NEW PATIENT INFORMATION 2023

Date | Patient Number

Patient's Name	Social Security Number / /	Sex (Choose One) M F	Date of Birth	Age

Street address Perm. Or Temp.	Apt./Suite/Unit	City / State	Zip Code	Country

Marital Status (Choose One) S M W Div. Sep. DP	Race: (Check all that apply) American Indian/Alaska native Asian White Black/African American Native Hawaiian/Pacific islander Other	Ethnicity (Check One) Hispanic Non-Hispanic

Primary Language Spoken	Home Phone	Mobile Phone	Business Phone	Preferred Phone Home Work Mobile

Occupation Of Patient	Patient's Employer	How Long Employed	Preferred Method Of Communication Phone Call Text Email Don't Call

Driver's License Number	Employer's Street Address	City / State	Zip Code

Primary Care Physician Name	Phone Number	Fax Number	Were You Referred By A Physician? Yes No

Spouse/Domestic Partner Name	Employer	How Long Employed	Occupation

Employer's Street Address	City / State	Zip Code	Business Phone

Next of KIN Name	Relationship To Patient	Phone Number

Address	City / State	Zip Code

IF THE PATIENT IS A MINOR OR STUDENT

Mother's Name	Street Address	City / State	Zip Code	Phone Number

Mother's Employer	Occupation	How Long Employed	Mobile Phone

Employer's Street Address	City / State	Zip Code	Business Phone

Social Security Number / /	Date of Birth	Driver's License Number

Father's Name	Street Address	City / State	Zip Code	Phone Number

Father's Employer	Occupation	How Long Employed	Mobile Phone

Employer's Street Address	City / State	Zip Code	Business Phone

Social Security Number / /	Date of Birth	Driver's License Number

INSURANCE INFORMATION

Insurance Company	PPO POS HMO EPO INDEMNITY MEDICARE/MEDICAID W/C SELF PAY

Primary Insurance Holder	Date of Birth	Employer

PHYSICIAN RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Florida Center For Allergy & Asthma Care of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim as required by law. I request payment of medical insurance benefits either to myself or to Florida Center For Allergy & Asthma Care who accepts assignment. I understand that I am financially responsible for charges regardless of coverage.

Patient's/Guarantor's Signature: ______________________ Date ___ ___ ___

PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Florida Center For Allergy & Asthma Care as your healthcare provider. We are committed to provide you with the best quality care. We ask that you please read and sign this form acknowledging your understanding of our patient financial policies.

Check here if you agree to our self pay rates for all services rendered
Check here if you elect to use your health insurance

INITIALS

________ • **Insurance Coverage:** It is the patient's responsibility to be familiar with their insurance coverage, policy provisions, exclusions and limitations, as well as requirements for authorizations. We attempt to verify that your coverage is active at the time of your visit. However, we depend on you to provide us with the most accurate information. If for any reason, your coverage is not active you must know that the cost of the visit is your responsibility.

________ • **Change of Insurance:** If you have had any changes to your insurance coverage, you must notify us immediately.

________ • **Referrals:** It is your responsibility to obtain referrals whenever required by your insurance plan. We will assist you whenever possible. If you change your Primary Care Physician, you must notify us immediately and obtain a new referral.

________ • **Co-Payment, Co-Insurance and Deductibles:** You must pay for your Co-Payment at the time of your visit. If your plan has a deductible and/or co-insurance, we will collect a portion at the time of your visit and the remainder will be billed to you once your insurance has processed the claim.

________ • **Non-Covered Services:** Patients are responsible for non-covered services when they are denied by their insurance company.

________ • **Labwork:** Your physician may order labwork. It is your responsibility to confirm whether the labwork is covered under your insurance plan.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges.

Signature of Patient or Authorized Representative	Date
________________	____________
Print name of Patient or Authorized Representative	**Relationship to Patient**
________________	____________
Witness Signature	**Date**
________________	____________

REVIEW OF BODY SYSTEM

Does the patient have or had any of the following symptoms?
Check **YES** or **NO** for each. Please do not leave any blank spaces as this affects our results.

