Allergy
Asthma
Arthritis
Center

709 N. Clyde Morris Blvd. • Daytona Beach, FL 32114 • (386) 252-1632 • FAX (386) 257-5526

Michael D. Kohen, M.D.

Dear New Patient,

Welcome to the Allergy, Asthma, & Arthritis Center. Attached is our New Patient Paperwork. **Please complete the entire packet, print it out and bring it with you.** (If you cannot print out and bring the paperwork with you, please arrive 15-20 minutes prior to your appointment time for paperwork.)

We are a "Specialty Office" and your insurance company may require a pre-approval (Referral) for you to be seen. This can be obtain from your primary care physician and faxed to our office *prior to your appointment date*.

Please allow 2 hours for your first appointment and we ask that you *Do Not Wear any Colognes or Perfumes* to the office since many of our patients have allergies.

Please bring the following: (Check List)

- Photo ID and Insurance Cards
- New Patient Paperwork – Medical Questionnaire
- Medical Information and List of Medications
- Lab Work and Imaging Reports that are related to the reason for your visit

New Allergy patients:

- Bring any previous allergy testing
- DO NOT take any antihistamines or decongestants 5 days prior to your appointment to allow for allergy testing.

Please arrive on time for your appointment. Tardiness, incomplete medical information or failure to provide a necessary referral may leave us with no choice but to reschedule your appointment.

Please give us a minimum 24 hour notice if you are unable to make your appointment or need to reschedule.

Thank you for your cooperation and we look forward to seeing you.

Sincerely,
Dr. Michael Kohen and Staff

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Patient Registration & Insurance Verification Form

Physician at AAA Center - Check One ❑ **Dr. Kohen**

Name: _____ **DOB:** _____ **Age:** _____ **SS#:** _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Sex: _____ Marital Status _____ Emergency Contact: _____ Phone: _____

Employer: _____ Address _____ Phone: _____

PRIMARY INSURANCE CARRIER: _____

ID# _____ Group #: _____

Claims Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Effective Date: _____

Name of Insured: _____ Insured's Date of Birth: _____ Insured's Relationship to Patient: _____

Insured's SS #: _____

SECONDARY INSURANCE CARRIER: _____

ID# _____ Group #: _____

Claims Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Effective Date: _____

Name of Insured: _____ Insured's Date of Birth: _____ Insured's Relationship to Patient: _____

Insured's SS #: _____

PRIMARY CARE PHYSICIAN: _____ Phone #: _____

Address: _____ City: _____ St: _____ Zip: _____

Is the referring physician different from the PCP? ❑ Yes ❑ No If Yes, Please Provide the Following....

Referring Physician Name: _____

Referring Physician Address: _____

Referring Physician Phone #: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION THAT MAY BE NECESSARY FOR MY MEDICAL CARE. I AUTHORIZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS FOR SERVICES RENDERED. I AUTHORIZE AAA CENTER TO FILE CLAIMS ON MY BEHALF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CO-PAYMENTS, DEDUCTIBLES, AND CO-INSURANCE REQUIRED BY MY INSURANCE. I AM ALSO REQUIRED TO PAY FOR HMO SERVICES RECEIVED WITHOUT PRIOR AUTHORIZATION AND FOR OBTAINING HMO REFERRALS.

SIGNATURE: _____ DATE: _____

MEDICAL Questionnaire **MEDICAL Questionnaire**

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Michael D. Kohen, M.D.

Patient's Name Address **Date of Birth**

Date of Appointment **Referring Physician**

Chief Complaint:

Present Illness:

PHYSICIAN USE ONLY

1. Instructions: Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your problem. **BRING THIS COMPLETED FORM TO YOUR FIRST APPOINTMENT.**

Briefly describe the reason for your office visit and what you hope to accomplish.

2. List of Your Medications: Please, to the best of your ability, fill out this current list of medications. If you are unable to list them here, bring in your current bottles of medications.

Name of Medication	Strength	Dose	Name of Medication	Strength	Dose

3. Drug Allergies: Aspirin? ❒ Yes ❒ No Penicillin? ❒ Yes ❒ No

Other? Please List Here.

