The Health Associates of Tampa

Date of Visit: _____

Patient Demographic Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Social Security #: _____

Primary Phone Number: _____ HOME CELL WORK

Alternate Phone Number: _____ HOME CELL WORK

Email Address: _____

Preferred Method of Contact: Phone Email Text Patient Passport Sex: Male / Female

Ethnicity: _____ Marital Status: _____ Occupation: _____

Full Time _____ Part Time _____ Self Employed _____ Unemployed _____ Other _____ Student _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: _____ Alternate Phone Number: _____

Address: _____

INSURANCE INFORMATION

Insurance Carrier Name: _____

Group ID: _____ Member ID: _____

Patient Relationship to Policy Holder: _____

Primary Policy Holder Name: _____ Date of Birth: _____

Address: _____

PREFERRED PHARMACY

Pharmacy Name: _____ Phone Number: _____

Address: _____ City: _____

REFERRING PHYSICIAN AND/OR PHYSICIAN SPECIALISTS

Name: _____ Phone Number: _____

Specialty: _____

Name: _____ Phone Number: _____

Specialty: _____

Name: _____ Phone Number: _____

Specialty: _____

Patient Signature: _____ Date: _____

The Health Associates of Tampa
508 S. Habana Ave Suite #300 Tampa,
FL 33609
Phone:(813) 877-6770
Fax: (813) 877-6771

Name:_____Date of first visit: _____

Reason for visit: _____

Past Medical History

☐ High Blood Pressure	☐ High Cholesterol	☐ Diabetes
☐ Heart Disease	☐ Blood Clots	☐ Stroke
☐ Mini Stroke (TIA)	☐ Emphysema/COPD	☐ Asthma
☐ Pneumonia	☐ Positive PPD	☐ TB
☐ Acid reflux	☐ Stomach Ulcers	☐ Gall stones
☐ Diverticulitis	☐ Colon polyps	☐ Hemorrhoids
☐ Liver Disease	☐ Kidney disease	☐ Kidney stones
☐ Osteoarthritis	☐ Lupus	☐ Rheumatoid
☐ Gout	☐ Psoriasis	☐ Osteoporosis
☐ Thyroid disease	☐ Anemia	☐ Bleeding
☐ Blood Transfusion	☐ Headaches	☐ Migraines
☐ Back pain	☐ Glaucoma	☐ Enlarged
☐ Seizures	☐ Depression	☐ Anxiety
☐ Irregular periods	☐ Macular degeneration	☐ Hearing loss
☐ Other		

Current Medications:

Allergies:

_____

Surgical History

☐ Appendectomy ☐ Cholecystectomy ☐ Thyroid surgery

☐ Hysterectomy ☐ _____ ☐ _____

Social History

Tobacco abuse: Packs per day_____ X years smoked_____.

Alcohol Consumption: _____ Drugs: _____

Family History

Mother:_____

Father:_____

Brothers/Sisters:_____

Other: _____

Vaccination History

Please check if you had any of these	Vaccinations	Date of the most recent
☐	Influenza (Flu shot)	
☐	Pneumonia	
☐	Hepatitis A	
☐	Hepatitis B	
☐	Shingles	
☐	Tetanus	
☐	Other:	

Screening

Please check if you had any of these	Test	Date of the most recent	Any prior dates
☐	Colonoscopy		
☐	Mammogram		
☐	Bone density scan		
☐	PSA		
☐	PAP smear		
☐	Eye exam		
☐	Stool cards		

Is there any other medical information you would like us to know?

_____

_____

_____

_____

The Health Associates of Tampa

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:	
Date of Birth:	Social Security #:
Patient's Address:	
City, State, Zip:	Phone:

I authorize the following entity:

Entity:
Address:
City, State, Zip:
Phone:

To release my confidential Protected Health Information (PHI) to:

The Health Associates of Tampa
508 S Habana Ave Suite #300 ● Tampa, FL 33609 ● Phone: (813) 877-6770 ● Fax: (813) 877-6771

The PHI to be disclosed is relevant medical records and reports relating to my medical treatment, consultation and/or examination. I understand the information disclosed based on this authorization may include mental health treatment, records and information regarding HIV/AIDS status, treatment and/or testing.

