Pulmonary Group
of Central Florida, LLC

Dear New Patient,

We would like to take this opportunity to welcome you as a patient and to thank you for choosing Pulmonary Group of Central FL. It is our goal to assist you with all of your pulmonary and sleep apnea needs. We wish to make your visits informative and your appointment pleasant and rewarding.

I encourage you to make a list of any questions you may have. You will find we are dedicated to excellence in patient care. During your consultation we will review your medical history, perform a physical exam and discuss your goals for procedures.

Please bring these items with you, *only if they are available*:

- **List of Medications**
- **Chest X-Ray, CT Chest report**
- **Pulmonary Function Test (PFT)**
- **Sleep study report**
- **Copies of Medical Records from referring physician**
- **Picture ID and Insurance card(s)**

If your insurance requires authorization #, please be sure your Primary Care Physician has obtained one for you or your appointment will be rescheduled.

We kindly ask that you provide twenty-four hours' notice for appointment cancellation.

I look forward to participating in your health care needs.

Jose L. Diaz, M.D, FCCP	Rose Alay, APRN	Shiji Aby, APRN	Riley Lee, APRN
Pulmonary/Critical Care	*Pulmonary*	*Pulmonary*	*Pulmonary*

1038 W. NORTH BLVD, SUITE 102
(Tel) 352-315-1627 (fax) 352-326-8744
www.pg-cf.com

Pulmonary Group
of Central Florida, LLC

PATIENT'S NAME		**DATE OF BIRTH: / /**	**AGE:**
EMAIL ADDRESS:		**CELL PHONE #:**	
MAILING ADDRESS:		**HOME PHONE #:**	
CITY:	**STATE:**	**ZIP CODE:**	
PATIENT'S EMPLOYER:		**OCCUPATION:**	
Race: ***Please circle*** Asian, Black, Indian, White, More than 1 race, Refuse, Other		**Ethnicity:** Hispanic, Not Hispanic	
SOCIAL SECURITY #:		**CIRCLE MARITAL STATUS: M S D W**	
SPOUSE'S NAME:	**DOB: / /**	**SPOUSE'S SOCIAL SECURITY #:**	
EMERGENCY CONTACT:		**RELATIONSHIP:**	
ADDRESS:		**PHONE #:**	
PRIMARY CARE PHYSICIAN:		**REFERRING PHYSICIAN:**	
ONSET OF ILLNESS (DATE):			
	INSURANCE INFORMATION		
PERSON RESPONSIBLE FOR PAYMENT:		**HOME PHONE #:**	
MEDICARE #:			
OTHER MEDICAL INSURANCE:			
INSURED'S NAME:	**INSURED'S ADDRESS:**		**DOB: / /**
GROUP #:	**CERTIFICATE #:**	**PHONE #:**	
How did you hear about our office**?** ***Please circle*****. Magazine Ad, Friend, Doctor, Newspaper, Other: _____**			

WE ARE PARTICIPATING WITH MEDICARE. IF YOU HAVE A SUPPLEMENTAL INSURANCE THAT CROSSES OVER FROM MEDICARE AND PAYS THE DOCTOR, THEN WE WILL NOT COLLECT THE 20%. IF IT DOES NOT CROSS OVER OR YOU HAVE NO SECONDARY INSURANCE, THEN WE WILL COLLECT THE 20% PLUS DEDUCTIBLE AT THE TIME OF SERVICE. PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO YOUR APPOINTMENT. AN INSURANCE RECEIPT WILL BE GIVEN TO YOU TO SEND TO YOUR INSURANCE COMPANY. THIS OFFICE WILL FILE FOR PROCEDURES AND HOSPITALIZATION.

I GUARANTEE PULMONARY GROUP OF CENTRAL FL PAYMENT ALL CHARGES FOR THE ABOVE NAMED PATIENT IN ACCORDANCE WITH THEIR REGULATION AND CHARGES. IN THE EVENT THAT PULMONARY GROUP OF CENTRAL FL CHOOSES TO BILL MY INSURANCE COMPANY. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO THEM ALL MEDICAL BENEFITS DUE ME UNDER THIS POLICY, IF THE SERVICES ARE NOT COVERED BY MEDICARE OR THE OTHER INSURANCE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND AND AGREE THAT ANY OUTSTANDING BILLS WILL BE MY RESPONSIBILITY.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIMS TO MEDICARE OR ANY OTHER INSURANCE OF WHICH I AM A BENEFICIARY; I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS FROM AN OUTSIDE FACILITY THAT MAY BE REQUESTED TO THE OFFICE.