GENERAL	YES or NO
Always tired	
Fever	
Overweight	
Weight gain	
Weight loss	
Other	

HEAD	YES or NO
Dizziness	
Headache	
Recurrent sinus infection	
Sinus pain	
Sinus problem	
Other	

EARS	YES or NO
Clogged ears	
Earaches	
Recurrent infections	
Ringing or popping ears	
Tinnitus	
Vertigo	
Other	

EYES	YES or NO
Darkness under eyes	
Dry eyes	
Frequent blinking	
Itchy eyes	
Red eyes	
Swelling around the eyes	
Watery eyes	
Other	

NOSE	YES or NO
Change in sense of smell	
Itchy nose	
Nasal congestion	
Nasal polyps	
Nose bleeding	
Runny nose	
Sneezing	
Other	

MOUTH/THROAT	YES or NO
Difficulty swallowing	
Drip in back of throat	
Excessive snoring	
Hoarseness/Laryngitis	
Mouth breathing	
Sore throat	
Swollen lips	
Swollen tongue	
Throat tightness	
Loss of taste	
Other	

Cardiovascular	YES or NO
Chest pain	
High blood pressure	
Other	

RESPIRATORY	YES or NO
Chest tightness	
Cough at night	
Coughing up blood	
Dry cough	
Frequent bronchitis/ Chest colds	
Frequent coughing	
Recurrent pneumonia	
Shortness of breath	
Wet cough	
Wheezing	
Other	

GASTROINTESTINAL	YES or NO
Abdominal pain	
Food intolerance	
Heartburn/Indigestion	
Nausea/Vomiting	
Other	

GENITOURINARY	YES or NO
Increased urinary frequency	
Painful urination	
Urine retention	
Other	

ENDOCRINE	YES or NO
Diabetes	
Excessive thirst	
Other	

MUSCULATURE	YES or NO
Arthritis	
Back pain	
Fractures	
Other	

SKIN	YES or NO
Eczema	
Hives	
Persistent itch	
Recurrent abscess	
Skin rash	
Swelling	
Other	

ALLERGY/IMMUNOLOGY	YES or NO
Drug allergy	
Food allergy	
Hay Fever	
Insect allergy	
Check one: Local Hives Generalized	
Other	

NEUROLOGICAL	YES or NO
Insomnia	
Numbness	
Seizures	
Stops breathing (apnea)	
Other	

HEME/LYMPH	YES or NO
Anemia	
Bleeding disorders	
Easy bruising	
Swollen glands	
Other	

**FOR OFFICE USE ONLY **
All systems negative except noted

Tobacco Exposure Yes No

Tobacco Use Yes No

Cigarette (Check one)
1. Daily 2. Socially 3. Rarely 4. Never

No. of cigarettes/day ______
No. of packs/day

Cigars (Check one)
1. Daily 2. Socially 3. Rarely 4. Never

No. of cigars/day ______
No. of cigars/week

COVID-19	YES or NO
Have you had COVID-19	
Have you received the COVID-19 Vaccine and if so which one	

NAME: ______________ PATIENT SIGNATURE: ______________

PHYSICIAN/PA/NP: ______________ DATE: ___ ___ ___

CANCELLATION/NO SHOW, LATE ARRIVAL POLICIES AND FEES

Our goal is to provide punctual quality medical care. In order to do so, we have had to implement an appointment policy to better optimize available appointments for patients in need of attention.

APPOINTMENT CANCELLATION /NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If you need to "cancel your appointment" we require that you call at least one (24-hour) working day in advance. Appointments are high in demand, and your early cancellation will open the schedule to another person in need of medical attention.

A "no show" is considered a missed appointment without cancellation within or no later than a 24-hour working day. No-shows inconvenience those individuals who need access to immediate medical care.

How to Cancel Your Appointment

To cancel an appointment you can: call the office, send an e-mail, use our automated system or access the patient portal.

LATE ARRIVAL POLICY

We understand that delays can happen, however, we must respect the time of the other patients and doctors. If you are running late, please notify the office. If a patient is 15 minutes past their scheduled time, we may need to reschedule.

