Allergy
Asthma
Arthritis &
Lung Center

Patient Registration & Insurance Verification Form

Name: ______ **DOB:** ______ **Age:** ______ **SS#:** ______

Mailing Address: ______ City: ______ St: ______ Zip: ______

Home Address: ______ City: ______ St: ______ Zip: ______

Home Phone: ______ Cell Phone: ______ Business Phone: ______

Sex: ______ Marital Status ______ Emergency Contact: ______ Phone: ______

Referring Physician: ______ Address / Phone: ______

Physician at AAAL Center - Circle One Dr. Kohen Dr. Diamond

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 #: ______

If HMO or Point of Service (POS), please list the following:

Assigned PCP Name: ______ Phone #: ______

Address: ______ City: ______ St: ______ Zip: ______

Referral Authorization #: ______ Is the referring physician different from the PCP? ☐ Yes ☐ No

Referring Physician Name: ______

Are Other Family Members, Who Are Patients, Covered? ☐ Yes ☐ No If yes, who? ______

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 AAAL CENTER TO FILE CLAIMS ON MY BEHALF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COPAYMENTS, DEDUCTIBLES, AND COINSURANCE REQUIRED BY MY INSURANCE. I AM ALSO REQUIRED TO PAY FOR HMO SERVICES RECEIVED WITHOUT PRIOR AUTHORIZATION AND FOR OBTAINING HMO REFERRALS.

SIGNATURE: ______ DATE: ______

Allergy
Asthma
Arthritis
Center

Dr. Kohen, Dr, Domingues, Katheryn Rogan PA.C
709 N. Clyde Morris Blvd, Daytona Beach FL, 32114

Name: ______________________
DOB: ____/____/____

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

____

____

____

____

____

____

____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:

LEFT RIGHT LEFT

LEFT RIGHT

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment - Listening to the patient - A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42(9):1797-808. Used by permission.

Date symptoms began *(approximate)*:

Diagnosis:

Previous treatment for this problem *(include physical therapy, surgery and injections; medications to be listed later)*:

Please list the names of other practitioners you have seen for this problem:

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? *(check if "yes")*

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions:

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SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last Bone Density ____/____/____

Constitutional
- ❑ Recent weight gain amount
- ❑ Recent weight loss amount
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Eyes
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose-Mouth-Throat
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing

Cardiovascular
- ❑ Chest Pain
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory
- ❑ Shortness of breath
- ❑ Difficulty breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary
- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

Musculoskeletal
- ❑ Morning stiffness
  Lasting how long?
  Minutes Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling
  List joints affected in the last 6 mos.

Integumentary (skin and/or breast)
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric
- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine
- ❑ Excessive thirst

Hematologic/Lymphatic
- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when

Allergic/Immunologic
- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient's Name: Date: Physician Initials:

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SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day?

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago?

Do you drink alcohol? ❑ Yes ❑ No Number per week

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No

If yes, please list:

How many hours of sleep do you get at night?

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

PAST MEDICAL HISTORY

Do you now have or have you ever had: *(check if "yes)*

❑ Cancer	❑ Heart problems	❑ Asthma
❑ Goiter	❑ Leukemia	❑ Stroke
❑ Cataracts	❑ Diabetes	❑ Epilepsy
❑ Nervous breakdown	❑ Stomach ulcers	❑ Rheumatic fever
❑ Bad headaches	❑ Jaundice	❑ Colitis
❑ Kidney disease	❑ Pneumonia	❑ Psoriasis
❑ Anemia	❑ HIV/AIDS	❑ High Blood Pressure
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness *(please list)*

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes *Describe:*

Any other serious injuries? ❑ No ❑ Yes *Describe:*

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings Number living Number decreased

Number of siblings Number living Number decreased List ages of each

Health of children

Do you know any blood relative who has or had: ***(check and give relationship)***

❑ Cancer	❑ Heart disease	❑ Rheumatic fever	❑ Tuberculosis
❑ Leukemia	❑ High blood pressure	❑ Epilepsy	❑ Diabetes
❑ Stroke	❑ Bleeding tendency	❑ Asthma	❑ Goiter
❑ Colitis	❑ Alcoholism	❑ Psoriasis	