SIGNED: _____ **DATE: / /20___**

WITNESS: _____

DME Company:_____

Pharmacy Name and Number: _____

Pulmonary Group
of Central Florida, LLC

Patient Name: _____
Date of Appointment: _____/_____/_____
Referring Physician: _____
Primary Physician: _____

Chief Complaint: _____
_____

Are you currently working? __ Yes __No If so, please state occupation: _____
Exposure to chemicals? __ Yes __No If yes, please list: _____
Any pets at home? __ Yes __No Type of pet? _____

Life Style Status

Smoking Status:

Never Smoked Current: How many years _____ Packs per Day _____
Former: How many years _____ Packs Per Day (when you smoked) _____ Year Quit _____

Alcohol Use:

Never drank Former drinker Past drinker
Current drinker: Beer Wine Liquor Amount per week: _____

Sleep Patterns:

How many hours per night do you sleep? _____ restless continuous off and on

Advanced Care Plan: Yes No Unable to decide

Immunizations

Pneumonia Date: _____ Influenza Date: _____ Shingles Date: _____

Family History

Father: Living or deceased: Medical conditions: _____
_____

Mother: Living or deceased: Medical conditions: _____
_____

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of Central Florida, LLC

Medication Allergies:

_____

_____

Medication List

Medication Name	Strength	Times Taken Per Day

Surgeries – Please list type of surgery and year of surgery (approximate).

Surgery	Year

Pulmonary Group
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Past Medical History

Do you have, or have you ever had the following:

Eye problem	___	Dialysis	___
Cataracts	___	Urinary Incontinence	___
Hoarseness	___	Kidney Stones	___
Glaucoma	___	Prostate Problems	___
Ear Problem	___	Testicular Problems	___
Mouth Problem	___	Abnormal PAP smear	___
Throat Problem	___	Pelvic Inflammatory Disease	___
Nasal Problem	___	Chronic Pelvic Pain	___
Diabetes	___	Polycystic Ovarian Syndrome	___
Thyroid Disease	___	Endometriosis	___
Seasonal allergy	___	Recurrent Vaginal Infection	___
Asthma	___	Arthritis	___
Ulcer	___	Osteoporosis	___
Scarlet Fever	___	Osteoarthritis	___
Sleep Apnea	___	Fractures	___
Pneumonia	___	Back Pain	___
Bronchitis	___	Gout	___
Rheumatic Fever	___	Rheumatoid Arthritis	___
COPD	___	Breast Cancer	___
Emphysema	___	Tuberculosis	___
Breathing Disorder	___	Lung Cancer	___
Whooping Cough	___	Uterine Cancer	___
Hay Fever (Sinusitis)	___	Prostate Cancer	___
Angina	___	Ovarian Cancer	___
Irregular Heartbeat	___	Colorectal Cancer	___
Coronary Artery Disease	___	Lymphoma	___
Congestive Heart Failure	___	Chicken Pox	___
Valvular Heart Disease	___	Measles	___
Hypercholesterolemia	___	Mumps	___
Hypertension	___	Hepatitis: A – B – C	___
Peripheral Vascular Disease	___	MRSA	___
Chest Pain	___	HIV	___
Heart Attack	___	COVID-19	___
GERD (Acid Reflux)	___		
Gallbladder Disease	___	Other: _____	
Hiatal Hernia	___	_____	
Irritable Bowel Syndrome	___	_____	

Review of Systems – please circle any complaints within the last 6 months

Pulmonary Group of Central Florida, LLC

Constitutional
No complaints Weight Loss Weight Gain Anorexia Night Sweats Weakness Fever Insomnia Fatigue Chills Irritability Malaise

Dietary Restrictions
Disease related dietary restrictions Allergy dietary restriction Religious dietary restrictions
Appetite: Loss of appetite Increased appetite Decreased appetite

