West Coast Infectious Diseases

Quality and Compassionate Care is Our Priority

1840 Mease Drive
Suite 319
Safety Harbor, FL 34695

8607 Easthaven Court
Suite 101
New Port Richey, FL 34655

727-669-6800 Phone
727-669-2540 Fax

Dear Patient:

We are delighted to welcome you to our office. At West Coast Infectious Diseases we are dedicated to providing our patients with the best care. Our physicians are well-known throughout the Tampa Bay community for their friendly, compassionate, professional manner, and leading-edge treatment of infectious diseases.

Below please find our New Patient Packet. Please print out these forms, review and complete them as thoroughly as possible. Once completed you can either mail them to one of the addresses listed above or bring them with you at the time of your appointment.

Please arrive at least 10 minutes before your appointment, and bring any insurance cards, a form of identification, co-payments, a list of your current medications and other pertinent information with you.

If you need to reschedule or cancel your appointment please give at least 48 hours advance notice by calling our office at 727-669-6800.

Thank you for choosing our office for your medical needs. Please feel free to contact our office with any questions or concerns. We look forward to meeting you.

Sincerely,
The Staff of West Coast Infectious Diseases

West Coast Infectious Diseases

Today's date:	❑ DR. LAARTZ ❑ DR. GROOM ❑ DR. JONES DR. GONZALEZ ❑ PAMELA SHERWOOD, APRN ❑ JAMES DESMARAIS, APRN

PATIENT INFORMATION

Patient's Last Name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss Ms.	Marital status (circle one) Choose

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Race: (check one)	Ethnicity: (check one)	Preferred Language: (only one)	
❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic or Latino ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Declined	❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined (as directed by CMS)	English Spanish Other _____	Cell phone no.: ( )

Pharmacy (including address + Telephone #)	Employer Name:	Employer Phone #:	Occupation:

Mother's maiden name:	Other family members seen here:	Email:

PLEASE FILL OUT INSURANCE INFORMATION COMPLETELY

(Please fill out **FULLY** and give your insurance card and picture I.D. to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? Yes No

Please list primary insurance: (including address please)

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	Self	❑ Spouse	Child	Other

Please list secondary insurance

Secondary Subscriber's name:	Secondary Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I agree and authorize West Coast Infectious Diseases to appeal any claim(s) on my behalf to my insurance company, if necessary. I understand that I am financially responsible for any balance. I also authorize West Coast Infectious Diseases or insurance company to release any information required to process my claims. I agree and understand that I may be charged 1.5% interest rate per month on any unpaid balance and that I am responsible for any costs of collection including a reasonable attorney fee, whether or not suit is filed. I have read and understand the above and agree to comply. I also give my permission for my treating provider to download any electronic prescriptions that will help in my medical treatment. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

*Patient/Guardian signature:*_____ *Date:*_____

West Coast Infectious Diseases

Patient History

Date _____ **Age** _____

Patient's Name _____
First Middle Last

REFERRING PHYSICIAN: _____

Address: _____ Phone: _____

PRIMARY CARE PHYSICIAN: _____

Address: _____Phone:_____

May we contact these Physicians and send them reports of your progress/findings: **Yes** **No**

Signature: _____

ALLERGIES: _____

MEDICATIONS:

_____ _____

_____ _____

PREVIOUS ANTIRETROVIRALS (HIV MEDICATIONS) _____

Have you traveled out of the country recently? If so where? ○ **YES** **NO** ○ _____

Have you had contact with anyone who has recently traveled out of the country? ○ **YES** **NO** ○ _____

HISTORY: (Yes or No)

Headaches: _____	Kidney Disease: _____	Blood transfusion: _____
Eyes Problems: _____	Diabetes: _____	Meningitis: _____
Thrush: _____	STD: _____	HIV: _____
Heart Attack: _____	Bowel problems: _____	Tuberculosis: _____
Chest Pain: _____	Cancer: _____	Pneumonia: _____
Lung Problems: _____	Ulcers: _____	PCP pneumonia: _____
Liver Problems: _____	Depression: _____	Toxoplasmosis: _____
Hepatitis: _____	Bone infection: _____	Retinitis: _____
Stroke: _____	Skin infection: _____	CMV: _____

Do you have any concerns about domestic violence in your household? _____

Do you have risk factors for HIV – unprotected intercourse, transfusions, IV drug use? _____

Comments: _____
_____

SURGERIES AND DATES:

_____ _____

West Coast Infectious Diseases

Brent W. Laartz, MD / Todd M. Groom, PhD MD /
Lily N. Jones, DO / Arnoldo A. Gonzalez, MD
Pamela Sherwood, APRN / James Desmarias, APRN

Patient Authorization to Discuss Patient Protected Health Information (PHI) With Other Individual(s)

By Federal law, West Coast Infectious Diseases, PA, its physicians and staff must obtain your authorization to discuss your Protected Health Information (medical condition or test results) with other individuals. Examples are your spouse, partner, children, parents, family friends or caregivers. The exception to requiring your authorization is for treatment, payment, health care operations, and under certain law provisions:

I, _____, the patient, authorize West Coast Infectious Diseases, PA, its physicians and staff to discuss my medical Protected Health Information with the following persons or organizations:

INITIALS

Which is your Preferred Method of Contact (please provide information below)

☐ **Home** ☐ **Cell** ☐ **Text** ☐ **Us Mail** ☐ **Patient Portal**

_____ To call me at work: ( ) _____

_____ To call me at home ( ) _____

_____ To call me on my cell ( ) _____

_____ To speak with the following family/friends **(Please list their Name, Relationship & Phone Number):** _____

_____

_____

_____ To speak with me only

_____ To leave messages on my answering machine or voice mail

_____ To send my information to an address other than my home address:

_____

_____ Other: _____

By law, this authorization is good for one year (1-year). This authorization is revocable at any time in writing by the patient or West Coast Infectious Diseases, PA, its physicians and staff.