4. Problems: Have you ever had the following conditions?

Yes	No	(Check all items)	Age at Onset	Severity			Comments
				Mild	Mod.	Sev.	
		Asthma					
		Any Other Breathing Problems					
		Sinus Trouble					
		Hay Fever (runny, stuffy, itchy nose; sneezing)					
		Hives or Swelling					
		Exzema or Other Rashes					
		Frequent Infections					
		Food Reactions					
		Drug Reactions					
		Insect Reactions					
		Headaches					
		Sudden Loss of Vision					
		Dry Eyes					

4. Problems: Continued

Have you ever had the following conditions?

Yes	No	(Check all items)	Age at Onset	Severity			Comments
				Mild	Mod.	Sev.	
		Dry Mouth					
		Mouth or Nasal Ulcers					
		Sun Sensitivity					
		Permanent Skin Color Change					
		Psoriasis					
		Bald Places on Scalp and/or Body					
		Raynauds Phenomena -Cold, Numb, White or Blue Fingertips or Toe tips.					

5. Symptoms:

Have you ever had the following conditions? If not, leave blank.

Yes	No	How many days in the last month	Severity Mild	Mod.	Sev.	Circle the Months Most Severe
		Runny or stuffy nose				J F M A M J J A S O N D
		Itchy eyes				J F M A M J J A S O N D
		Wheezing				J F M A M J J A S O N D
		Coughing				J F M A M J J A S O N D
		Wheezing or coughing with exercise				J F M A M J J A S O N D
		Skin problems				J F M A M J J A S O N D
		Joint Pain -				J F M A M J J A S O N D
		Joint Swelling Which Joint? _____				J F M A M J J A S O N D
		Joint Deformity				J F M A M J J A S O N D
		Lesser Motion				J F M A M J J A S O N D
		Sleeping Problems				J F M A M J J A S O N D
		Have you ever stopped breathing during sleep?				J F M A M J J A S O N D
		Morning Stiffness If Yes, How Long? _____				J F M A M J J A S O N D
		Stiffness After Sitting				J F M A M J J A S O N D
		Burning During Urination				J F M A M J J A S O N D

6. Bites:

Any travel or tick bites at the onset of the symptoms? ❒ Yes ❒ No

7. Food Reactions:

Have you ever had any symptoms (rash, hay fever, vomiting, gas, cramps, diarrhea, colic as an infant) after the ingestion of any food or liquid? If yes, specify below.

Food	Approximate Date	Symptoms	Can food be eaten? Yes	No	Date food was last eaten.

8. PRECIPITATING FACTORS/ TRIGGERS:

For each item below, check the appropriate square to indicate whether your (or your child's) condition is affected by the following precipitants/triggers.

	Made Worse	Made Better	No Change
Cutting or playing in grass, raking leaves	❒	❒	❒
High winds, riding in a car	❒	❒	❒
Other outdoor exposure	❒	❒	❒
Mold/mildewed areas or items (attic, basement, etc	❒	❒	❒
Sweeping, dusting or vacuuming	❒	❒	❒
Smog, smoking or smoke exposure	❒	❒	❒
Air conditioning or heating	❒	❒	❒
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, toothpaste, etc.	❒	❒	❒
Paint lacquer, glue, mothballs,motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc.	❒	❒	❒
Trips away from home	❒	❒	❒
Other strong odors (perfume, etc.)	❒	❒	❒
Medications:			
Antihistamines or cold preparations	❒	❒	❒
Asthma medications	❒	❒	❒
Nose drops or spray	❒	❒	❒
How often per day?_____			
Other			
Exposure to animals Specify: _____	❒	❒	❒

8. PRECIPITATING FACTORS/ TRIGGERS: Continued

For each item below, check the appropriate square to indicate whether your (or your child's) condition is affected by the following precipitants/triggers.

	Made Worse	Made Better	No Change		Made Worse	Made Better	No Change
Colds or viruses	☐	☐	☐	Cold Weather	☐	☐	☐
Physical exertion or exercise	☐	☐	☐	Other factors	☐	☐	☐

9. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests? Yes ☐ No ☐ If yes, date _____ Physician's Name _____

Results of these tests: (If possible, please provide us with a copy)

