AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS AND USE/DISCLOSURE OF MEDICAL RECORDS

I. AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I do hereby consent to medical evaluation and treatment by my physician, physician representatives and technicians. In the case of diagnostic studies, laboratory tests, psychology and physical therapy treatment, as prescribed by my physician, I hereby consent to treatment by the technologist, psychologist and physical therapist (and their representatives).

I do hereby authorize Southeastern Integrated Medical, PL (SIMED) to release to any third party payer (such as an insurance company or government agency) any necessary medical and/or psychiatric information and records concerning diagnosis and treatment when requested by such a third party for use in determining payment for medical services.

I do hereby authorize payment directly to any SIMED Provider examining and/or treating me, from any group or individual medical benefits herein specified and otherwise payable to me for their services.

I certify that the information given to me in applying for payment under the Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Health Care Financing Administration, Social Security Administration/Division of Family Services, Blue Cross Blue Shield of Florida, Medicare/Medicaid/MediGap or its intermediaries or any other carriers any additional information needed for this or a related Medicare/Medicaid claim. I hereby certify that all insurance pertaining to treatment shall be assigned to the SIMED provider treating me.

I permit a copy of these authorizations and assignments to be used in place of the original, which is on file with SIMED. I understand this is a lifetime authorization remaining in effect until revoked by me in writing.

I agree that payment for professional services is due and payable when services are rendered. I agree that should the amount of the insurance benefits be insufficient to cover the amount of the claim, I will be responsible for payment of the balance of my account for any professional services rendered. **I agree to be responsible for any co-payment and/or deductible associated with my insurance policy. I understand a $10.00 billing fee will be charged for co-pays and deductibles not paid at time of service.** I also understand SIMED will help in billing my insurance company for payment but it is my responsibility to follow-up on any claim submitted if any payment is not received in a reasonable amount of time. A finance charge of 1.5% periodic will be added to all patient account balances left outstanding for more than 30 days. I agree that I will be responsible for any collection fees if it becomes necessary to send my account for collections. I agree that I will be responsible for any fees for returned checks.

If this is in regards to an auto accident and I am pursuing treatment under my auto insurance, I permit SIMED to obtain pertinent information from the insurance company and provide information to the insurance company when requested.

In the case that my services are related to a **Worker's Compensation** case, I understand that I am still responsible for certain charges as allowed by Worker's Compensation law.

_____ _____

Patient or Responsible Party Signature Date

PLEASE READ THE OTHER SIDE OF THIS DOCUMENT

Effective 4/13/2003
Updated: 01/13

SIMED
SOUTHEASTERN INTEGRATED MEDICAL

AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS AND USE/DISCLOSURE OF MEDICAL RECORDS

II. USE AND DISCLOSURE OF HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is this corporation's policy to require your reading and signing this consent form prior to the provision of treatment or any other medical services. If you have any questions, please ask for the Privacy Officer of this corporation.

I, _____, currently residing at _____ of

(City)_____, (county) _____ (state)_____ do hereby consent to the use and disclosure of my individually identifiable health information ("Health Information") by **Southeastern Integrated Medical, PL (SIMED) and its Professional Providers** ("Provider") for the purposes of providing treatment to me, receiving payment from responsible parties for health care services rendered by the Provider, and/or engaging in health care operations, such as office management, credentialing, case management, and quality assessment. This authorizes the release of my Health Information or copies of such to be transferred to myself and/or any physician that I am referred to by a SIMED Provider.

I understand that Provider's Notice of Privacy Practices ("Notice") describes in more detail the types of uses of disclosures of Health Information involved in treatment, payment or health care operations, and that I have a right to request and review such Notice prior to signing this consent.

I understand that the Provider has reserved the right to change its privacy practices as described in the Notice. In the event of any change in the Provider's privacy practices, Provider will revise the Notice. I understand that I can obtain a copy of the revised Notice by writing to Provider.

I understand that if I choose to not sign this consent, Provider may withhold medical services, other than emergency services.

I understand that I have the right to request a restriction (ask for and see Patient Authorization to Use/Disclose Health Information) on Provider's use or disclosure of any and/or all Health Information to any and/or all locations, entities, or persons (including family members I wish to have or not have access to my Health Information). I further understand that Provider is not obligated to agree to my request. However, if Provider does agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has relied on this consent, and that any revocation will become effective on the date it has been received by Provider and will apply to uses and disclosures of the Health Information after the date of receipt.

Dated this _____day of _____, 20____. _____

Patient's Signature

If not signed by the patient, please print name & indicate relationship: _____

Name Relationship

OFFICE USE ONLY

- ☐ Patient requested and received the Notice of Health Information Practices. Date: _____: Initials: _____
- ☐ Patient requested and filled out restrictions on Patient Authorization to Use/Disclose Health Information form (see chart).