I have read, understand, and have identified individuals or organizations that I authorize or West Coast Infectious Diseases, PA, its physicians and staff to discuss any PHI with. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

_____ _____

Patient or Guardian's Signature of Authorization **Date of Authorization**

West Coast Infectious Disease, PA

1840 Mease Drive, Suite 319 *Phone (727) 669-6800*
Safety Harbor, Florida 34695 *Fax (727) 669-2540*

Controlled Substances Agreement

Before receiving prescriptions for controlled medications, certain conditions must be acknowledged and agreed upon as follows:

INITIALS

_____ 1. I *have/have not* (circle one) been diagnosed with, treated, or arrested for substance dependence or abuse.

_____ 2. I have never been involved in the sale, illegal possession, diversion, or transport of controlled substances (narcotics, sleeping pills, nerve pills, or pain killers, etc.)

_____ 3. I agree to obtain all prescriptions and renewals for controlled medications from West Coast Infectious Diseases, and their physician and to notify the office immediately if other outside physicians prescribe the same.

_____ 4. I agree to use only one pharmacy for filling prescriptions and renewals of controlled medications, and to notify the office immediately if another physician prescribes same.

_____ 5. I agree to allow the staff of West Coast Infectious Diseases office to communicate with any other Physicians, any pharmacist and review of the state, federal and other database regarding my use of controlled substances and other medications.

_____ 6. I agree to take the medicines only as prescribed by West Coast Infectious Diseases, and their physicians, and I understand that **NO EARLY REFILLS** will be issued.

_____ 7. I will notify the office of a need for a refill up to 3 working days in advance, and understand that **no refills will be made after hours, on weekends, or on holidays.**

_____ 8. I agree to follow the advice of the physician(s) in regards to stopping controlled substances, should it be felt advisable.

_____ 9. I agree to a psychological evaluation if it is felt advisable.

_____ 10. I certify that I am not pregnant. I certify that I will use appropriate measures to prevent pregnancy during the course of my treatment with opioids and other controlled substances

_____ 11. I agree to submit to random drug screens as requested by the office.

_____ 12. I agree to keep all scheduled appointments related to my treatment plan. I will call in advance and reschedule if I am unable to keep an appointment.

_____ 13. I will be responsible for all prescriptions I receive and I understand that if they are lost, misplaced, etc, that they **cannot be replaced**. In the event that they are stolen, I will present a police report as evidence in order for a refill to be considered.

_____ 14. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, I understand that I must notify your office immediately. The pharmacy that I have selected is:

_____ Phone: _____.

_____ 15. I understand that I may be discharged as a patient and/or receive no further pain medication if any of the following occur:

a. I give away, sell or misuse the drugs
b. The office finds me non-compliant with any terms of this Agreement
c. I obtain opioids and other controlled substances from sources other than this office

I have read this Agreement, understand it, have had the opportunity to ask questions, and have had all my questions answered satisfactorily. I acknowledge the conditions and consent to the use of controlled substances under the terms outlined in this Agreement. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

_____ _____ __/___/____
Print Name Witness Date

_____ __/___/____ _____ __/___/____
Patient signature Date Physician Date

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OFFICE FINANCIAL POLICY

PATIENT'S NAME_____ **DATE:** _____

Welcome to Our Office

Please read this policy carefully and feel free to ask questions regarding any part of this form. We believe that a clear definition of our office and financial policies will allow us to concentrate on the primary goal of taking care of your health. Our practice will strive to provide you with the finest quality care. If you have any questions regarding your treatment, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship.

Appointments

If you are unable to keep an appointment please call the office to reschedule at least 72 hours in advance. Patients with two missed appointments will be charged a $15.00 no-show fee which is not reimbursable by any insurance. Patients with repeated missed appointments may be dismissed from the practice. Patients who are more than 15 minutes late may be asked to reschedule.

Transferring Records

Patient's requesting copies of their records are asked to submit a request in writing to include all relevant information, including your payment history **upon request**. Please be aware that our policy is to provide records within 30-days from receipt of request. The fee for copying your records is $1.00 for this first 25 pages, and .25 cents for each additional page. If you are requesting your records to be transferred from another doctor or organization to us, you have to authorize us to receive all relevant information including your payment history.

Financial Policy

This is an agreement between West Coast Infectious Diseases, PA, a Florida corporation, as creditor and the patient/debtor named on this form. In this agreement the words "you", "your", and "yours" means the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payment credited. The words "we", "us", and "our" refer to the West Coast Infectious Diseases, PA. By executing this agreement you are agreeing to pay for all services rendered.

