this Authorization form after signing it and that I should retain that copy for my records.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE | TODAY'S DATE (MM/DD/YYYY)

IF SIGNED BY LEGAL REPRESENTATIVE

_____

RELATIONSHIP TO PATIENT/AUTHORITY TO SIGN

_____

REASON PATIENT UNABLE TO SIGN

_____

ADDRESS, CITY, STATE, ZIP

_____

PHONE NUMBER

Verbal Consent Received from Capable Patient if Unable to Sign: ☐ Yes

FORM INVALID IF NOT SIGNED AND DATED

HIPAA 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.

This Notice of Privacy Practices ("NPP") describes how we may use and disclose your protected health information ("PHI") to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

RIGHTS OF THE PATIENT

Obtaining Information: When it comes to your health information, you have certain rights. You may obtain a paper copy of this NPP promptly at any time, even if you agreed to receive the notice electronically. You can ask to see or get an electronic or paper copy of your medical record and other PHI we have about you. Let us know in writing if you would like to do this. We will provide a copy or summary of your PHI, with limited exceptions, usually within 30 days of your written request. We may charge a reasonable, cost-based fee. You can request a specific method you wish to be contacted about your PHI to ensure confidential communications, such as home or office phone, or to send mail to a different address. Let us know your preference in writing. We will agree with all reasonable requests. If you believe there is PHI that is incorrect or incomplete, you can request a correction in writing. We may say "no" to your request, but will explain why in writing within 60 days.

Withholding/Sharing of Information: You can ask for certain PHI for treatment, payment, or our operations to not be shared. We are not required to agree to your request, and may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket, you can ask us not to share that information for payment purposes or our operations with your health insurer. We will agree unless a law requires us to share that information. You can request a list of the times we've shared your PHI for six years prior to the date you ask, including whom we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures excepted by law (such as any you asked us to make). We will provide one accounting per year for free but will charge a reasonable, cost-based fee if another is requested within a 12-month time period.

Unless you tell us not to, we may share your PHI in the following ways: with family, close friends, or others involved in your care; in the event of a disaster relief situation; to include information in a facility directory; or in contacting you for fundraising efforts (but you can tell us not to contact you again). If you have a clear preference for how we share your information in these situations, talk to us. Tell us what you want us to do, and we will follow your instructions. If you are unable to tell us your preferences, for example if you are unconscious, we may go ahead and share your PHI if we believe it is in your best interest. We never share your PHI without your written consent regarding marketing purposes, sale of information, or most sharing of psychotherapy notes.

Assigning Power of Attorney: If you have given someone medical power of attorney or if someone is legally authorized under law to make health care decisions on your behalf, that person can exercise your rights and make choices about your PHI. We will make sure the person has this authority and can act for you before we take any action.

Filing a Complaint: If you feel your rights have been violated, a complaint can be filed by contacting us using the information at the end of this notice, or by filing a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. They may be reached through the mail at 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or online at www.hhs.goviocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment and Public Health: We can share your PHI in certain situations regarding your treatment or public health. These may include sharing with other professionals who are treating you (for example, if a doctor treating you for an injury asks another doctor about your overall health condition), or preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, or preventing a serious threat to anyone's health or safety.

Payment: We can use and share your PHI to bill and get payment from health plans or other entities, such as giving information to your health insurance plan so it will pay for your services.

Operate Our Practice: We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we may use health information about you to conduct quality assessment and improvement activities or to review the competence or qualifications of health care professionals. When an individual dies, we can share that individual's PHI with a coroner, medical examiner, or funeral director. We can also share PHI for communications between other administrations such as organ procurement organizations, health research, workers' compensation claims, law enforcement purposes, health oversight agencies, or special government functions such as military, national security, and presidential protective services. We can also disclose PHI in response to a court or administrative order or subpoena or when state or federal law requires it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Our Responsibilities: We are required by law to maintain the privacy and security of your PHI, to provide you with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. We will inform you promptly if a breach occurs that may have compromised the privacy or security of your PHI. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your PHI other than as described here unless you give permission in writing. If you tell us we can, you can change your mind at any time. Let us know in writing if you change your mind.

We will not share any substance abuse, mental health, genetic testing, HIV, or sexually transmissible disease records without your written permission unless specifically permitted or required by law.

Notwithstanding anything to the contrary in this notice, if you are a patient in Florida, we may only use or disclose your PHI to you, your legal representative, other health care practitioners and providers involved in your care or treatment, and for purposes expressly permitted or required by law (including certain civil, criminal, or worker's compensation proceedings), unless you provide written authorization.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site www.jmsbc.org.

This NPP applies to the following organizations, which are designated as an Affiliated Covered Entity and will all comply with this NPP:

Acute Surgical Care, LLC

Burn and Reconstructive Centers of Colorado, PC

Burn and Reconstructive Centers of Florida, Inc.

Burn and Reconstructive Centers of Florida, Inc. d/b/a Miami Reconstructive Center

Burn and Reconstructive Centers of Florida, Inc. d/b/a Palm Aesthetics

Burn and Reconstructive Centers of Idaho, PLLC

Burn and Reconstructive Centers of Idaho, PLLC d/b/a Southeast Idaho Surgical Group

Burn and Reconstructive Centers of Texas, PLLC

Joseph M. Still Burn Centers, Inc.

CONTACT US

Director of Human Resources: Susan Zachow, CMOM
susan.zachow@burncenters.com
706-863-9595 ext 7338 or Toll Free 877-863-9595

For more information, see https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/consumers/consumer_rights.pdf. Effective date of this notice: May 19, 2017

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PRACTICE NAME ("PRACTICE")

PATIENT NAME | PATIENT ADDRESS

I received a copy of the Notice of Privacy Practices ("NPP") for the above-named practice.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

PRINTED NAME (OF SIGNEE) | DATE

If signed by Legal Representative:

RELATIONSHIP TO PATIENT/AUTHORITY TO SIGN | REASON PATIENT UNABLE TO SIGN

LEGAL REPRESENTATIVE ADDRESS | LEGAL REPRESENTATIVE PHONE NUMBER

Verbal Consent from Capable Patient if Unable to Sign: ☐ Yes

FOR OFFICE USE ONLY

Date NPP provided to patient: _____

Method of delivery (e.g., in person, electronically, etc.): _____

We were unable to obtain a written acknowledgement of receipt of the NPP because:

☐ An emergency existed and a signature was not possible at the time.

☐ The individual refused to sign.

☐ A copy was mailed with a request for signature by return mail.

☐ Unable to communicate with the patient for the following reason: _____

_____

☐ Other: _____

PREPARED BY (PRINTED NAME) | SIGNATURE

DATE

FLORIDA AUTHORIZATION FOR USES AND DISCLOSURES OF MEDICAL RECORDS

PRACTICE NAME ("PRACTICE")

PATIENT NAME | PATIENT ADDRESS

I agree that medical records and information about me may be used or disclosed in all ways described in the Practice's Notice of Privacy Practices, notwithstanding any provision to the contrary. I understand that the Practice will not use or share this information other than as described unless I give additional permission in writing.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

PRINTED NAME OF SIGNEE | DATE

If signed by Legal Representative:

RELATIONSHIP TO PATIENT/AUTHORITY TO SIGN | REASON PATIENT UNABLE TO SIGN

LEGAL REPRESENTATIVE ADDRESS | LEGAL REPRESENTATIVE PHONE NUMBER

Verbal Consent from Capable Patient if Unable to Sign: ☐ Yes