Eyes
No complaints Change in vision Irritation Double Vision Eye Pain Glaucoma Redness Blind Spot Excessive Tearing Photophobia Blurred Vision

Ears-Nose-Mouth-Throat
Hearing Loss Deaf Vertigo Sore Throat Nosebleed Eye/Ear Discharge Tinnitus Snoring Sinus Pain Frequent Colds Post nasal Drip Sleep Apnea

Respiratory
Shortness of Breath: Yes No
(If yes, does shortness of breath occur during): Sitting Standing Bending Exertion Talking Hot Weather At all times

Cough: Yes No
(If yes, is cough): Productive Non-productive Occasional Acute Chronic
(If productive, what color is the sputum):
Clear White Beige Lt. Yellow Yellow Dark Yellow Tan Brown Green Gray Blood tinged Blood Clots

Wheezing: Yes No (If yes, is your wheezing): Occasional During the day At night

Cardiovascular
No complaints Chest Pain Heart Murmur Palpitations Arrhythmia Hypertension Pacemaker Calf Pain Leg Swelling Tachycardia

Gastrointestinal
No complaints Heartburn Difficulty swallowing Food Intolerance Vomiting Nausea Diarrhea Constipation Blood in stool Flatulence Bloating Abdominal Pain

Genitourinary
No complaints Frequent Urination Painful Urination Inability to Urinate Discharge Blood in urine Urinary Tract Infection Kidney Stones

Musculoskeletal
No complaints Chronic Joint Pain Warmness Aches Swelling Stiffness Fibromyalgia Redness Muscle Pain Arthritis

Neurologic
No complaints Loss of Control Stroke Paralysis Dementia Seizures Intellectual Decline Headaches Weakness Memory Problems Numbness

Skin
No complaints Cancer Psoriasis Acne Disease

Psychiatric
No complaints Anxiety Depression Sleep Disturbance

Pulmonary Group of Central Florida, LLC

Print Name

Financial Policy

Welcome and thank you for choosing our practice! We believe that establishing a written financial policy is mutually beneficial for all parties. If you have any questions regarding our policies, our staff will be happy to assist you.

We participate with most insurance plans. However, each insurance plan has different benefits as well as different financial obligations. Therefore you, as the patient, are responsible for verifying these benefits with your insurance company. We will file your insurance, as a courtesy to you, but you are responsible for any unpaid balances.

Please review the following guidelines:

- **Payment is required at the time of service**. This may include your co-pay, co-insurance, deductible, and any other unpaid balances.
- Be prepared to show your insurance card, prescription card, and photo ID at **each visit**.
- You are required to bring **all medications**, or current list of medications, at **each visit**.
- You *may* be charged a **$50 no-show fee** for any missed appointments that are not cancelled/rescheduled with a 24 hour notice. This is the patient's responsibility to pay.
- We charge a **$15 fee**, payable in advance from the patient, for any forms or detailed letters that are completed by our office. We ask that you complete your portion of the form along with stamped envelope and submit those to our office as soon as possible. Please allow up to two weeks for completion of forms.
- There will be a **$36 NSF fee** for all returned checks.
- **We urge you to keep your account current**. **If your account becomes delinquent, your account will be referred to an outside agency for collections**. At that point, you will not be able to make an appointment with our office. You will then be responsible for your balance and the 20% collection fee. Please contact our business office with payment arrangements prior to this to keep our account in good standing. Continued non-payment on your account may result in discharge from Pulmonary Group.

Insurance Policies:

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within sixty (60) days from the date-of-service, we may look to you for payment in full. We strongly suggest you monitor your account with us by closely following the balance as it ages beyond 30 days, at which time we recommend calling your insurance carrier and request a "claim status report".
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for complete charge. Payment is due upon receipt of statement from our office.
- It is your responsibility to understand your healthcare benefit coverage. If you are unsure of your benefit coverage, we encourage you to contact your health insurance prior to your appointment as ultimately you will be responsible for unpaid balances by your insurance carrier.

We appreciate the opportunity to be involved in your healthcare. If you have any questions regarding your account or need to make payment arrangements, you may contact our business office at (352) 315-1627 ext. 103. We are open Monday – Friday 9:00 am – 4:00 pm.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays, co-insurance, and deductibles are my responsibility, and I will pay them at each visit. I agree to notify you of any changes in my health insurance coverage.