FEES

- Same Day Appointment Cancellation Fee - **$35**
- No Show Fee - **$50**
- Medical Records Fee (Florida Statutes 395.3025): **$1.00** per page up to 25 pages and **0.25** cents per page thereafter plus postage and shipping cost (shipping costs not to exceed ten dollars)
- Returned Check Fee **$50**
- Disability/FMLA/School Forms to be completed by Doctor: **$25** per form

Patient Name ______________________ Date ___ ___ ______ Signature / Parent / Guardían ______________________

This area is intended for office use only

Patient Number ______________________

HOW DID YOU HEAR ABOUT US?

Physician – Primary Care Physician/Pediatrician ____________________

Physician – Specialist ____________________________________

Community Events

Internet Search

Social Media

Word of Mouth

TV/Radio

Health Insurance

Hospital Emergency Room

Urgent Care Center

Yelp

I am a former patient

International Patient

Magazine/Newspaper/Mail Advertising

Thank you for your collaboration!
Make sure you follow us on our social media

EMAIL UPDATES

The Physicians and Staff at Florida Center For Allergy & Asthma Care would like the opportunity to provide you with the latest information, news and messages that can benefit you and your treatment. In order to better serve you and contact you more efficiently, we ask you to provide us with your e-mail address. Please note that the use of email is intended only for use by Florida Center For Allergy & Asthma Care. Your email will never be sold or shared with any other third parties.

First and Last Name ____________________ Date of Birth ___ ___ ____

Email Address ____________________________________

Thank you for your assistance!

This area is intended for office use only

Patient Number ____________________ Office Manager ____________________

PHARMACY INFORMATION SHEET

Date Patient # Office

Patient Name

Pharmacy Name and Address

Pharmacy Phone Number

MAIL ORDER PHARMACY ONLY

CHECK HERE IF MAIL ORDER INFORMATION IS DIFFERENT FROM THE INFORMATION ABOVE.

If applicable, fill in the following:

Pharmacy Name

Pharmacy Address

Pharmacy Phone Number

Prescription Card Number

Company FAX

AUTHORIZATION TO CONSENT TO MEDICAL CARE OF A MINOR WHEN LEGAL GUARDIAN or PARENT(S) IS UNABLE TO BRING PATIENT.

I, ______________________________ parent/legal guardian of the child(ren) listed below do hereby give my authorization to the below named authorized person(s) to consent to the medical evaluation and treatment of my child(ren) at Florida Center For Allergy & Asthma Care.

I have submitted a copy of my drivers' license/ID card/passport as a form of proof of identity.

I am, by this document, representing that I have the authority to consent for all medical care and treatment of said child(ren):

Signature	Relationship to Child(ren)	Date
____________________	____	________________

CHILDREN

Name

____

Name

____

Name

____

Person(s) who are authorized to bring child(ren) for medical evaluation and treatment: step-parent, grandparent, adult aunt or uncle, adult children, and any adult who has a power of attorney to provide medical consent for the minor.

Name, Relationship to Child(ren)

____

Name, Relationship to Child(ren)

____

Name, Relationship to Child(ren)

____

Name, Relationship to Child(ren)

____

If there is any change in the list, please send a written authorization to add any other person.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Authorization

Name	Address
Phone	Email
Patient #	Date of birth

SECTION B: To The Patient *(Please read the following statements carefully):*

Purpose of Consent: By signing this form (Consent), you will consent to the use and disclosure by Florida Center For Allergy & Asthma Care (FCAAC) of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read FCAAC's Notice of Privacy Practices (Notice) before you decide whether to sign this Consent. FCAAC's Notice provides a description of FCAAC's treatment, payment activities, and healthcare operations, of the uses and disclosures FCAAC may make of your protected health information, and of other important matters about your protected health information. A copy of FCAAC's Notice accompanies this Consent. FCAAC encourages you to read it carefully and completely before signing this Consent.

FCAAC reserves the right to change its privacy practices as described in its Notice. If FCAAC changes its privacy practices, FCAAC will issue a revised Notice, which will contain the changes. Those changes may apply to any of your protected health information that FCAAC maintains.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time on our website, or by contacting

FCAAC'S Privacy Officers,
Geidy Rodriguez, Director of Office Operations.
2699 Stirling Rd. Suite B-100 | Ft. Lauderdale, FL 33312 | 305-223-8808

Right to Revoke. Please understand that revocation of this consent will not affect any action FCAAC took in reliance on the consent before FCAAC received your revocation. However, revocation of this consent will result in FCAAC being prohibited from sharing your PHI with your health insurance carrier, if applicable, and, thus, FCAAC's inability to bill your medical treatment to that insurance carrier. Therefore, patients that either refuse to sign this consent or revoke it after signing it will be required to self-pay for all medical treatment provided by FCAAC and then seek reimbursement directly from the medical insurance carrier for such treatment."