Completion of Forms/Medical Letters

There is a **$20.00 fee** for completing of each Form (including but not limited to, FMLA, disability forms, and handicap stickers), and Medical Letters relating to your condition. This fee is not reimbursable or billable to your insurance company, and must be paid by you before the form is completed. Please allow 7 to 10 days for completion of any form.

Insurance

Insurance is a contract between you and your insurance company. (We are **not** a party to this contract, in most cases). We will bill your insurance company as a courtesy. We will accept secondary insurances, as long as it is medigapped (automatic crossover). Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Referrals

If your insurance company requires a referral and/or preauthorization/pre-certification **you are responsible for obtaining it.** We most likely will not be able to obtain a referral on the date of service, (and this will be at our discretion if time permits). Options at this point will be to reschedule the appointment or to pay at the time of service. We suggest you call your primary doctor at least 24 hours in advance to confirm that your referral has been generated and faxed. **The most reliable method is to obtain it yourself.**

Workers Compensation

We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury

If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We do not accept letters of protection and subsequently cannot bill your attorney for charges incurred due to a personal injury case.

Payments

Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Required Payments

Any co-payment, deductibles or coinsurances, fees for non-covered services, or outstanding balances must be paid at the time of service.

Payment Options

You may choose to pay cash, check, or credit card on the day that the treatment is rendered.

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West Coast Infectious Diseases

OFFICE FINANCIAL POLICY Continued

Verification of Benefits

We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what insurance coverage is available on your policy. This can only be done on the day of your appointment if time permits. **You as the policyholder are primarily responsible to verify benefits and provide our office with the current insurance coverage information and any other information that has changed on your account for each visit**. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result.

Medicare Shared Savings Program

If applicable, please be aware they we do participate in a Medicare Shared Savings Program. Therefore, we may from time to time share medical data with our Accountable Care Organization. You have the right to opt out of this data sharing at any time by indicating below. By signing this form, you are authorizing us to share your medical data with our Accountable Care Organization and CMS as applicable under federal law.

Past Due Accounts

If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to our collection attorneys, you agree to be responsible for all costs of collection, including a reasonable attorney fee, whether or not suit is filed. In case of a suit, you agree the venue shall be in Pinellas County, Florida. You expressly waive your right to jury trial.

Returned Checks

There is a fee (currently $25) for any checks returned by the bank.

Monthly Statement

If you have a balance on your account, we will send you a monthly statement. It will show separately the balance, any new charges to the account, and the finance charge, if any.

Waiver of Confidentiality

You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date

Once you have signed this document you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. If you have any questions or require clarification on this policy please ask to speak with our Billing Department or our Administrator.

Statement Clause

We reserve the right to interpret, change, suspend, cancel, or dispute with or without notice all or any part of our policy, and procedures, at any time without verbal or written notification.

☐ I hereby declined to participate in Medicare Shared Savings Program and will not allow any of my medical data to be shared with any Accountable Care Organization.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise we urge you to contact us for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. We are here to help you. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____ _____

Patient's Signature **Date**

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West Coast Infectious Diseases

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West Coast Infectious Diseases Patient Portal Authorization Form

Patient Name (please print clearly):_____DOB:_____

Personal Email Address (please print clearly):

_____

Purpose of this Form:

The patient portal is designed to enhance secure patient-physician communications and is provided as a courtesy to our valued patients. Please read this form thoroughly before signing.

How the Patient Portal Works:

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site. Once you are logged into the portal you will have access to only your records or those of whom you are legally responsible.

Via the Patient Portal you will be able to:

- Use the message function to communicate with our staff
- Communication of laboratory & diagnostic results from staff to patient
- View medication list and request refills
- View or print health summary information and send staff requests to update information
- View demographic/insurance information and send staff requests to update information
- Print or save an electronic copy of the health summary
- View or print immunization record
- View upcoming scheduled appointments
- Communicate about billing questions

Response time:

- We will respond to non-urgent portal inquiries within 48 hours.
- Prescription refills 48-72 hours after receiving request.

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The Patient Portal is NOT intended for the following:

- **NO** diagnosis or treatment is offered by portal email. Diagnosis can only be made and treatment rendered after the patient schedules and is SEEN (face-to-face encounter) by the physician
- **NO** emergent communications or services. Go to the nearest emergency room or dial 911
- **NO** request for controlled substances will be accepted

If there is persistent abuse or negligence with the use of the patient portal, we reserve the right at our own discretion to terminate offering patient portal, suspend user account, or modify services offered through the patient portal.

Protecting Your Private Health Information and Risks:

This method of communicating and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two important factors, we need you to make sure we have your correct email address and you must inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address. You need to keep unauthorized persons from learning your password. If you think someone has learned your password, you should promptly change it via the patient portal. We understand the importance of privacy with regard to your health care and will continue to protect the privacy of you medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

How to Participate in the Patient Portal:

Once this form is agreed to and signed, you will be set up with an account for the patient portal. Immediately following the account set up you will receive a welcome email with the link to access the portal. In a separate email you will receive your user name and a temporary password. Once you log in to the portal for the first time you must change your password.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of patient portal and agree that I understand the risks associated with online communication between my physician and patient, and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from West Coast Infectious Diseases. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for the online communications.