Patient Signature **Date**

1038 W North Blvd
Leesburg, Fl 34748

www.pg-cf.com

(352) 315-1627
(352) 326-8744 (fax)

Notice of Privacy Practice

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.

1. Introduction

Pulmonary Group of Central Florida is required by law to maintain the privacy and security of your health information and provide individuals with notice of its legal duties and privacy practices with respect to health information. Pulmonary Group of Central Florida is required to abide by the terms of the Notice currently in effect. Pulmonary Group of Central Florida reserves the right to change the terms of this Notice at any time and to make new Notice provisions effective for all health information that it maintains. Upon your request, we will provide you with a current copy of this Notice.

This Notice of Privacy Practices outlines our practices and legal duties to maintain the confidentiality of your protected health information ("PHI") under the privacy and security regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").

PHI includes demographic information that can be used to identify you such as your name, address, and telephone number; information concerning your past, present, or future physical or mental health condition; information concerning the provision of health care to you; and information concerning the past, present, or future payment for health care. Your PHI may be maintained by us electronically and/or on paper.

This Notice describes uses and disclosures of PHI to which you have consented, that you may be asked to authorize in the future, and that are permitted or required by state or federal law. Also, it advises you of your rights to access and control your PHI.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with Pulmonary Group of Central Florida. If you have any questions about Pulmonary Group of Central Florida's Notice of Privacy Practices, please contact the office at 352-315-1627.

2. Safeguarding Your PHI

We have in place appropriate administrative, technical, and physical safeguards to protect and secure the privacy and security of your PHI. We train our employees on the regulations and policies that are in place to protect the privacy and security of your PHI. Medical records are maintained in secure areas within our practice and electronic medical record systems are monitored and updated to address security risks in compliance with the HIPAA Security Rule. Only employees who have a legitimate "need to know" are permitted access to your medical records and PHI. Our employees understand their legal and ethical obligations to protect your PHI and that a violation of this Notice of Privacy Practices may result in disciplinary action.

3. Uses and Disclosures of PHI

As part of our registration materials, we will request your written consent for our practice to use and disclose your PHI for the following types of activities:

- **Treatment.** Treatment means the provision, coordination, or management of your health care and related services by Pulmonary Group of Central Florida and health care providers involved in your care. It includes the coordination or management of health care by a provider with a third party insurance carrier, communication with lab or imaging providers for test results, consultation between our clinical staff and other health care providers relating to your care, or our referral of you to a specialist physician or facility.
- **Payment.** Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims management, and collection activities. Payment also may include your insurance carrier's efforts in determining eligibility, claims processing, assessing medical necessity, and utilization review. Payment may also include activities carried out on our behalf by one or more of our collection agencies or agents in order to secure payment on delinquent bills.
- **Health Care Operations.** Health care operations mean the legitimate business activities of our practice. These activities may include quality assessment and improvement activities; fraud and abuse compliance; business planning and development; and business management and general administrative activities. These can also include our telephoning you to remind you of appointments, or using a translation service if we need to communicate with you in person, or on the telephone, in a language other than English.

  When we involve third parties in our business activities, we will have them sign a Business Associate Agreement obligating them to safeguard your PHI according to the same legal standards we follow.

4. Electronic Exchange of PHI

We may transfer your PHI to other treating health care providers electronically. We may also transmit your information to your insurance carrier electronically.

5. Uses and Disclosures of PHI Requiring Your Written Authorization

Uses and disclosures of your PHI made for purposes of psychotherapy, marketing and disclosures that constitute a sale of PHI will be made only with your written authorization.

Other uses and disclosures of your PHI will be made only with your specific written authorization. This allows you to request that Pulmonary Group of Central Florida disclose limited PHI to specified individuals or companies for a defined purpose and timeframe. For example, you may wish to authorize disclosures to individuals who are not involved in treatment, payment, or health care operations, such as a family member or a school physical education program. If you wish us to make disclosures in these situations, we will ask you to sign an authorization allowing us to disclose this PHI to the designated parties.