Patient's Name: Date: Physician Initials:

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MEDICATIONS

Drug allergies: ❑ No ❑ Yes If yes, please list:

Type of reaction:

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: *Helped?* A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS: Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. *Record your comments in the spaces provided.*

Drug names/Dose	Length of time	Please check: *Helped?* A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	

Circle any you have taken in the past

Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac

Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate

Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac

Drug names/Dose	Length of time	A Lot	Some	Not At All	Reactions
Pain Relievers					
Acetaminophen		❑	❑	❑	
Codeine		❑	❑	❑	
Propoxyphene		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		❑	❑	❑	
Golimumab		❑	❑	❑	
Hydroxychloroquine		❑	❑	❑	
Penicillamine		❑	❑	❑	
Methotrexate		❑	❑	❑	
Azathioprine		❑	❑	❑	
Sulfasalazine		❑	❑	❑	
Quinacrine		❑	❑	❑	
Cyclophosphamide		❑	❑	❑	
Cyclosporine A		❑	❑	❑	
Etanercept		❑	❑	❑	
Infliximab		❑	❑	❑	
Tocilizumab		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name: Date: Physician Initials:

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: *Helped?*			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen		❑	❑	❑	
Alendronate		❑	❑	❑	
Etidronate		❑	❑	❑	
Raloxifene		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal		❑	❑	❑	
Risedronate		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen		❑	❑	❑	
Tiludronate		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyaluronan		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	

Please list supplements:

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list:

Patient's Name: Date: Physician Initials:

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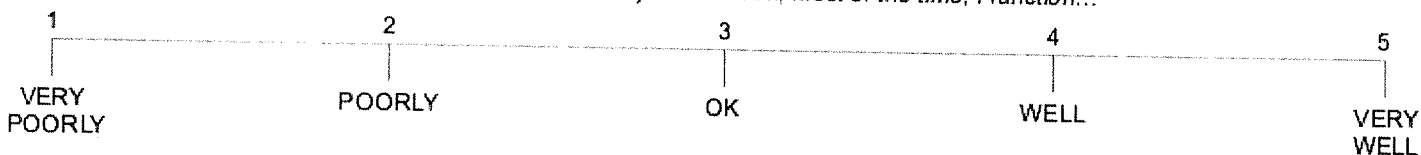
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No *If yes, how many?*

How many people in household? Relationship and age of each

Who does most of the housework? Who does most of the shopping? Who does most of the yard work?

On the scale below, circle a number which best describes your situation; *Most of the time, I function...*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness	❑	❑	❑
Do you use a cane, crutches, walker or wheelchair? *(circle one)*	❑	❑	❑

What is the hardest thing for you to do?

Are you receiving disability? .... Yes ❑ No ❑

Are you applying for disability? .... Yes ❑ No ❑

Do you have a medically related lawsuit pending? .... Yes ❑ No ❑

Patient's Name: Date: Physician Initials:

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Allergy
Asthma
Arthritis &
Lung Center

709 N. Clyde Morris Blvd. • Daytona Beach, FL 32114 • (386) 252-1632 • FAX (386) 257-5526
1545 Hand Avenue, Suite 2 • Ormond Beach, FL 32174

Michael D. Kohen, M.D.

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:

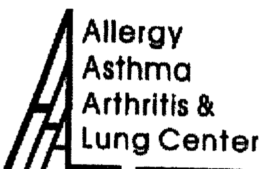
- ☐ Summary of records to include: one year of lab results, one year of office notes and one year of radiology reports.
- ☐ Last lab result
- ☐ Last office note
- ☐ Other: ____________________

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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Michael D. Kohen, M.D.

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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Michael D. Kohen, M.D.

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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Michael D. Kohen, M.D.

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

Allergy, Asthma & Arthritis Center
Our Notice of Privacy Practices

This Noticc 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 disclosures"	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 filed 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 | 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