_____

_____

Have you ever received allergy injections? Yes ☐ No ☐ If yes, date _____

10. OTHER MEDICAL PROBLEMS: Have you ever had any of the following? Answer all items.

	Yes	No		Yes	No		Yes	No
Frequent Headaches	☐	☐	Pneumonia, number past year _____	☐	☐	Kidney or Bladder Trouble	☐	☐
Frequent Nosebleeds	☐	☐				Liver Trouble (e.g. Hepatitis)	☐	☐
Nasal Polyps	☐	☐	Coughed Up Blood	☐	☐			
Operation on Sinuses	☐	☐	Tuberculosis	☐	☐	Frequent Diarrhea	☐	☐
Sinus X-Rays	☐	☐	Chest X-Ray	☐	☐	Bone Joint	☐	☐
Ear Inflections Number past year_____	☐	☐	Heart Trouble	☐	☐	Poison Ivy or Poison Oak	☐	☐
			High Blood Pressure	☐	☐	Thyroid Diabetes	☐	☐
Hearing Problems	☐	☐	Colic or Spitting Up as an Infant	☐	☐	Other _____	☐	☐
Glaucoma	☐	☐						
Tonsils / Adenoids Removed (date)_____	☐	☐	Frequent Heartburn	☐	☐			
			Diabetes	☐	☐			

11. HOSPITALIZATIONS:

List most recent first.	Reason	Date

12. SURGERY:

List most recent first.	Reason	Date

13. Other Serious Illnesses: Other than 11 & 12 Above.

Type of Illness:	Date

14. FAMILY HISTORY: Do any members of your family have a history of allergy?

	Yes	No	If yes, list all relatives, (e.g. parents, brothers & sisters, children, aunts, uncles, grandparents, etc.
Asthma			
Hay Fever			
Eczema			
Hives			
Swelling			
Frequent Pneumonia			
Headaches			
Other Allergies			

14. FAMILY HISTORY: Continued

Do any members of your family have a history of allergy?

	Yes	No	If yes, list all relatives, (e.g. parents, brothers & sisters, children, aunts, uncles, grandparents, etc.
Emphysema			
Cystic Fibrosis			
Tuberculosis			
Thyroid Disease			
Glaucoma			
Diabetes			
Arthritis			
Other Autoimmune Disease			
Other			

15. ENVIRONMENTAL SURVEY:

Where do you live ? ❒ City ❒ Rural

Age of House: _____ Years

Number of Indoor Plants: _____

House Construction: ❒ Brick ❒ Wood ❒ _____

Any rooms damp or musty? ❒ Yes ❒ No

Do You have: ❒ An Air Cleaner ❒ Neither
❒ An Air Humidifier

Type of Carpet: Bedroom Living Room Den Dining Room
Type of Pad:

Is your pillow: ❒ feather ❒ foam rubber
❒ dacron ❒ Other
❒ encased in plastic

Is your mattress: ❒ foam rubber ❒ cotton
❒ innerspring & cotton ❒ waterbed
❒ encased in plastic ❒ Other _____

What kind of grasses, shrubs and trees are in the immediate vicinity of your house?

What type of work do you do?

Are you exposed to anything at work that might aggravate your condition? Which things?

Have you missed any time from work or school because of your allergies? How much time?

Do you have any other exposures from hobbies, recreational activities, etc.?

16. MARITAL STATUS: ❒ Married ❒ Single ❒ Widowed ❒ Separated Number of Children _____

17. SMOKING / WEIGHT:

Have you ever smoked? ❒ Yes ❒ No If Yes, how many Years? _____
Do you presently smoke? ❒ Yes ❒ No If Not, when did you stop? _____

Average cigarettes per day at highest point? _____ If you still smoke, do you think you could stop? ❒ Yes ❒ No
Which other family members now smoke in your home? _____
Weight now: _____ Weight on year ago: _____ Maximum weight: _____ When? _____

18. MOBILITY:

At this moment, I can:	No Trouble	Some Trouble	Much Trouble	Unable To Do
Dress Myself	❒	❒	❒	❒
Get in & out of bed	❒	❒	❒	❒
Lift a full cup or glass to my mouth	❒	❒	❒	❒
Walk outdoors on flat ground	❒	❒	❒	❒
Wash and dry myself	❒	❒	❒	❒
Bend down to pick up clothes off floor	❒	❒	❒	❒
Turn regular faucets on and off	❒	❒	❒	❒
Get in and out of car	❒	❒	❒	❒
Run errands and shop	❒	❒	❒	❒

