Psychiatric Specialty Center, LLC
560 Village Blvd, Suite 150
West Palm Beach, FL 33409
Phone: (561) 331-8800
Fax: (561) 331-8074

CONSENT FOR TREATMENT

Treatment

Psychiatric Specialty Center, LLC ("PSC') provides psychiatric evaluation, psychotherapy, and medication management. It is important that I am prepared to be an active participant in my psychiatric treatment. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with my clinician.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the clinicians of PSC or members of this office. I understand that the initial interview with the clinician does not constitute a contract or agreement for treatment if it is felt the best treatment possible for me cannot be offered. I understand that the initial visit is only a consultation and does not establish a patient-doctor relationship.

Confidentiality

I understand that all information shared with the clinicians at PSC is confidential and no information will be released without my consent. During the course of treatment at PSC, it may be necessary for my psychiatrist or therapist to communicate with other providers to provide, coordinate, or manage my health care and any related services. PSC may also disclose my protected health information for the purposes of obtaining payment for the health care services provided by PSC and for quality assessment activities or other health care operations of PSC. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances.

☐ No Primary Care Provider ☐ I refuse contact with my Primary Care Provider

Primary Care Provider Name & Contact phone number: _____

I authorize PSC to contact my PCP (initial) _____

I give consent to Psychiatric Specialty Center to view my medication history retrieved from Surescripts.

_____ _____ _____ _____

Signature Name Date

I further understand that there are specific and limited exceptions to this confidentiality which include the following:
A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

Medication Management

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Medications may have unwanted side effects. I will be asked to acknowledge whether I understand the potential adverse effects related to psychotropic medications which may include tardive dyskinesia, weight gain, abnormal cholesterol and elevated blood sugar. It is also not advisable to drink alcohol or use illicit drugs while taking psychotropic medications. I will contact this office if I experience adverse effects.

Controlled Substances

I understand that I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced, stolen or if I use it up sooner than prescribed, I understand that it will not be replaced. Refills of controlled substance medication will be made only during regular business hours. I am aware that I will not receive a refill if I do not keep my appointment. I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medication from Psychiatric Specialty Center.

24 Hour services

Our practice is open only during business hours. To satisfy your 24/7 needs, our practice is credentialed with St. Mary's Medical Center. If your symptoms become urgent, you have an emergency, or you need to be seen earlier than can be accommodated, you are directed to present to the nearest emergency room.

Phone Calls
Messages will be returned typically within 24 hours depending on the urgency of the case as determined by the provider.

Requesting a change of physicians
Doctors in this office DO NOT exchange patients. If your doctor has referred you to other providers we DO NOT allow switching to another physician in this office.

Telepsychiatry
PSC offers telepsychiatry services for return visits in limited circumstances. In most instances this service is not covered by insurance. Some insurance plans prohibit telepsychiatry services. As with any medical procedure, there are potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

• In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);

• Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;

• In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

Please initial if you are willing to participate in telepsychiatry services. _____

Payment
I will be expected to pay in full at the time of service. If insured, I am responsible for my co-pay, co-insurance, and deductible on the day of my visit. Many insurance companies have additional stipulations that may affect my coverage. It is ultimately my responsibility to know my coverage and benefits. I authorize PSC to furnish information to insurance carriers concerning my care. I authorize my insurer to remit payment directly to PSC. I am responsible for any amounts not covered by my insurance. If my insurance carrier denies any part of my claim, or if I elect to continue services past my coverage/policy period, I will be responsible for my balance in full.

PSC understands there may be times when I miss an appointment due to emergencies or obligations to work or family. However, there is ***a $30.00 No show Fee*** And a ***$30.00 Late Cancellation Fee*** for any cancellation 24 hours prior to the appointment without a valid reason. If my appointment is on Monday I must call Saturday at noon the latest to cancel or reschedule otherwise a late cancellation fee will apply. If I No show, I am required to pay a ***$15.00 deposit, and/or Store a credit card on file*** if I choose to reschedule, which will be refunded on the following appointment. I will not be allowed to schedule another appointment until that fee is paid in full. After two No shows without a valid reason, I might ***not*** be eligible for another appointment.