ADDITIONAL AND/OR SPECIFIC REQUEST:

_____

_____

I understand that I have the right to refuse to sign this authorization. I understand that I have the right to revoke the authorization in writing. I understand that such revocation will not have any effect on any information already used/disclosed by THAT prior to our office receiving written notice of revocation. I also understand that the information disclosed under this release is subject to re-disclosure by the recipient and is no longer subject to protections of HIPAA. Treatment or payment for treatment cannot be conditioned on this authorization, except as allowed in the Privacy Rule.

I understand this authorization is in effect for 1 year from my signature date.

My signature below indicates that I have read and understand the authorization and its terms.

_____ _____

Signature of Patient Date

The Health Associates of Tampa
508 S. Habana Ave, Suite 300
Tampa, FL 33609
Office: (813) 877-6770
Fax: (813) 877-6771

Office and Financial Policies

We would like to thank you for choosing The Health Associates of Tampa as your primary care provider, where your health is our priority. We are committed to provide our patients with high quality medical care in a cost-effective manner. To accomplish this, we depend on receiving prompt payment for our services. To keep you informed of our current office and financial policies, we ask that you read and sign acknowledgment of our policies prior to any treatment Please keep this document for future reference.

1. No Call No Show Appointments: A No Call No Show appointment is when a patient fails to show for a scheduled appointment. **The Health Associates of Tampa reserves the right to charge a $125 fee for a No Call No Show Appointment.** The patient is expected to pay this fee if charged to their account prior to their next scheduled appointment. If a patient has **three (3) No Call No Show appointments within one (1) calendar year**, the practice reserves the right to terminate the patient from the clinic. If patient refuses to pay the fee, the practice reserves the right to terminate the patient from the clinic and has the right to send patients account to collections and charge additional legal fees if necessary.

2. Same Day Cancellation: If a patient calls and cancels an appointment less than 24 hours before the scheduled appointment time, **The Health Associates of Tampa reserves the right to charge a $75 fee.** The patient is expected to pay this fee if charged to their account. If patient shows a habit of cancelling within less than 24 hours on a regular basis, the practice reserves the right to terminate the patient from the clinic. If patient refuses to pay the fee, the practice reserves the right to terminate the patient from the clinic and has the right to send patients account to collections.

3. Late Appointment: A patient is considered late if they show up 15 minutes after the scheduled appointment time. If patient shows up late and the provider is unable to accommodate within their schedule, patient will be expected to reschedule their appointment. If patient is late, and the appointment is for a medication review, the provider is under no obligation to provide an extension of medications to any patient. If the provider chooses to extend this courtesy, it will be a one-time courtesy. If the patient shows a habit of showing up late to appointments, the practice reserves the right to terminate the patient from the clinic.

4. Medication Refills: It is the patient's responsibility to provide sufficient time for a refill request from a provider before patient runs out of medication. Refill requests will only be filled Monday – Friday during regular business hours of 9:00 am – 5:00 pm. Patient needs to allow a minimum of 48 hours for a refill to be acknowledged and filled or denied with explanation. Requests can take up to 72 hours at times.

5. Controlled Medications: Florida state law requires that if a patient is on a controlled medication that the patient must be seen in office by a provider once every three (3) months. It is the patient's responsibility to be sure to schedule these appointments as well as show for the appointment on time. The provider is not obligated to provide any extensions of refills if the patient does not make and/or keep these state law required appointments.

6. Adderall Refills: If a patient is prescribed Adderall, they are required to have an in-office appointment once every three months. At the time of this appointment, the patient will be provided three months of paper prescriptions. It is the patient's responsibility to keep track of these prescriptions as the provider will not be able to provide a duplicate prescription. If patient loses or has a prescription stolen, the patient must file a police report and provide a copy for records for a replacement prescription to be considered.