At this moment, I can:	No Trouble	Some Trouble	Much Trouble	Unable To Do
Climb up a flight of stairs	❒	❒	❒	❒
Walk two miles	❒	❒	❒	❒
Run or jog two miles	❒	❒	❒	❒
Drive a car 5 miles from home	❒	❒	❒	❒
Participate in sports & games	❒	❒	❒	❒
get a good nights sleep	❒	❒	❒	❒
Deal with daily stress	❒	❒	❒	❒
Deal with anxiety or nervousness	❒	❒	❒	❒
Deal with the feeling depressed/blue	❒	❒	❒	❒

At present, how would you rate your overall pain? (Circle 1 number) **NO PAIN** 1 2 3 4 5 6 7 8 9 10 **SEVERE PAIN**

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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____
Name of Healthcare Provider/Physician/Facility

_____
Street Address

_____
City, State and Zip Code

RE: Patient Name: _____

Date of Birth: _____ SSN (Last 4): _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- ☐ Summary of records to include: one year of lab results, one year of office notes and one year of radiology reports.
- ☐ Last lab result
- ☐ Last office note
- ☐ Other: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purpose of:

- ☐ Continued care
- ☐ Transfer of care
- ☐ Other: _____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

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I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____

Signature of Patient or Legally Authorized Representative — Date

_____ _____

If applicable, Name and Relationship of Legally Authorized Representative to Patient — Date

_____ _____

Witness Signature — Date

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Allergy, Asthma & Arthritis Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care options (TPO). The Notice of Privacy Practices provided by Allergy, Asthma & Arthritis Center describes such uses and disclosures more completely. Note: This can be found on the last page of the new patient paperwork.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Allergy, Asthma & Arthritis Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Allergy, Asthma & Arthritis Center, 709 N Clyde Morris Blvd., Daytona Beach, Florida 32114.

With this consent, Allergy, Asthma & Arthritis Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Allergy, Asthma & Arthritis Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Allergy, Asthma & Arthritis Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Allergy, Asthma & Arthritis Center may decline to provide treatment to me.

With this consent, Allergy, Asthma & Arthritis Center may disclose protected health information (PHI) to the people who are listed below.

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Patient Signature	_____ Date Signed

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Financial Policy

Your health is first and foremost. Medical care will always be rendered on the basis of need, and no other factor will affect the quality of that care.

This is an agreement between Allergy, Asthma & Arthritis Center as creditor, and the patient/debtor named on this form. Be executing this agreement, you and agreeing to pay for all services that are received. In the event that a patient does not meet their financial obligation, the patient will be discharged from the practice.

Monthly statement: If you have a balance on your account, we will send you a monthly statement by mail. It will show the current patient balance that is the patient/debtor's responsibility.

Payment option if you have no insurance: You may choose to pay by cash, check, visa or MasterCard. You are required to pay on the day that treatment is rendered.

Payment option if you have insurance: You may choose to pay by cash, check, visa or MasterCard. The patient/debtor will be responsible for any copays, deductibles or out-of-pocket expenses after insurance has paid.

Insurance: We will bill your insurance company. 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 all of the charges not covered by insurance or all those charged deemed your responsibility based on a managed care contract that we are a party to (if applicable). Additionally, it is the patient's responsibility to notify us of any insurance changes.

Referrals: If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company. It is the patient's responsibility to get all information to the primary care doctor for processing within seven (7) business days. If the correct time is not allowed the patient may need to reschedule. We may send a request for this information *as a courtesy* to the patient but this action is not required.

Cancellations and no shows: A 24-hour notice must be given to reschedule or cancel appointment to avoid additional charges. If proper notice is not given there is a charge of $30. Monday cancellations must be done by 4:00pm on Friday.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____ _____

Patient Name Signature

_____

Date Signed

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Michael D. Kohen, M.D.

Agreement for Long-term Controlled Substances Therapy for Chronic Pain

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from Dr. Kohen or Dr. Diamond or, during their absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

   _____ phone: _____.

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

5. You may not share, sell, or otherwise permit others to have access to these medications.

6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.

8. New prescriptions for certain prescribed medications require that you be seen by the physician at least every 3 months.

9. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.

12. Early refills will generally not be given early *except that* prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they should not be filled prior to the appropriate date.

13. Renewals are contingent upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

15. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent upon evidence of benefit.

16. It is understood that failure to adhere to these policies may result in discharge, in cessation of therapy with controlled substances, or referral for further specialty assessment.

17. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

Patient Signature _____

Patient Date of Birth_____

Patient Name (Printed) _____ Date _____

Allergy, Asthma & Arthritis Center
Our 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.