We do NOT prescribe Benzodiazepines (Xanax, Klonopin, Ativan, Valium) except for rare occasions. These medications will not be prescribed at all if you are also taking an opiod or Ambien.

Please note that there is a $35 dollar fee for returned checks or declined credit cards. If your account has payment overdue for over 120 days, PSC has the option of using legal means to secure payment, including collection agencies or small claims court. I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of any balance due.

My signature below indicates that I understand and agree with all of the above statements. My signature below also indicates that I have read and received a copy of the Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient Printed name of Legal Guardian

OFFICE USE ONLY

Physician signature indicates that:
□ Patient has capacity to consent and has signed above.
□ Patient does not have capacity to consent. Legal Guardian has signed above.

_____ _____
Signature of Physician Date

PATIENT INFORMATION FORM

Date:_____ Name: _____ Telephone #_____

Address:_____

Please print the telephone number and email address where you want to receive notification about your appointments if other than your home phone number:

Telephone #_____ Email: _____

Can confidential messages be left on your telephone answering machine? If yes, please initial _____

Emergency Contact: _____ Relationship:_____Phone#:_____

IF NO EMERGENCY CONTACT, PLEASE CHECK OFF BOX □

How did you hear about our practice? □ Insurance □ Web Site _____□ Hospital _____
□ Provider Referral _____

REASON FOR VISIT:_____

IS THIS EVALUATION COURT ORDERED OR FOR ANY LEGAL PURPOSES? YES / NO

MENTAL HEALTH HISTORY □ No psychiatric conditions

Prior Diagnosis □ Depression □ General Anxiety □ Bipolar Disorder □ PTSD □ OCD
□ Eating Disorder □ ADHD □ Schizophrenia □ Personality Disorder
□ Other _____

Last Psychiatrist _____

Hospitalizations □ No □ Yes, Where: _____ Date: _____
Where: _____ Date: _____

Suicide Attempts □ No □ Yes, number of times _____

Prior Medications

□ Abilify	□ Adderall	□ Ativan	□ Celexa	□ Clozaril	□ Concerta
□ Cymbalta	□ Depakote	□ Effexor	□ Elavil	□ Fanapt	□ Geodon
□ Haldol	□ Klonopin	□ Lamictal	□ Latuda	□ Lexapro	□ Librium
□ Lithium	□ Methadone	□ Neurontin	□ Pamelor	□ Paxil	□ Pristiq
□ Prozac	□ Remeron	□ Ritalin	□ Seroquel	□ Strattera	□ Suboxone
□ Tegretol	□ Trazodone	□ Trileptal	□ Valium	□ Viibryd	□ Vyvanse
□ Wellbutrin	□ Xanax	□ Zoloft	□ Zyprexa	□ Other _____	

Previous ECT □ No □ Yes, Where: _____ Date: _____ # Sessions: _____

Previous TMS □ No □ Yes, Where: _____ Date: _____ # Sessions: _____

SOCIAL HISTORY

Are you currently pregnant, or is there a good chance that you are pregnant? □ No □ Yes

Do you have siblings? □ Brothers (how many) ___ □ Sisters (how many) ___

How far did you go in school? _____

What is your employment status? □ Unemployed □ Part Time □ Full Time □ Disabled

What is your marital status? □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

Religious / spiritual status □ Atheist □ Agnostic □ Buddhist □ Christian □ Hindu □ Jewish □ Other:_____

What is your sexual orientation or gender preference? □ Bisexual □ Heterosexual □ Homosexual □ Transgender

Do you have any children? □ No □ Yes, age and gender _____

Living situation □ Live alone □ with roommates □ with spouse □ with family

Do you drink alcohol? □ No □ Yes, amount _____

Do you smoke cigarettes? □ No □ Yes, amount _____

Do you smoke marijuana? □ No □ Yes, amount _____

Do you use any other drugs? □ No □ Yes, list _____

Trauma History:

_____

FAMILY HISTORY

Mother	□ None	□ Depression	□ Anxiety	□ Bipolar	□ Schizophrenia	□ Drugs □ Alcohol
Father	□ None	□ Depression	□ Anxiety	□ Bipolar	□ Schizophrenia	□ Drugs □ Alcohol
Sister	□ None	□ Depression	□ Anxiety	□ Bipolar	□ Schizophrenia	□ Drugs □ Alcohol
Brother	□ None	□ Depression	□ Anxiety	□ Bipolar	□ Schizophrenia	□ Drugs □ Alcohol
Daughter	□ None	□ Depression	□ Anxiety	□ Bipolar	□ Schizophrenia	□ Drugs □ Alcohol
Son	□ None	□ Depression	□ Anxiety	□ Bipolar	□ Schizophrenia	□ Drugs □ Alcohol
Aunt	□ None	□ Depression	□ Anxiety	□ Bipolar	□ Schizophrenia	□ Drugs □ Alcohol
Uncle	□ None	□ Depression	□ Anxiety	□ Bipolar	□ Schizophrenia	□ Drugs □ Alcohol

MEDICAL HISTORY □ No medical conditions **SURGICAL HISTORY**

Please list:

Allergies: □ No medical allergies

Please list:

Have you ever experienced any of the following illnesses?

Seizures	NO	YES
Head Trauma with loss of consciousness	NO	YES
Coma	NO	YES

Over the last two days have you been experiencing any of the following symptoms?

Fever	NO	YES	Diarrhea	NO	YES
Dizziness	NO	YES	Constipation	NO	YES
Weight Loss	NO	YES	Nausea or Vomiting	NO	YES
Weight Gain	NO	YES	Stomach Pain	NO	YES
Dry Eyes	NO	YES	Burning with urination	NO	YES
Tremor	NO	YES	Urinary Incontinence	NO	YES
Ear Pain	NO	YES	Chronic Muscular Pain	NO	YES
Ringing in the ears	NO	YES	Joint Pain	NO	YES
Sore throat	NO	YES	Hair Loss	NO	YES
Difficulty swallowing	NO	YES	Abnormal Menses	NO	YES
Cough	NO	YES	Headaches	NO	YES

PHARMACY

Name: _____

Street Address & City: _____

Zip Code: _____ Phone Number:_____

CURRENT MEDICATIONS

MEDICATION NAME	DOSE	HOW MANY TIMES PER DAY

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PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor, a family member or an insurance company). You must also complete this form if you're accompanied to this appointment with another individual (For Example; Mother, Father Uncle, Case worker). NOTE: No information will ever be discussed to individuals not on the list.

By signing this form, I, (please print) **_____ DOB: _____, request and authorize the practice of Psychiatric Specialty Center, LLC to release and/or disclose with the people or agencies listed below protected health information including confidential psychiatric information unless noted by exclusions or limitations. This form is being signed voluntarily and I may withdraw it at any time.**

Check all that apply: **___ To RELEASE information to Psychiatric Specialty Center, LLC**
___ To SEND and RECEIVE information from:

Name: _____
Address:_____
_____
Phone:_____
Fax:_____
Email: _____

Name: _____
Address:_____
_____
Phone:_____
Fax:_____
Email: _____

The purpose(s) for which this information will be released:

___ Continuing Care or Consultation
___ Partner/Spouse/Family Member
___ Billing Purposes
___ Other: _____

Information to be released:

___ Psychiatric Evaluation or Clinical Status
___ Progress Notes
___ Letter or Summary regarding _____
___ Laboratory or other Test Results

Note any exclusions or limitations here: _____

I understand that there may be information in these records that I would not want to b released. I have been provided a copy of the office Notice of Privacy Practices. I understand that I may discuss any concerns that I may have about the use or misuse of my health information with my clinician at PSC or the staff.