Patient /Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

1840 Mease Drive
Suite 319
Safety Harbor, FL 34695

8607 Easthaven Court
Suite 101
New Port Richey, FL 34655

727-669-6800 Phone
727-669-2540 Fax

WCID
West Coast Infectious Diseases
Quality and Compassionate Care is Our Priority

Patient: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. I acknowledge that I have received the Notice of Privacy Practices. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

_____
Signature of Patient or Patient's Representative Date

_____
Print Name Relationship to Patient

Interpreter (if applicable)

(FOR OFFICE USE ONLY)

Please document your efforts to obtain acknowledgement and reason it was obtained or not obtained.

- ◯ Notice of Privacy Practices Given – Patient Able to Sign
- ◯ Notice of Privacy Practices Given – Patient Unable to Sign
- ◯ Notice of Privacy Practices Given – Patient Declined to Sign
- ◯ Notice of Privacy Practices and Acknowledgement Mailed to Patient
- ◯ Other Reason Patient Did Not Sign _____

_____ _____
Signature of Office Representative Date

WEST COAST INFECTIOUS DISEASES, PA

PATIENT NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: January 1, 2010, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

This is your Notice of Privacy Practices from West Coast Infectious Diseases, PA. The Notice refers to West Coast Infectious Diseases, PA by using the terms "us", "we," or "our." We are required by law to maintain the privacy of Personal Health Information. We are required to provide this Notice of Privacy Practices to you by the privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA".)

This notice describes how we protect the Personal Health Information we have about you that relates to your medical information or Personal Health Information. Personal Health Information is medical and other 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. (The HIPAA law uses the term "protected health information" where we use "Personal Health Information.")

This Notice of Privacy Practices describes how we may use and disclose to others your Personal Health Information to carry out payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control of your Personal Health Information. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all Personal Health Information that we maintain at that time. This notice may also be revised if there is a material change to the uses or disclosures of Personal Health Information, your rights, our legal duties, or other privacy practices stated in this notice. Additionally, upon your request, we will provide you with any revised Notice of Privacy Practices by calling us at 727-669-6800 and requesting that a revised copy be sent to you in the mail.

I. Your Rights Regarding Medical Information About You

Your health record is the physical property of **West Coast Infectious Diseases, PA**. The information contained in the record, however, belongs to you. You have the right to:

A. Request a restriction or limitation on the medical information we use or disclose about you for your treatment, payment or health care operations. For example, you may request that a particular visit be kept confidential and not shared with other providers. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend or when we notify a family member, personal representative or other person responsible for your care to inform them of your location and general condition.
B. We are not required to agree to your requested restrictions on uses or disclosures of your Personal Health Information to carry out treatment, payment or healthcare operations.
C. If we agree to a restriction on uses or disclosures of your Personal Health Information to carry out treatment, payment, or healthcare operations, then we may not use or disclose Personal Health Information in violation of such restriction. However, if you are in need of emergency treatment and the restricted Personal Health Information is needed to provide the emergency treatment, we may disclose such information to a healthcare provider to provide such emergency treatment to you and we will request that such healthcare provider not further use or disclose your information.

D. If we agree to a restriction, such restriction would not prevent uses or disclosures as follows:
    - required by the U.S. Department of Health and Human Services to investigate or determine our compliance with the HIPAA privacy regulation; required by law; for public health activities; about victims of abuse, neglect, or domestic violence; for health oversight activities; for judicial and administrative proceedings; for law enforcement purposes; about decedents; for cadaveric organ, eye or tissue donation purposes; for research purposes; to avert a serious threat to health or safety; for specialized government functions; or for workers' compensation.

E. If we agree to a restriction, we may terminate that agreement if: you agree to or request the termination in writing; you orally agree to the termination and the oral agreement is documented by us; or we inform you that we are terminating our agreement to a restriction, except that such termination is only effective with respect to Personal Health Information created or received after we have so informed you.

II. Your Right to Receive Confidential Communications of Personal Health Information

A. We will accommodate any reasonable request you might make to receive communications of Personal Health Information from us by alternative means or at alternative locations, if you clearly inform us in writing that the disclosure of all or part of that Personal Health Information could endanger you.

B. We require that you make a request for a confidential communication in writing and specify how or where you wish to be contacted.

C. We may condition the provision of a reasonable accommodation on when appropriate, information as to how payment, if any, will be handled; and specification of an alternative address or other method of contact.

D. You do not need to explain to us why you are requesting confidential communications.

III. Your Right to Inspect and to Copy Personal Health Information

A. Right of Access – Except for conditions regarding "Unreviewable Grounds for Denial of Access" and "Reviewable Grounds for Denial of Access" listed below, you have the right of access to inspect and to obtain a copy of your Personal Health Information that we maintain in a Designated Record Set, for as long as the Personal Health Information is maintained in the Designated Record Set, except for psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We require you to make requests for access in writing.

B. Unreviewable Grounds for Denial of Access – We may deny you access to your Personal Health Information without providing you an opportunity for review, in the following circumstances: The Personal Health Information is not something to which you have a right of access.

C. The Personal Health Information is contained in records that are subject to the federal Privacy Act and your access to it may be denied, if the denial of access under the Privacy Act would meet the requirements of that law.