Additional Person Authorized to Access PHI: I authorize the following person(s) access to my PHI:

Name	Relationship	Date	Date Revoked

I, ______________________________ have had full opportunity to read and consider the contents of this Consent and have received a copy of FCAAC's Notice of Privacy Practices. I understand that, by signing this Consent, I am giving my consent to FCAAC's use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I also understand I am agreeing to allow FCAAC to request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Signature: ______________________________ Date: ______________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________ Relationship to Patient: ______________________________

You are entitled to a copy of this consent after you sign it.

This area is intended for office use only

Individual refused to sign
An emergency situation prevented us from obtaining acknowledgment
Communication barriers prohibited obtaining the acknowledgment
Other

Dear Patient,

We believe that patients and your caregivers should have easy access to your medical information, no matter where you receive care. That's why we're participating in CommonWell, a service that allows a network of healthcare providers to identify you, securely send and receive your medical information, and help ensure that you receive optimal care.

What is CommonWell?

A *free, secure service* offered by your doctor, so your health information can be available to you and your doctors regardless of where you've received care.

You simply need to enroll in the service with a driver's license and then confirm the other CommonWell network doctors you see. Don't worry if you don't have a government-issued picture ID, you can still register.

How do we use the health information we share through CommonWell?

- **Better coordinate your care across different doctors** — We'll provide and request to receive your information where and when it's needed for your healthcare provider to deliver the care you need as you move from doctor to doctor.
  - Only healthcare staff directly involved in your care will access your medical information shared through CommonWell.
- **Support better care decision-making** — With timely access to information from other healthcare providers you've seen, your doctors may be able to make better decisions about your health.
  - This information will only be used to help improve your care; and won't be shared without your permission or unless it's required by law.
- **Deliver care more promptly and efficiently** — With less time wasted on tracking down your test results and other health information, your healthcare providers can treat you more efficiently, and spend less time on paperwork and more time on your care.
  - We do need your help in confirming the other doctors or hospitals you've visited when you enroll in CommonWell.
- **Securely and confidentially** — Your Protected Health Information ("PHI") will always be confidential and used to inform the CommonWell participating healthcare providers. We won't use your PHI for discriminatory purposes of any kind or to deny medical treatment.
  - You can opt-out of this service anytime by calling or visiting this doctor's office and asking them to unenroll you from CommonWell.

How do I sign up?

It's quick and easy. Show the staff at the front desk or during patient discharge your government-issued ID (driver's license, etc.) and tell them what other doctors, hospitals and healthcare providers you've seen.

Patient #:________________ Patient Name:____________________________________

Patient Signature: ________________________________Date_____________________

CommonWell Health Alliance

The CommonWell services are provided by the CommonWell Health Alliance trade association. We are devoted to the notion that patient data should be safely, securely and immediately available to patients and doctors regardless of where care occurs to deliver better care. We are committed to fostering standards that make this possible, and in having health information technology companies build these capabilities into their systems. The end results: higher quality, more timely, more cost-effective care that delivers better health outcomes. Participating vendors are: Allscripts, athenahealth, Cerner, CPSI, Greenway, McKesson, and Sunquest.

December 19, 2019

Dear Patient,
The Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA, require Florida Center For Allergy & Asthma Care ("FCAAC") to provide a notice to our patients about our privacy practices, our legal duties and their rights concerning their health information. We also, are required to attempt to obtain a written acknowledgment of receipt of our Notice of Privacy Practices.

I am enclosing our Privacy Notice and an acknowledgment form. Please read the notice, complete the acknowledgment and return it to the office in which you are being treated. If you have any questions concerning our Privacy Notice, please call the office which you are being treated. The staff will direct you to the appropriate employee for additional information.

