ALTAMONTE WOMEN'S CENTER, P.A. NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed, and how you can access this information. Please view it carefully.

At the **Altamonte Women's Center, P.A.** We have always kept your information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in hour treatment. For example, a review of your file by a specialist Doctor whom we may involve in your care.

We may use or disclose your health information for payment of our services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operation. For example, one of our staff will enter your information into our computer.

We my share your medical information with our business associates, such as a billing service. We have a written contact with each business associate that requires them to protect your privacy.We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointment. If you are not at home, **we may leave this information on your answering machine or with the person who answers the telephone. Sign here**_____

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

Please indicate whom:_____

IF this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not disclose your health information without written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill this request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, **please specify address or telephone number you prefer.**

_____

You have the right to transfer copies of your health information to another practice. ***Upon signed consent.***You have the right to see and receive a copy of your health information, with a few exceptions. Give us written request regarding the information you want to see. If you also want a copy of your records, according to **Florida law** we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may, or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information. You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing. You may also file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Maureen Henson @ 407 331 7784. This notice goes into effect as of April 14, 2003, amended, August 8, 2007, January 19, 2012. **April 21,2016**

Acknowledgement : I have received a copy of the Altamonte Women's Center, P.A, Notice of Privacy Practices.

Date _____Signed_____ Print Name_____

If signing as a parent or guardian, please print the name of the Patient_____.

AAGab01192012.08072007.12312003. 04212016

Patient's Name: _____ Date: _____

As a patient of **Altamonte Women's Center** I have been informed of the following:

- It is my responsibility to know if there are any deductibles, copays, clauses and/or exclusions in my insurance policy that would prevent the insurance company from paying any of my claims.
- It is my responsibility to provide **Altamonte Women's Center** with accurate insurance information to submit claims on my behalf.
- My insurance company may not cover ALL physician fees, and I will be responsible for payment if my insurance company denies payment.
- It is my responsibility to obtain physician referrals if needed. If a referral is not obtained, but treatment is provided as an emergency and the insurance company denies payment, it is my responsibility to make payment for any outstanding charges.
- The office bills my insurance company for all visits, and office procedures performed IN office. Any questions related to outside bills (Labs) should be directed to whoever provided the services.
- I understand that some insurance companies have timely filing limits in reference to submission of medical claims. **I understand that information in regards to correct insurance policies must be given to the office within that time frame or I, as the patient, am solely responsible.**

My signature below indicates that I understand the information explained above. I acknowledge my financial responsibility for all charges including all reasonable costs, expenses, including court and attorney's fees incurred in pursuing collection of such charges

_____ _____

Signature of patient or legal guardian Date