If Pulmonary Group of Central Florida intends to engage in fundraising, you have the right to opt out of receiving such communications. If you authorize us to use or disclose your PHI for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose your PHI for the reasons contained within your authorization. However, we cannot take back disclosures already made with your permission.

6. Uses and Disclosures of PHI Permitted or Required by Law

In some circumstances, we may be legally permitted or required to use or disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization in certain situations, including, but not limited to:

- **Emergencies.** If you are incapacitated and require emergency medical treatment, we will use and disclose your PHI to ensure you receive the necessary medical services. We will attempt to obtain your consent as soon as practical following your treatment.
- **Others Involved in Your Healthcare:** Upon your verbal authorization, we may disclose to a family member, close friend or other person you designate only that PHI that directly relates to that individual's involvement in your health care and treatment. We may also need to use PHI to notify a family member, personal representative or someone else responsible for your care of your location and general condition.
- **Communication Barriers.** If we try but cannot obtain your consent to use or disclose your PHI because of substantial communication barriers and your physician, using his or her professional judgment, infers that you consent to such use or disclosure, or the physician determines that a limited disclosure is in your best interests, we may permit such use or disclosure.
- **Required by Law:** We may disclose your PHI to the extent that its use or disclosure is required by law. This disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Public Health/Regulatory Activities:** We may disclose your PHI to an authorized public health authority to prevent or control disease, injury, or disability or to comply with state child or adult abuse or neglect law. We are obligated to report suspicion of abuse and neglect to appropriate regulatory agencies.
- **Food and Drug Administration:** We may disclose your PHI to a person or company as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations as well as to track product usage, enable product recalls, make repairs or replacements or to conduct post-marketing surveillance.
- **Health Oversight Activities.** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, and other activities necessary for the appropriate oversight of the health care system and government benefit programs such as Medicare and Medicaid.
- **Judicial and Administrative Proceedings.** We may only disclose your PHI in the course of any judicial or administrative proceeding in response to a court order expressly directing disclosure, or in accordance with specific statutory obligations compelling us to do so, or with your permission.
- **Law Enforcement Activities.** We may disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, or missing person, or complying with a court order or other law enforcement purpose. Under some limited circumstances we will request your authorization prior to permitting disclosure.
- **Coroners and Medical Examiners,** We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other lawful purpose.

- **Funeral Directors and Organ Donation Organizations**. We may disclose your PHI to enable a funeral director to carry out his or her lawful duties. PHI may also be disclosed to organ banks for cadaveric organ, eye, bone, tissue and other donation purposes.
- **Research.** We may disclose your PHI for certain medical or scientific research where approved by an institutional review board and where the researchers have a protocol to ensure the privacy and security of your PHI.
- **Serious Threats to Health or Safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military and National Security Activities.** We may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military authorities to assure proper execution of military missions. We also may disclose your PHI to certain federal officials for lawful intelligence and other national security activities.
- **Worker's Compensation:** We may disclose your PHI as authorized to comply with worker's compensation laws.
- **Inmates of a Correctional Facility:** We may use or disclose PHI if you are an inmate of a correctional facility and our practice created or received your PHI in the course of providing care to you while in custody.
- **US Department of Health and Human Services:** We must disclose your PHI to you upon request and to the Secretary of the United States Department of Health and Human Services to investigate or determine our compliance with privacy and security laws.
- **Disaster Relief Activities:** We may disclose your PHI to local, state or federal agencies engaged in disaster relief and to private disaster relief assistance organizations (such as the Red Cross if authorized to assist in disaster relief efforts).

7. Your Rights Regarding PHI

- **Right to Request Restrictions for Certain of Uses and Disclosures.** You have the right to request that we not use or disclose your PHI unless such a use or disclosure is required by law. Such a request must be made in writing and include the specific PHI you wish restricted as well as the individual(s) who should not receive the restricted PHI. If we agree to your request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. However, we not required to agree to your requested restriction except in the case of restricting disclosure of PHI to a health plan as described below.