7. Payment for Services Rendered:

    a. Patients with Medical Insurance: Please bring your insurance card with you at the time of your appointment.

        i. Patients are responsible for knowing the benefits covered by their insurance policy. Our services are documented to comply with federal law and will be billed accordingly. Verification that our providers are "in network" with an insurance plan is the patient's responsibility. Patients are responsible for verification that all referrals or prior authorizations are attained before services are provided, as imposed by their benefit plan.
        ii. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, a processing fee will be added to your account to cover additional billing expenses that will be incurred.
        iii. Patient is responsible for any co-insurance deductibles or non-covered services as required by your insurance. You will receive a statement from our third-party billing company, Premium Billing Solutions, indicating what your insurance has paid. Any remaining balance is due upon receipt of this statement. Any balance over 60 days will be assessed a late fee. A payment can be arranged with our Billing Department upon request.
        iv. As stated, The Health Associates of Tampa utilizes a third-party billing company. Charges could take several weeks for the office to be notified that our provider and/or clinic, or certain services are not covered by a patient's insurance plan. With each insurance company having multiple plans, it is not possible for our office staff to know the details of each patient's individual plan. Due to this, it is important to stress that it is the patient's responsibility to understand and know their benefits and coverage.

v. It is the patient's responsibility to provide a copy of any new or updated insurance cards received from insurance carrier as a new card could contain different information when filing any claims.

b. Patients without medical insurance; Self-pay / Cash

i. Payment will be due prior to services rendered. A new patient appointment is **$125** and a follow-up for an established patient is **$75**.
ii. If you are unable to pay your balance in full, arrangements must be made and approved by management within the office prior to services being rendered.
iii. Any outside services that may be recommended during appointment, such as labs or imaging, an order will be provided to the patient, and it will be the responsibility of the patient to seek these services on their own.

c. Payment: The Health Associates of Tampa accepts a variety of payment methods. We accept cash, checks and major credit cards.

d. Returned Checks: a **$50** charge will be added to your account for any check returned by your bank for any reason. This is subject to change based on bank charges.

8. Auto Accidents, Liability Injuries and Workman's Comp: The Health Associates of Tampa does not participate in these services currently. If you are an established patient and need to be seen for one of these types of appointments, please contact our office for a referral to our recommended offices that can assist you with these needs.

9. Medical and Other Forms: There is a minimum fee of $20 for the completion of forms such as school physicals, school sports, employment, adoption, fitness center, FMLA, disability forms, etc. The charges are based on and can increase with the number of pages and complexity of information requested. Please speak with the Office Coordinator after presenting the forms to discuss the amount that will be charged for the completion of requested forms.

10. Medical Records: The Health Associates of Tampa will provide you with a copy of your medical records upon request.
    a. You will need to complete and sign a Release of Information (ROI) form before we can begin the request.
    b. Allow 7 – 10 business days for completion
    c. The fee for printed records is $1 per page up to $25, and then .25¢ per page after that.
    d. If records must be mailed, the mailing fee will also be the patient responsibility.
    e. Records that can be provided electronically do not have a fee.

PATIENT NAME_____ DATE OF BIRTH_____

PATIENT SIGNATURE _____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by The Health Associates of Tampa. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including coinsurance, deductibles and co-pays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to The Health Associates of Tampa for any medical services furnished. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my charges as outlined in office and financial policies guidelines. I acknowledge that I have received a copy of the office policies.

Signed_____ Date_____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby give my consent to The Health Associates of Tampa to use or disclose, for the purpose of carrying out treatment, payment or healthcare operations all protected health information contained in the patient record of (patient name) _____.

For a more detailed description of this consent and other uses and disclosures please review our Notice of Privacy Practices. I understand that The Health Associates of Tampa reserves the right to change its privacy practices that are described in the Notice. I also understand that any Revised Notice will be posted on The Health Associates of Tampa's website and will be posted at the office.

We may make your protected health information available electronically through an electronic health information exchange to other health care providers that request your information for their treatment purposes. In all cases the requesting provider must have or have had a treating relationship with you. Participation in an electronic health information exchange also lets us see other provider's information about you for our treatment purposes.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied upon it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed _____ Date_____

The Health Associates of Tampa
508 S Habana Ave. Suite 300
Tampa, FL 33609
813-877-6770 (Phone)
813-877-6771 (Fax)

Use and Disclosure Authorization

Patient Name: _____

Date of Birth: _____

You may discuss information regarding my treatment and care with the following family members and/or friends:
(Please list name, relationship to patient, and contact number)

_____

_____

1. You may leave the following messages on answering machines:

☐ Referral Information

☐ Prescription refill information

☐ Test results

☐ Appointment Reminder

☐ Other: _____

This Release of Information will remain in effect until terminated by me in writing.