D. The Personal Health Information was obtained from someone other than a healthcare provider under a promise of confidentiality and the access you requested would be reasonably likely to reveal the source of the information

E. Reviewable Grounds for Denial of Access – We may deny you access to your Personal Health Information, provided that we give you the right to have such denials reviewed (as required by the Review of a Denial of Access procedures listed below) in the following circumstances:
    - A licensed healthcare professional determines that the access you requested is reasonably likely to endanger the life or physical safety of you or another person.
    - The Personal Health Information makes reference to another person (unless such other person is a healthcare provider) and a licensed healthcare professional determines that the access you requested is reasonably likely to cause substantial harm to such other person; or

- The request for access is made by your personal representative and a licensed healthcare professional determines that the provision of access to such personal representative is reasonably likely to cause substantial harm to your or to another person.

F. Review of a Denial of Access – If we deny you access to your Personal Health Information on a ground that qualifies as a Reviewable Ground for Denial of Access, you have the right to have the denial reviewed by a licensed healthcare professional who is designated by us to act as a reviewing official and who did not participate in the original decision to deny access. We will promptly provide written notice to you or to your personal representative (as applicable) of the determination of the designated reviewing official and we will carry out the designated reviewing official's determination.

G. We Will Respond Promptly to Your Request for Access to Personal Health Information under the following conditions*:*

- If you request access to Personal Health Information that is not maintained by us or is not accessible to us on-site, we will, no later than 30 days from the receipt of your request, take one of the following actions:
- If we grant your request we will inform you of our acceptance of your request and we will provide you the access requested in accordance with the Provision of Access requirements listed below.
- If we deny your request we will provide you with a written denial in accordance with the Denial of Access requirements listed below.
- If you request access to Personal Health Information that is maintained by us or is accessible to us on-site, we will act on such a request no later than 30 days after receiving your request as follows:
- If we grant your request for access we will inform you of our acceptance of your request and provide the access requested in accordance with the Provision of Access requirements listed below.
- If we deny your request we will provide you with a written denial in accordance with the Denial of Access requirements listed below.

H. Provision of Access – If we provide you access to your Personal Health Information, we will do so by adhering to the following requirements:

I. Providing the Access Requested. We will provide the access requested by you of the Personal Health Information we maintain about you in Designated Record Sets.

IV. Form of Access Requested.

A. We will provide you with access to the Personal Health Information in the form you request, in a hard copy form or another form upon which we both agree.

B. We may provide you with a summary of the Personal Health Information requested, in lieu of providing you access to your Personal Health Information or we may provide an explanation of the Personal Health Information to which access has been provided, if you agree in advance to such a summary or explanation and you agree in advance to the fees imposed, if any, by us for such summary or explanation.

C. Manner of Access. We will arrange with you for a convenient time and place for you to inspect or to obtain a copy of your Personal Health Information, or we will mail a copy of the Personal Health Information at your request.

D. Fees*.* If you request a copy of your Personal Health Information or agree to a summary or explanation of such information, we may impose a reasonable, cost-based fee.

E. Denial of Access – If we deny you access, in whole or in part, to your Personal Health Information, we will do so only by adhering to the following requirements:

F. To the extent possible, we will give you access to any other of your Personal Health Information requested, after excluding the Personal Health Information as to which we have a ground to deny you access.

- Provide you with a timely, written denial.
- If we do not maintain the Personal Health Information that is the subject of your request for access, and we know where the requested information is maintained, we will inform you where to direct your request for access.

V. Your Right to Amend Personal Health Information We Maintain About You

A. Right to Amend – You have the right to have us amend Personal Health Information or a Record about you maintained in a Designated Record Set for as long as we maintain the Personal Health Information in the Designated Record Set.
B. Denial of Amendment – We may deny your request for amendment of Personal Health Information or a Record about you maintained in a Designated Record Set, if we determine that the Personal Health Information or Record that is the subject of the request:
    - Was not created by us, unless you provide us with a reasonable basis to believe that the originator of Personal Health Information
    - is no longer available to act on the requested amendment;
    - Is not part of the Designated Record Set;
    - Would not be available for inspection under the rights that the HIPPA privacy regulation gives to individuals to access Personal Health Information; or
    - Is accurate and complete.

VI. Requests for Amendment and Timely Action

A. You may request that we amend your Personal Health Information that we maintain in a Designated Record Set. You must make such requests for amendments in writing and provide us with a reason that supports your proposed amendment.
B. We will act on your request for an amendment no later than 60 days after receiving your request as follow:
    - If we grant your requested amendment we will make the amendment, inform you and inform certain others.
    - If we deny your requested amendment we will provide you with a timely written denial that uses plain language and contains the basis for the denial of an amendment. The denial notice will also include other information regarding future disclosures of your Personal Health Information and how you may disagree with or complain about our denial of your amendment.
    - If we are unable to act on your request to amend your Personal Health Information that we maintain in a Designated Record Set, within 60 days after receiving your request, we may take up to an additional 30 days to act on your request, by, within 60 days after receiving your request for an amendment, providing you with a written statement of the reasons for our delay in acting on your request and the date by which we will complete our action on your request.

VII. Actions on Notices of Amendment

A. When we are informed by a healthcare provider, a healthcare clearinghouse or another health plan of an amendment to your Personal Health Information then we will amend your Personal Health Information that we maintain in a Designated Record Sets by, at a minimum, identifying the Records in the Designated Record Set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment.