  If you request a restriction on certain uses and disclosures of your PHI to a health plan for a particular health care item or service where said health care item or service is paid for out of pocket and in full, we will abide by your request. Such a request must made be made in writing to the practice Privacy Officer. Your request must describe in a clear and concise fashion the health care item or service you wish restricted.
- **Right to Access.** You have the right to inspect and obtain a copy of your PHI. You may request copies of your PHI in either paper or electronic form. In very limited circumstances, we may deny access to your PHI. To request access to your PHI, please submit a request in writing to the practice Privacy Officer including whether you want your copy in electronic or paper form. We will respond to your request as soon as possible, but no later than 30 days from the date of your request. If access is denied you will receive a denial letter within 30 days. If access is denied, an appeals process may be available in certain cases. We have the right to charge a reasonable fee for providing copies of your PHI (and for electronic media, if applicable). Furthermore, you may request that a copy of your PHI be transmitted directly to a third party provided such request is made in writing, signed by you and clearly identifies the designated third party and location to send your PHI.
- **Right to Confidential Communications.** You have the right to request to receive communication of PHI by alternative means or at alternative locations. For example, you may wish your bill to be sent to an address other than your home. Such requests must be made in writing to the practice Privacy Officer. We will not require an explanation of your reasons for the request, and will accommodate reasonable requests.
- **Right to Amend.** You have the right to request that we amend your PHI. Your request must be made in writing. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for amendment, you have the right to submit a written statement disagreeing with the denial. Pulmonary Group of Central Florida has the right to submit a rebuttal statement. A record of any disagreement regarding amendments will become part of your medical record and may be included in subsequent disclosures of your PHI.
- **Right to an Accounting of Disclosures.** Subject to certain limitations, you have the right to a written accounting of disclosures by us of your PHI for not more than 6 years prior to the date of your request. Your right to an accounting applies to disclosures other than those made for purposes of treatment, payment, or health care operations. Please make your request in writing to the practice Privacy Officer. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. We will provide you with one accounting every 12 months free of charge. We will charge a reasonable fee based upon our costs for any subsequent accounting requests.

- **Right to a Copy of our Notice of Privacy Practices.** We will ask you to sign a written acknowledgement of receipt for our Notice of Privacy Practices. We may update this Notice of Privacy Practices at any time. Upon your request, we will provide you with a current copy of this Notice.
- **Right to Notice of Breach.** You have a right to receive notice if there has been a breach of your unsecured PHI.

8. Complaint Procedure

- **Within our Practice:** If you have a complaint about the denial of any of the specific rights listed above, about our Notice of Privacy Practices, or about our compliance with state and federal privacy laws you may receive more information about the complaint process by contacting the practice Privacy Officer at 352-315-1627
- **Outside our Practice:** If you believe that Pulmonary Group of Central Florida is not complying with its legal obligations to protect the privacy of your PHI, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights.
- We will not retaliate against you for filing a complaint.

9. Effective Date. This Notice is effective as of September 23, 2013.

Legal Notice:

This sample Notice of Privacy Practices is provided to you to serve as an example for creating your own documentation and agreements and is not to be construed as legal advice. Any sample that you adapt for your organization should be carefully reviewed and modified as necessary to ensure that it accurately reflects your organization's privacy practices. Document and form approval should follow your standard operating procedures including, as applicable, consultation with your legal counsel.

Disclaimer of Liability:

The information contained herein is for informational purposes only and is provided on an "as is" basis. WVMI, Quality Insights of Delaware, and their employees make no representation concerning the suitability or accuracy of this information for any purpose. Neither WVMI, Quality Insights of Delaware, nor any of their employees makes any warranty, express or implied, including warranties of merchantability and fitness for a particular purpose, or assumes any legal liability or responsibility for the accuracy, completeness, or usefulness of any information, apparatus, product or process disclosed, or represents that its use would not infringe privately owned rights and shall not be liable for any damages whatsoever arising from the use of or reliance on any information contained herein

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Pulmonary Group of Central Florida's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Pulmonary Group of Central Florida may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Pulmonary Group of Central Florida's *Notice of Privacy Practices* by submitting a request in writing for a current copy of Pulmonary Group of Central Florida's *Notice of Privacy Practices*.

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

For PGCF Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Pulmonary Group of Central Florida made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other_____

_____
Employee Name (printed)

_____ _____
Employee Signature Date