_____ _____

Patient Signature **Date**

THE HEALTH ASSOCIATES OF TAMPA BAY, P.A.
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Revised as of January 5th, 2018

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.

If you have any questions or wish to receive additional information about the matters covered by this Notice of Privacy Practices ("Notice"), please contact the Privacy Officer for THE HEALTH ASSOCIATES OF TAMPA BAY, P.A. ("THAT"), Jeetpaul Saran, M.D. at 508 S. Habana Ave. Suite 300, Tampa, FL 33609 or call: (813) 877-6770.

This Notice is provided to you in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and associated regulations, as may be amended (collectively referred to as "HIPAA") describing THAT's legal duties and privacy practices with respect to your Protected Health Information ("PHI"). THAT is required to abide by the terms of this Notice currently in effect, and may need to revise the Notice from time to time. Any required revisions of this Notice will be effective for all PHI that THAT maintains. A current copy of the Notice will be posted in each office and you may request a paper, or electronic, copy of it.

PHI consists of all individually identifiable information which is created or received by THAT and which relates to your past, present or future physical or mental health condition, the provision of health care to you, or the past, present or future payment for health care provided to you.

USE AND DISCLOSURE OF PHI FOR WHICH YOUR CONSENT OR AUTHORIZATION IS NOT REQUIRED

HIPAA permits THAT to use or disclose your PHI in certain circumstances, which are described below, without your authorization. However, Florida law may not permit the same disclosures. THAT will comply with whichever law is stricter.

1. **Treatment**: THAT may use and disclose your PHI to provide, coordinate or manage your health care and related services, including consulting with other health care providers about your health care or referring you to another health care provider for treatment. For example, THAT may discuss your health information with a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you. Further, THAT may contact you to remind you of a scheduled appointment.

2. **Payment**: THAT may use and disclose your PHI, as needed, to obtain payment for the health care it provides to you. For example, THAT may disclose to a third-party payer the treatment you are going to receive to ensure that the payer will cover that treatment. Additionally, THAT may disclose to a third party payer or grant funding service, as necessary, the type of services you received to reimbursement for your treatment.

3. **Health Care Operations**: THAT may use or disclose your PHI in order to carry out its administrative functions. These activities include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, conducting training programs in which students provide treatment under the supervision of one of THAT's health care professionals, business planning and development, business management and general administrative activities. For example, THAT may disclose your PHI to accreditation agencies reviewing the types of services provided.

4. **Required by Law**: THAT may use or disclose your PHI to the extent that such use or disclosure is required by law.

5. **Public Health**: THAT may disclose your PHI to a public health authority, employer or appropriate governmental authority authorized to receive such information for the purpose of: (a) preventing or controlling disease, injury or disability; reporting disease or injury; conducting public health surveillance, public health investigations and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency in collaboration with a public health authority; or reporting child abuse or neglect; (b) activities related to the quality, safety or effectiveness or activities or products regulated by the Food and Drug Administration; (c) notifying a person who may have been exposed to a communicable disease or may otherwise be at risk of spreading a disease or condition.

6. **Abuse, Neglect or Domestic Violence**: THAT may disclose your PHI to a government authority authorized to receive reports of abuse, neglect or domestic violence if it reasonably believes that you are a victim of abuse, neglect or domestic violence. Any such disclosure will be made: 1) to the extent it is required by law; 2) to the extent that the disclosure is authorized by statute or regulation and THAT believes the disclosure is necessary to prevent serious harm to you or other potential victims; or 3) if you agree to the disclosure.

7. **Health Oversight Activities**: THAT may disclose your PHI to a health oversight agency for any oversight activities authorized by law, including audits; investigations; inspections; licensure or disciplinary actions; civil, criminal or administrative actions or proceedings; or other activities necessary for the oversight of the health care system, government benefit programs, compliance with government regulatory program standards or applicable laws.