VIII. Your Right to Receive an Accounting of Our Disclosures of Your Personal Health Information

A. Right to an Accounting of Disclosures of Personal Health Information. You have the right to receive an accounting of Disclosures of Personal Health Information made by us in the 6 years before the date of your request for the accounting.
B. Disclosures NOT required to be listed in the Accounting. The following are disclosures to which you do not have a right to an accounting and we will not include a listing of such disclosures to you.
    - Disclosures made to carry out our payment activities and purposes.
    - Disclosures made to carry out our healthcare operations activities and purposes.
    - Disclosures made by us for the treatment activities of a healthcare provider.
    - Disclosures made by us to a healthcare provider, a healthcare clearinghouse, or another health plan for the payment activities of the entity that receives the information.

- Disclosures made by us to a healthcare provider, a healthcare clearinghouse, or another health plan for certain healthcare operations activities of the entity that receives the information, if we and the entity receiving the information either has or had a relationship with you, the Personal Health Information pertains to such relationship, and the disclosure is for certain limited purposes.
- Disclosures of your Personal Health Information made to you.
- Disclosures made incident to a use or disclosure otherwise permitted or required by the HIPAA privacy regulation.
- Disclosures made pursuant to your authorization.
- Disclosures made pursuant to the HIPAA privacy regulation regarding those disclosures made to persons involved in your care or other notification purposes.
- Disclosures made for national security or intelligence purposes to authorized federal officials for the conduct of lawful national security activities.
- Certain disclosures made to correctional institutions or law enforcement officials having lawful custody of you or other Personal Health Information about you.
- Disclosures that are part of a Limited Data Set under the HIPAA privacy standards and implementation specifications regarding Limited Data Sets and Data Use Agreements.
- Disclosures that occurred before January 1, 2009.
- Under certain circumstances we are required to temporarily suspend your right to receive an accounting of the disclosures we made to a health oversight agency or law enforcement official.
- You have the right to request from us an Accounting of Disclosures for a period of time less than 6 years from the date of your request.
- Unless the disclosure is one that we are not required to list in the accounting, or you have requested a time period of less than 6 years, the written Accounting of Disclosures will include disclosures of your Personal Health Information that occurred during the 6 years before the date of your request for an Accounting, including disclosures to or by our Business Associates.

IX. Provision of the Accounting of Disclosures of Your Personal Health

A. Information – Within 60 days after receiving your request for an Accounting of Disclosures of your Personal Health Information, we will provide you with such an accounting. If we are unable to provide an accounting of disclosures within the 60 day period, we may take an additional 30 days on which to provide the accounting by providing you, within 60 days after receiving your request for an accounting, a written statement of the reasons for our delay and the date by which we will provide to you an Accounting of Disclosures of your Personal Health Information.

B. Fees for an Accounting – The first accounting of disclosures that you request within any 12 month period will be provided to you by us at no charge. For any additional accountings of disclosures that you make within a 12 month period we will charge you a reasonable, cost-based fee. We will notify you in advance of this fee, and you will have the opportunity to withdraw or modify your request for a subsequent accounting of disclosures of your Personal Health Information in order to avoid or reduce the fee.

C. Your Right to Receive a Paper Copy of This Notice. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically. At least once every three (3) years, we will notify all Updated individuals covered by our plan of the availability our Notice of Privacy Practices and how to obtain the notice.

D. Your Right to File a Complaint. If you think that we have violated your privacy rights, you have the right to file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact: Privacy Officer, WCID, 1840 Mease Drive, Suite 319, Safety Harbor, FL 34695. All complaints must be submitted to us in writing. We will not penalize you nor will we retaliate against you for filing a complaint.

E. Contact Information. For further information about matters covered by this notice please contact Privacy Officer at 727-669-6800

F. Effective Date. This notice was published and becomes effective on January 1, 2007

X. Omnibus Final Rule

A. Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information technology for Economic and Clinical Health (HITECH) Act, are as follows:
   - You have the right to be notified of a data breach.
   - You have the right to ask for a copy of your electronic medical record in an electronic form.
   - You have the right to opt out of fundraising communications from JFS, and JFS cannot sell your health information without your permission.

B. Certain uses of your medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in this notice will be made only with your authorization.

C. If you pay in cash in full (out of pocket) for your treatment, you can instruct West Coast Infectious Diseases, PA not to share information about your treatment with your health plan.

XI. Our Responsibilities Regarding Your Medical Information

We are required by law to:

A. Maintain the privacy of your health information.

B. Provide you with this Notice, which describes our legal duties and privacy practices with respect to information we collect about you and a revised copy of the Notice if it is amended or otherwise changes.

C. Abide by the terms of this Notice.

D. Notify you if we are unable to agree to a requested restriction.

E. Accommodate reasonable requests that you have made to have us communicate your health information to you in a certain way or at a certain location.

WE RESERVE THE RIGHT TO CHANGE THIS NOTICE. We reserve the right to make the revised and changed notice effective for medical information that we already have about you, as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain the effective date on the first page.

XII. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

Each time you visit us, a record of your visit is made. We may use or disclose the health information contained in this record to certain employees and staff members of the office or certain persons or entities outside the office in certain situations without first obtaining your authorization. The following categories describe the different ways that we may use and disclose your medical information. We must obtain your prior written authorization before using or disclosing your medical information in all other situations which are not listed below.

A. **Treatment.** We may use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians, or other office personnel who are involved in taking care of you at the office. For example, information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. Members of your health care team will then record the actions that they took and their observations. By reading your medical record, the physician will know how you are responding to treatment.