Sincerely,

Cari Crucet
Chief Operating Officer

NOTICE OF PRIVACY PRACTICES

Effective July 17, 2013

This notice of privacy practices (notice) describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review this notice carefully. The privacy of your health is important to Florida center for allergy and asthma care (FCAAC).

THIS NOTICE COVERS THE FOLLOWING HEALTH CARE PROFESSIONALS PROVIDING YOUR CARE THROUGH FCAAC:
All employees, physicians, physician assistants, nurse practitioners, nurses, administrative staff and any other health care professionals providing you care through FCAAC must abide by this Notice of Privacy Practices. FCAAC may share your information with our workforce to help them provide medical care to you.

PART 1 – FCAAC'S LEGAL DUTY

FCAAC is required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA, to (i) maintain the privacy of your protected health information, (ii) provide you notice of FCAAC's legal duties and privacy practices with respect to protected health information, and (iii) notify affected individuals following a breach of unsecured protected health information. FCAAC is required to abide by the terms of the Notice currently in effect. Your health information is anything FCAAC has created or received regarding your health or payment for your healthcare. It includes both your medical records and personal information such as your name, social security, address and phone number.

PART 2- HOW FCAAC MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Generally, FCAAC may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, FCAAC must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which FCAAC is permitted by the law to use or disclose your personal health information:

A. Without Your Consent for Treatment Payment and Operations

Without your consent, FCAAC may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, FCAAC is permitted to disclose your personal health information within and among its workforce in order to accomplish these same purposes. However, even with your permission, FCAAC is still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of Treatment Activities. FCAAC may use or disclose your health information to a physician, nurse, or other healthcare professional providing treatment to you. Treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of Payment Activities.
FCAAC may use and disclose your health information to obtain payment for services FCAAC provides to you, including billing and collection activities and related data processing.

Examples of Healthcare Operations.
FCAAC may use and disclose your health information in connection with FCAAC's healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

B. As Required by Law

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect.
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health
or safety of others.

National Security.
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information or inmate or patient under certain circumstances.

C. Miscellaneous Permitted Activities

We may also use or disclose medical information when contacting you by phone, email, text message or mail to remind you of appointments, treatments, referrals, authorizations and test results.

D. All Other Situations With Your Authorization

Except as otherwise permitted or required, as described above and set forth in HIPAA, FCAAC may not use or disclose your personal health information without your written authorization. You may give FCAAC written authorization to use your health information or to disclose it to anyone for any purpose. Uses and disclosures not described in this Notice will be made only with your authorization. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

E. Communicating with a Patient's Family, Friends, or Others Involved in the Patient's Care

Even though HIPAA requires health care providers, like FCAAC, to protect patient privacy, providers are permitted, in most circumstances, to communicate with the patient's family, friends, or others involved in their care or payment for care. This section is intended to clarify these HIPAA requirements so that FCAAC does not unnecessarily withhold your health information from these persons.

Patient is Present and has the Capacity to Make Health Care Decisions.
If the patient is present and has the capacity to make health care decisions, a health care provider may discuss the patient's health information with a family member, friend, or other person if the patient agrees or, when given the opportunity, does not object. A health care provider also may share information with these persons if, using professional judgment, he or she decides that the patient does not object. In either case, the health care provider may share or discuss only the information that the person involved needs to know about the patient's care or payment for care.

The following are a few examples:
- FCAAC may discuss a patient's bill with the patient's adult daughter who is with the patient at the patient's medical appointment and has questions about the charges.
- FCAAC may discuss the drugs a patient needs to take with the patient's health aide who has accompanied the patient to a medical appointment.
- A nurse may discuss a patient's health status with the patient's brother if she informs the patient she is going to do so and the patient does not object.

BUT:
- A nurse may not discuss a patient's condition with the patient's brother after the patient has stated she does not want her family to know about her condition.

Patient is Not Present or is Incapacitated.
If the patient is not present or is incapacitated, a health care provider may share the patient's information with family, friends, or others as long as the health care provider determines, based on professional judgment, that it is in the best interest of the patient. When someone other than a friend or family member is involved, the health care provider must be reasonably sure that the patient asked the person to be involved in his or her care or payment for care. The health care provider may discuss only the information that the person involved needs to know about the patient's care or payment. FCAAC will also use its professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

The following are a couple of examples:
- FCAAC may give information regarding a patient's drug dosage to the patient's health aide who calls the provider with questions about the particular prescription.