Effective 4/13/2003
Updated: 01/13

AUTHORIZATION TO RELEASE MEDICAL RECORDS
HIPAA RELEASE

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ SOCIAL SECURITY #: _____

PLEASE FILL IN THE BOXES BELOW. ANY OMISSIONS COULD RESULT IN DELAYS. PLEASE ALLOW UP TO 30 DAYS FOR PROCESSING.

☐ ***I AM REQUESTING RECORDS FROM A SIMED PROVIDER. PROVIDER NAME(S): _____***

☐ ***I AM REQUESTING RECORDS FROM A SIMED DIVISION (CHECK ALL THAT APPLY):***

☐ ALLERGY & ASTHMA	☐ ARTHRITIS CENTER	☐ FIRST CARE OF GAINESVILLE	☐ HAND SURGERY
☐ HEALTH PSYCHOLOGY	☐ INTERVENTIONAL PAIN MGMT.	☐ NEUROLOGY	☐ NEUROSURGERY
☐ PHYSICAL THERAPY	☐ PRIMARY CARE	☐ PSYCHIATRY	☐ REHABILITATION MEDICINE
☐ SLEEP CLINIC	☐ WOMEN'S HEALTH	☐ UROLOGY	

☐ ***I AM REQUESTING RECORDS FROM A PROVIDER OR FACILITY OUTSIDE OF SIMED***

NAME OF PHYSICIAN/FACILITY: _____

ADDRESS: _____

PHONE: _____ FAX: _____

SPECIFIC ITEMS TO BE RELEASED (*check all that apply*):

☐ Office Notes/Demographics	☐ History & Physical	☐ Allergy Test Results	☐ Radiological Reports / Images
☐ EMG/NCS Reports	☐ Cardiovascular Report	☐ Laboratory/Pathology Reports	☐ Pharmacy / Prescription Info
☐ Hospital_____	☐ Operative Reports	☐ Financial Information	☐ Other: _____

EXTREMELY CONFIDENTIAL MATERIALS *(check all that apply)*:

☐ HIV/AIDS ☐ Alcohol / Drug Abuse ☐ Psychiatric / Psychotherapeutic ☐ Sexually Transmitted Disease

I AM REQUESTING RECORDS FOR TREATMENT DATES _____ TO _____

PLEASE SEND MY RECORDS TO (NAME OF PERSON OR PROVIDER) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ FAX: _____

☐ ***INDIVIDUAL RELEASE: I PERMIT SIMED to discuss or review my personal health information, as indicated above, with the following individual(s):***

_____ _____

Print Name Print Name

_____ _____

Relationship to Patient Relationship to Patient

☐ ***I REVOKE approval for my personal health information to be released to the above listed individual(s) or entity.***

By signing below, I understand that: 1) This authority is good for one year from the date listed. 2) I am under no obligation to sign this authorization and that my ability to obtain treatment, eligibility for benefits, etc… will not depend in any way on whether I sign this authorization. 3) I have the right to inspect obtain a copy of any information disclosed pursuant to this authorization. 4) I may be charged a fee for these records as allowed by Florida Law. 5) I release the above entity or Southeastern Integrated Medical, PL (SIMED) and its employees from all liability that may arise from the release of this information. 6) State law prohibits re-disclosure of the information disclosed to the person/entities listed above without my further authorization. 7) SIMED cannot guarantee the recipient of the information will not re-disclose information contrary to such prohibition. 8) I may revoke this authorization at any time by signing the revocation section of this form and remitting it to my provider. 9) Any revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this information.

_____ _____

Signature of Patient/Legal Guardian Date

SIMED
SOUTHEASTERN INTEGRATED MEDICAL

ACKNOWLEDGMENT OF APPOINTMENT POLICY

Thank you for trusting SIMED physicians and healthcare professionals with your medical care. We give you our personal commitment that we will do everything possible to exceed your expectations for quality medical care. In return, we ask that you accept the following responsibility as a patient:

- **<u>You have the responsibility to keep your appointments or to telephone at least 24 hours in advance to reschedule if you cannot keep your appointment.</u>**
  - If you provide less than 24 hours notice you will be charged a fee of $50 for missing an appointment with one of our providers or our diagnostic and therapeutic services.
  - Please let us know what credit card you will be using to reserve your appointment.
- You have the responsibility, to the best of your ability, to bring with you information about past illnesses, hospitalizations, medications, or other matters relating to your health.
- You have the responsibility to participate in decisions regarding care, openly expressing any concerns, and asking questions if you do not understand any directions given to you.
- You have the responsibility to help your doctors, nurses, and all other health care team members, in their efforts to maintain your health by following their instructions.
- Co-payments and deductibles are due at time of service. A $10 service fee will be charged if we have to bill you for these amounts.
- Pre-payment will be required for non-insured services.

I have read and acknowledge my responsibilities as a patient.

Name: _____Date:_____
Signature

Name: _____
Printed Name ____ NT