B. **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the office may be billed to and payment may be collected from you, an insurance company, or third party. For example, we may need to give your insurance company information about your visit and care that you received at the office so that the insurance company will pay us or reimburse you for the visit.

C. **Health Care Operations**. We may use and disclose Personal Health Information about you for our health plan and insurance operations. For example we may use Personal Health Information to conduct quality assessment and improvement activities. We may also use or disclose Personal Health Information to review the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan

performance, training of non-healthcare professionals, accreditation, certification, licensing, or credentialing activities. We may also use or disclose Personal Health Information for purposes of underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for healthcare provided that if we receive Personal Health Information for the purpose of underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and if such health insurance or health benefits are not placed with us, we may not use or disclose such Personal Health Information for any other purpose, except as may be required by law. We may also use or disclose Personal Health Information to conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs. We may also use or disclose Personal Health Information for business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating an entity. We may also use and disclose Personal Health Information for the business management and general administrative activities of our entity (to the extent that such activities relate to functions that are covered under the federal HIPAA privacy laws.)

D. **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the office.

E. **Treatment Alternatives.** We may use and disclose medical information about you to contact you about or recommend possible treatment options or alternatives that may be of interest to you.

F. **Health-Related Benefits and Services**. We may use and disclose your medical information to inform you about health-related benefits or services that may be of interest to you.

G. **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care. We must inform you that we are going to use or disclose your information for this purpose and provide you with an opportunity to agree to, restrict or object to the disclosure or use.

H. **Notification**. We may use or disclose your medical information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location and general condition. We must inform you that we are going to use or disclose your information for this purpose and provide you with an opportunity to agree to, restrict or object to the disclosure or use.

I. **As Required by Law**. We will disclose medical information about you when required to do so by federal, state or local law.

J. **Avert Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. The office, however, will only disclose the information to someone able to help prevent the threat.

K. **Organ and Tissue Donation**. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

L. **Business Associates.** Some of the services provided at the office are provided by business associates. For example, we contract with certain laboratories to perform lab tests. When we contract for these services, we may disclose your health information to our business associates so that they can perform the job we have hired them to do. To protect your health information, we require our business associates to appropriately safeguard your information.

M. **Workers' Compensation**. We may release medical information about you to the extent authorized by and to the extent necessary to comply with the laws relating to workers' compensation or other similar programs established by law.

N. **Public Health Risks**. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

O. **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example,

audits, investigations, inspections, and licensure and disciplinary action that are necessary for the government to monitor the office, government programs, and compliance with civil rights laws.

P. **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in a dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Q. **Law Enforcement**. We may disclose health information for law enforcement purposes as Privacy Notice required by law or in response to a valid subpoena.

R. **Coroners, Medical Examiners and Funeral Directors**. We may release medical information to a coroner or medical examiner for purposes of identifying a deceased, determining a cause of death, or other duties authorized by law. We may also disclose health information to funeral directors consistent with applicable law to carry out their duties.

S. **HIPAA**. The law requires us to disclose your Personal Health Information when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of the HIPAA privacy regulation.

T. **Food and Drug Administration**. We may disclose to the FDA health information related to adverse events with respect to food, supplements, products and product defects, or post marketing surveillance information or to enable product recalls, repairs, or replacement.

U. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

V. **Victims of Abuse, Neglect or Domestic Violence**. We may release medical information to a government authority if we reasonably believe that you are a victim of abuse, neglect or domestic violence, to the extent authorized or required by law. We must inform you or your personal representative that we have disclosed information for this purpose unless we believe that telling you or your personal representative would place you in risk of serious harm or otherwise not be in your best interest.

W. **Child Abuse**. We may release medical information to a government authority authorized by law to receive reports of child abuse or neglect.

X. **How else can we use or share your health information:** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Y. **Special Notices:** We do not maintain Hospital Directories in this office. We require two signatures for the release of any senstive medical data, including but not limited the HIV, AIDS, Mental Health or drug or alcohol treatment. We do provide and receive electronic records from other Healthcare entities through Direct Mail or the Blue Button protocol. This process is through a secure third party vendor who receives medical records electronically from one Healthcare provider and then sends them to another intented provider who is providing care in the patient's treatment.

IV. OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only upon a specific written authorization that you provide to us. If you provide us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. The revocation, however, will not have any effect on any action the office took before it received the revocation.

V. "RED FLAG" INEDTITY THEFT PREVENTION PROGRAM

A. **West Coast Infectious Diseases, PA** will take all steps possible to prevent fraud and protect your identity. The staff are trained on preventing "Identity Theft" and to recognize any "Red Flag", pattern or practice, or specific activity that indicates the possible existence of Identity Theft.

B. To comply with these practices and to facilitate detection of the Red Flags, **West Coast Infectious Diseases, PA** policy is to require identifying information including but not limited to the following information, Full name (including middle initials), date of birth, address, and government issued PHOTO ID (such as a driver's license). If insurance information exists then an insurance verification process will be followed.

C. The staff of **West Coast Infectious Diseases, PA** is required to stop the registration, check-in or billing process if any red flag occurs. They are required to seek additional satisfactory information to verify identity if there are any, but not limited to the following flags; suspicious documents, suspicious personal identifying information, suspicious or unusual use of covered amount, and or alerts from others (i.e. Customer, Identity Theft Victim or Law Enforcement).