I understand that PSC assumes no responsibility for the se or misuse by others of my health information disclosed under this authorization. I release PSC, its owners, agents, or employees form all legal liability that may arise from this authorization.

I understand that I do not have to sing this authorization in order to receive treatment from PSC. In act, I have the right to refuse this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that PSC has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy officer (Amanda Darling, MD) at 560 Village Blvd, Suite 150, West Palm Beach, FL 33409. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation. This authorization will automatically expire in one year unless a different expiration date or event is specified.

_____ _____ _____
Signature of Patient or Legal Guardian D.O.B. Date
Relationship to patient (if signed by a personal representative of patient): _____

***

_____ DO NOT SHARE MY INFORMATION AT ALL (Initial) **_____**

OFFICE POLICIES:

Our practice is very restrictive with controlled substances. **We do NOT prescribe** short acting stimulants such as **Ritalin and Adderall**.

We do NOT prescribe Benzodiazepines (Xanax, Klonopin, Ativan, Valium) except for RARE exceptions. These medications will not be prescribed for new patients. These medications will not be prescribed at all if you are also taking an opioid or Ambien.

You are responsible for any controlled substance medication prescribed. If the prescription or medication is lost, misplaced, stolen or if you use it up sooner than prescribed **it will not be replaced.** Refills of controlled substance medication will be made only during regular business hours. **You will not receive a refill if you do not keep your appointment.** You agree to not request or accept controlled substance medications from any other physician or individual while receiving such medication from Psychiatric Specialty Center.

There is a $**35.00 fee** for any Returned checks, a **$30.00 No show Fee** And a **$30.00 Late Cancellation Fee** for any cancellation 24 hours prior to the appointment, If the appointment is on Monday patient must call Saturday at noon the latest to cancel or reschedule. Otherwise a Late cancellation will apply. Patient will not be allowed to schedule another appointment until that fee is paid in full. After two No shows without a valid reason, Patient might not be eligible for another appointment.

Disability Evaluations are completed for patients who are established with our practice for at least 3 months. It is not covered by most insurance companies. Our Current fee is $500.00

EMOTIONAL SUPPORT / SERVICE ANIMAL LETTERS WILL NOT BE WRITTEN

Government disability / exceptions, competency / capacity forms will NOT be written.

PLEASE BE ADVISED THE FOLLOWING FEES WILL APPLY TO DOCUMENTS REQUESTED AND THESE MAY NOT BE COVERED BY INSURANCE:

- Disability Evaluations_____$500.00
- Disability Medical Request Form_____ $50/each request received
- FMLA Documents_____$50.00
- Surgical and Pain Management Clearance Letter_____$30.00
- Certification/ Recommendation Letters_____$20.00
- Palm Tran or Other Transportation Letters _____$10.00
- Copies of Medical Records _____$1.00/per page
- Work/ School/ Jury Duty Excusal (Short form)_____ No Charge
- Work Excusal (Long Form) _____$20.00
- CORE/ Traffic School/ Probation Letter_____$35.00
- Psychological Evaluation_____$35.00

<u>Release of Information must be signed.</u>

Psychiatric Specialty Center, LLC
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.
If you ever decide to retract your authorization to release your medical/psychiatric information, please let us know. This will be updated in your current release of information disclosure.
If you have any questions about this Notice please contact our Privacy Officer, Amanda Darling, MD.
This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.
We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.
1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician’s practice. Following are examples of the types of uses and disclosures of your protected health information that your physician’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting a written request to Amanda Darling, MD. Call 561-331-8800 for details.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.
You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after July 27, 2015. The right to receive this information is subject to certain exceptions, restrictions and limitations.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.
3. COMPLAINTS
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.
You may contact our Privacy Officer, Gisselle Gonzalez at (561) 331-8800 for further information about the complaint process.
This notice was published and becomes effective on July 27, 2015.