8. **Judicial and Administrative Proceedings**: THAT may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process upon receipt of "satisfactory assurance" that you have received notice of the request.

9. **Law Enforcement Purposes**: THAT may disclose limited PHI about you for law enforcement purposes to a law enforcement official: (a) in compliance with a court order, a court-ordered warrant, a subpoena or summons issued by a judicial officer or an administrative request; (b) in response to a request for information for the purposes of identifying or locating a suspect, fugitive, material witness or missing person; (c) in response to a request about an individual that is suspected to be a victim of a crime, if, under limited circumstances, THAT is not able to obtain your consent; (d) if the information relates to a death THAT believes may have resulted from criminal conduct; (e) if the information constitutes evidence of criminal conduct that occurred on the premises of THAT ; or (f) in certain emergency circumstances, to alert law enforcement of the commission and nature of a crime, the location and victims of the crime and the identity, or description and location of the perpetrator of the crime.

10. **Coroners, Medical Examiners and Funeral Directors**: THAT may disclose your PHI to a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law. THAT may disclose your PHI to a funeral director, consistent with all applicable laws, in order to allow the funeral director to carry out his or her duties.

11. **Research**: THAT may use or disclose your PHI for research purposes, provided than an institutional review board authorized by law or a privacy board waives the authorization requirement and provided that the researcher makes certain representations regarding the use and protection of the PHI.

12. **Serious Threat to Health or Safety**: THAT may disclose your PHI, in a manner which is consistent with applicable laws and ethical standards, if the disclosure is necessary to prevent or lessen a serious threat to health or safety of a person or the public, or the information is necessary to apprehend an individual.

13. **Specialized Government Functions**: THAT may also disclose your PHI, (a) If you are a member of the United States or foreign Armed Forces, for activities that are deemed necessary by appropriate military command authorities to assure the proper execution of a military mission; (b) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by law; (c) to authorized federal officials for the provision of protective services to the President, foreign heads of state, or other people authorized by law and to conduct investigations authorized by law; or (d) to a correctional institution or a law enforcement official having lawful custody of you under certain circumstances.

14. **Workers' Compensation**: THAT may disclose your PHI as authorized by, and in compliance with, laws relating to workers' compensation and other similar programs established by law.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

15. If you do not object to the following uses or disclosures of your PHI, THAT may: 1) disclose to a family member, other relative, a close personal friend, or other person identified by you the information relevant to their involvement in your care or payment related to your care; 2) notify others, or assist in the notification, of your location, general condition, or death; or 3) disclose your PHI to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES OF PHI

16. Any use or disclosure of your PHI that is not listed herein will be made only with your written authorization. You have the right to revoke such authorization at any time, provided that the revocation is in writing, except to the extent that: 1) THAT has taken action in reliance on the prior authorization; or 2) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

YOUR RIGHTS REGARDING YOUR PHI

17. **Restriction of Use and Disclosure**: You have the right to request that THAT restrict the PHI it uses and discloses in carrying out treatment, payment and health care operations. You also have the right to request that THAT restrict the PHI it discloses to a family member, other relative or any other person identified by you, which is relevant to such person's involvement in your treatment or payment for your treatment. By law, THAT is not obligated to agree to any restriction that you request. If THAT agrees to a restriction, however, it may only disclose your PHI in accordance with that restriction, unless the information is needed to provide emergency health care to you. If you wish to request a restriction on the use and disclosure of your PHI, please send a written request to the Privacy Officer which specifically sets forth: 1) that you are requesting a restriction on the use or the disclosure of your PHI; 2) what PHI you wish to restrict; and 3) to whom you wish the restrictions to apply (e.g., your spouse). THAT will not ask why you are requesting the restriction. The Privacy Officer will review your request and notify you whether or not THAT will agree to your requested restriction. You also have the right to request to restrict disclosure of your PHI to a health plan, if the disclosure is for payment or health care operations and the disclosure pertains to a health care item or service for which you have paid out of pocket in full.

18. **Authorization Required**: Most uses and disclosures of PHI for marketing and the sale of PHI require your authorization. In addition, disclosure of psychotherapy notes is prohibited without your authorization, except as allowed by law.