D. All complaints or possible detection of Identity Theft will be thoroughly investigated, and if positive identification and verification of Identity Theft has been determine, continued treatment may be terminated and possible report of this fraud to a law enforcement agency may occur as appropriate.

VI. QUESTIONS OR COMPLAINTS

If you have questions and would like additional information, you may contact our **Privacy Office, at 727-669-6800, or email privacyofficer@westcoastid.com or mail to 1840 Mease Drive, Ste 319, Safety Harbor, FL 34695.**

If you believe your privacy rights have been violated, you can submit a written complaint describing the circumstances surrounding the violation to our **Privacy Office, at, 727-669-6800 or email privacyofficer@westcoastid.com or mail to 1840 Mease Drive, Ste 319, Safety Harbor, FL 34695** or to the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to, 200 Independence Avenue, S.W., Washington, D.C. 20201, or calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. You alerting us of any concerns you have is a necessary part of a continuous quality process we employ. You in no way will, be retaliated against or penalized for filling a complaint.

VIII. THIS NOTICE OF PRIVACY PRACTICES APPLIES TO THE FOLLOWING ORGANIZATIONS.

West Coast Infectious Diseases, PA, and West Coast Travel Medicine Consultants, LLC
We also have an affiliation with Baycare Accountable Care Organization that we will share medical information for treatment, payment and operations.

WCID

West Coast Infectious Diseases

Quality and Compassionate Care is Our Priority

CONSENT FOR TELEHEALTH SERVICES AND TREATMENT

1. Consent for Treatment: I authorize West Coast Infectious Diseases, PA, and such physicians, nurse practitioners assistants and other personnel chosen by me to perform Telehealth Services (the "Providers"). This includes examinations, diagnostic testing, treatment, and other health care services deemed medically necessary in the Providers' professional judgment. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I also understand that I have the option to refuse the delivery of health care services by telehealth at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

2. Consent for Telehealth Services: Telehealth involves transmission of video, photographs, and/or details of my medical record such as x-rays and test results (collectively, "Data"). All Data is sent by secure electronic means to the Providers to facilitate the medical service being performed. I understand that:

- I will be informed of any other people who are present at either end of the telehealth encounter and have the right to exclude anyone from either location.
- All confidentiality protections required by law or regulation will apply to my care.
- I have the right to refuse or stop participation in telehealth services at any time and request alternate services such as an in-person appointment. However, I understand that equivalent in-person services might not be available at the same location or time as telehealth services.
- If I do not want to receive health care services by telehealth, it will not affect my right to future care or treatment, or any insurance/ program benefits to which I would otherwise be entitled.
- If an emergency occurs during a telehealth encounter at a hospital or clinic, health care personnel at my location will manage the emergency. If an emergency occurs during a telehealth encounter when I am at a non-health-care site, I should call 911 and stay on the video connection (if applicable) until help arrives.
- Audio/Video will not be recorded without express permission from all parties involved.

3. Records and Release of Information: Transmitted Data may become part of my medical record. Data will not be transmitted to people outside my health care team except as described below, and/or if I provide additional written consent.

- I will have access to all of the information in my medical record resulting from the telehealth services that I would have for a similar in-person visit, as provided by federal and state law.
- The Providers may use or disclose my health information for treatment, continuity of care, payment, or internal operations, or when required by law or regulation in certain unique situations.
- All releases of information are subject to the same laws and regulations as in-person care. If I am participating in a human subject research protocol, my medical information may also be released as described in the research consent form(s).

WCID

West Coast Infectious Diseases

Quality and Compassionate Care is Our Priority

4. Payment Agreement/ Assignment of Benefits:
I agree to be responsible for any co-payments, deductibles, or other charges from the Providers and their providers that are not covered or paid by insurance or other third party payors – except as prohibited by any state or federal law, or any agreement between my insurance company and the Providers. I authorize the Providers to file any claims for payment of any portion of the patient bills and assign all rights and benefits payable for health care services to the provider or organization furnishing the services. I agree, subject to state and federal law, to pay all costs, attorney fees, expenses, delinquent charges, and interest in the event the Providers have to take action to collect the same because of my failure to pay all incurred charges in full. It is my responsibility to know what providers and telehealth services are covered under my insurance plan. I understand that I may be billed and agree to pay all bills submitted by the Providers and/or other providers involved with the provision of telehealth services.

5. Consent to be Contacted (Telephone Consumer Protection Act):
By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for the Providers with the provision of telehealth services to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s)), or to collect any amounts I may owe, the Providers involved with the provision of telehealth services may contact me at the telephone number(s) provided which could result in charges to me. I expressly consent that methods of contact may include SMS text messages, phone calls, including automated technology such as an auto-dialing device, prerecorded messages, and artificial voice messages as applicable. This consent applies to all services and billing associated with my account(s) and is not a condition of purchasing services.

By signing this form, I acknowledge that I have read this information and agree to treatment by telehealth.

_____
Printed Patient Name

_____
Patient or Parent/Legally Authorized Representative Signature

_____
Print Name & Relationship to Patient

A witness is only required if consent is obtained by telephone or video-conference

_____ _____
Name & title of person obtaining telephone or video-conference consent Date