Our pledge regarding your health information:

We understand that medical Information about you and your health is personal. We create a record of the care and services you receive from us. We need this record to provide you with quality care, obtain payment *for* the services we provide and to comply with legal requirements. This Notice applies to all of the records of your care generated by us, whether made by your personal doctor, other Practice doctors or Practice staff. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this Notice of our legal duties and privacy practices; and (3) follow the terms of the Notice that is currently in effect. The professional and non-professional staff at our Practice sites will follow the terms of the Notice. Our Practice sites may share medical information with each other for treatment, payment or practice operations purposes described in this Notice.

How we may use *and disclose medical Information about you:*

The following categories and examples describe the different ways that we use and disclose medical Information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Category:	**Description and Examples:**
Treatment	We may share medical information about you with another physician, a hospital or other health care provider involved in your care. For example, a hospital may need to see a part of your medical record before you have surgery.
For payment	We may share medical information with Medicare or other health plans to obtain payment for services provided to you, to verify insurance coverage or to obtain authorization for further treatment. For example, an insurance company may need to see a part of your medical record before they will pay for the services.
For Practice Operations	We may share medical information as necessary to manage the medical, legal and financial affairs of the Practice and to monitor the quality of services provided to our patients. For example, our attorney or accountant may need patient information in order to provide legal and financial services to the Practice. Any business associate with whom we share medical information will agree in writing to protect your privacy.
Appointment reminders	We may disclose medical information to remind you of an appointment. We will disclose only the date, time and location of the appointment.
Family members and friends	We will share medical information with a friend or family member that is involved in your care or payment of your bill. We will give you an opportunity to agree or object to these disclosures unless it is clear from the circumstances that you do not object.
Worker's compensation	We may report a work-related injury to a worker's compensation carrier or to advise your employer about a work-related injury.
To meet legal requirements and for public health activities	We may disclose medical information to a government agency that oversees medical practice in the State such as the Florida Agency for Health Care Administration or the Board of Medicine. We are also required to report certain diseases and conditions to the local unit of the Department of Health for its public health activities.
Law enforcement **lawsuits, disputes and reports of abuse or neglect**	We may disclose medical information to an attorney or law enforcement official to comply with a court order, subpoena, discovery request or other legal mandate. We may also disclose medical Information to assist law enforcement with investigating a crime. For example. we are required to report wounds resulting from violence and incidents of abuse or neglect.
To avert a 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 and safety or that of the public or another person. Any disclosure, however, would only be to someone able to respond to the threat.

Category:	Description and Examples:
For special government functions	We may be required to disclose medical information to a government agency for national security purposes to a correctional facility in which you may be incarcerated, or to a military authority if you are in the service or a veteran.
Organ and *tissue donation*	We may disclose medical information to an organization that handles organ, eye or tissue transplantation.
Medical Examiners and Funeral Directors	We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may also release medical information about individuals to funeral directors as necessary to carry out their duties.

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 with your written permission. If you provide us permission to use or disclose medical Information about you, you may revoke that permission, in writing, at any time. If you revoke your permission. we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission. and that we are required to retain our records of the care that we provided to you.

Your rights regarding medical information:

You may access medical information	To access your medical information, you must submit your request to us at our address listed below. If you request copies, we may charge a fee allowed by law. We may deny your request in certain very limited circumstances.
You may amend and/or correct your medical information	You may ask us to amend or correct your medical information. Please make your request in writing and submit it to our office. address listed below. You must provide a reason that supports your request.
You may request an "accounting of dis- **closures"**	You may request a list of the disclosures we made of medical information about you, other than for treatment, payment or Practice operations as described above, and without your written authorization.
You may request restrictions on the use or disclosure of your medical information	You may request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or Practice operations. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
You may request confidential communications	You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will try to accommodate all reasonable requests.
You may have a Notice	You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of this Notice at any time.

Changes to this Notice:

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for medical information 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 prominent locations at our Practice sites. The Notice will contain the effective date.

Exercise of privacy rights and complaints:

To exercise your privacy rights or to file a complaint, contact us at our address below. A complaint may also be flied with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Allergy, Asthma, Arthritis & Lung Center
Compliance Officer (Office Manager)
709 N. Clyde Morris Blvd.
Daytona Beach, FL 32114
386-252-1632 I Fax 257-5526

"Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Room 509F. HHH Building
Washington, D.C. 20201

Effective Date: April, 2003