19. **Fundraising**: THAT may contact you for purposes of fundraising to support its programs. You have the option to opt-out of this type of communication.

20. **Confidential Communications**: You have the right to receive confidential communications of your PHI. You may request that you receive communications of your PHI from THAT in alternative means or at alternative locations. THAT will accommodate all reasonable requests, but certain conditions may be imposed.

To request that THAT make communications of your PHI by alternative means or at alternative locations, please send a written request to the Privacy Officer setting forth the alternative means by which you wish to receive communications or the alternative location at which you with to receive such communications. THAT will not ask why you are making such a request.

21. **Access to PHI**: You have the right to inspect and obtain a copy of your PHI maintained by THAT. Under HIPAA, you do not have the right to inspect or copy information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or information that THAT is otherwise prohibited by law from disclosing.

If you wish to inspect or obtain a copy of your PHI, please send a written request to the Privacy Officer. If you request a copy of your PHI, THAT may charge a fee for the cost of copying and mailing the information. You may also request that a copy of your PHI be transmitted to you electronically.

HIPAA permits THAT to deny your request to inspect or obtain a copy of your PHI for certain limited reasons. If access is denied, you may be entitled to a review of that denial. If you receive an access denial and want a review, please contact the Privacy Officer. The Privacy Officer will designate a licensed health care professional to review your request. This reviewing health care professional will not have participated in the original decision to deny your request. THAT will comply with the decision of the reviewing health care professional.

22. **Amending PHI**: You have the right to request that THAT amend your PHI. To request that an amendment be made to your PHI, please send a written request to the Privacy Officer. Your written request must provide a reason that supports the request amendment. THAT may deny your request if it does not contain a reason that supports the requested amendment. Additionally, THAT may deny your request to have your PHI amended if it determines that: 1) the information was not created by THAT and amendment may be made elsewhere; 2) the information is not part of a medical or billing record; 3) the information is not available for your inspection; or 4) the information is accurate and complete.

23. **Notification of Breach**: THAT will notify you following a breach of your PHI as required by law.

24. **Accounting of Disclosure of Your PHI**: You have the right to request a listing of certain disclosure of your PHI made by THAT during the period of up to six (6) years prior to the date on which you make your request. Any accounting you request will not include: 1) disclosures made to carry out treatment, payment or health care operations; 2) disclosures made to you; 3) disclosures made pursuant to an authorization given by you; 4) disclosures made to other people involved in your care or made for notification purposes; 5) disclosures made for national security or intelligence purposes; 6) disclosure made to correctional institutions or law enforcement officials; or 7) disclosures made prior to April 14, 2003. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations set forth in applicable statutes and regulations.

To request an accounting of the disclosures of your PHI, please send a written request to the Privacy Officer. Your written request must set forth the period for which you wish to receive an accounting. THAT will provide one free accounting during each twelve (12) month period. If you request additional accountings during the same twelve (12) month period, you may be charged for all costs incurred in preparing and providing that accounting. THAT will inform you of the fee for each accounting in advance and will allow you to modify or withdraw your request in order to reduce or avoid the fee.

25. **Obtaining a Copy of this Notice**: You have the right to request and receive a paper or electronic copy of this Notice at any time.

COMPLAINTS

26. If you believe that your privacy rights have been violated, you may file a complaint with THAT or with the Secretary of Health and Human Services. To file a complaint with THAT, please contact the Privacy Officer at the address listed on page 1 of this notice. All complaints must be submitted in writing. THAT WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

THE HEALTH ASSOCIATES OF TAMPA BAY, P.A.
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Revised as of July 31, 2013

By law, we are required to make available to you a copy of our Notice of Privacy Practices ("Notice"). By signing below you acknowledge that you received, or been offered and declined, a copy the Notice.

A current copy of the Notice is also posted in the office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time.

You may decline to sign this acknowledgement.

I have ❒ received or ❒ declined a copy of the Notice of Privacy Practices.

Patient Name (Print): _____

Signature of Patient or Legal Representative: _____

If Legal Representative, list Relationship to Patient: _____

Date: _____

For Office Use Only

We were unable to obtain this written acknowledgement because:

_____

_____

Initials: _____ Date: _____