BUT:
- A nurse may not tell a patient's friend about a past medical problem that is unrelated to the patient's current condition.

PART 3 – PATIENT RIGHTS

In addition to the restrictions on our use and disclosure of your health information, you have the following specific rights regarding the use and disclosure of your health information:

Restrictions of Use and Disclosures.
You may request that FCAAC restrict the use and disclosure of your health information for various reasons such as restricting that certain health information not be disclosed to a specific family member, for example. Although there are numerous reasons why you may want FCAAC to restrict the use and disclosure of your health information, FCAAC is not required to agree to a requested restriction except requests to restrict disclosure of your protected health information to a health plan if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the protected health information pertains solely to a health care item or service for which you, or person other than the health plan on behalf of you, has paid FCAAC in full.

While FCAAC is generally not required to agree to any requested restriction, if FCAAC agrees to a restriction, FCAAC is bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. FCAAC will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right to Request Confidential Communications.
You may request in writing, and FCAAC must accommodate reasonable requests by you, to receive communications of protected health information from FCAAC by alternative means or at alternative locations. FCAAC may condition the provision of reasonable accommodation on (a) when appropriate, information as to how payment, if any, will be handled; and (b) specification of an alternative address or other method of contact. FCAAC may not require an explanation from you as the basis for the request as a condition of providing communications on a confidential basis.

Access to Health Information.
You have the right to look at or get copies of your health information, with limited exceptions. You may request that FCAAC provide copies in a format other than photocopies such as a PDF format via electronic mail. FCAAC will use the format you request unless we cannot practicably do so. However, providing copies of your health information in any format other than paper copies, such as electronically, comes at a risk that your information may be stolen or obtained by others. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Amending Health Information and Records.
You have the right to request that your health information or a specific record be amended provided you do so in writing to the person designated at the end of this Notice and you provide reasons why such health information or record should be amended. Although you have a right to request that your health information or records be amended, FCAAC may deny your request under certain circumstances such as when the information requesting to be amended was not created by FCAAC or the information is accurate and complete.

Accounting of Disclosures of Protected Health Information.
Excluding certain disclosures, for example by way of illustration and not limitation, FCAAC's disclosures for treatment, payment and health care operations and pursuant to an authorization as provided in the Federal regulations, you have a right to receive an accounting of disclosures of protected health information made by FCAAC up to the six years prior to the date on which the accounting is requested. If you want an accounting of our use and disclosure of your health information, then please do so in writing to the person designated at the end of this Notice. We will respond in writing to your request.

Right to Obtain Paper Copy of Privacy Notice.
You have the right to request a paper copy of this Notice upon request even if you agreed to receive it electronically.

PART 4 – HOW YOU MAY ASK FOR HELP OR COMPLAIN

If you need to request information from FCAAC regarding your health information or need to request an amendment to and/or restriction on the use and disclose of your health information you may do so by writing to one of FCAAC's Privacy Officers listed below in this Part 4. If you feel that your rights have been violated, you may file a complaint with one of FCAAC's Privacy Officers, and the Secretary of the Department of Health and Human Services (DHHS), the Office for Civil Rights, at the contact information below in this Part 4. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

FCAAC' s Privacy Officers
Geidy Rodriguez, Director of Office Operations.
2699 Stirling Rd. Suite B-100
Ft. Lauderdale, FL 33312 | 305-223-8808

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building,
Room 509H Washington D.C., 20201
Phone: 866-627-7748 TTY: 886-788-4989
Online: www.hhs.gov/ocr

PART 5 – AMENDMENTS TO THIS NOTICE OF PRIVACY PRACTICES

FCAAC reserves the right to revise or amend this Notice at any time. These revisions or amendments may be made effective for all personal health information FCAAC maintains even if created or received prior to the effective date of the revision or amendment. FCAAC will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by posting on its website the most recent version of this Notice, and upon written request, FCAAC will mail or electronically send to you the most recent version of this Notice.

PART 6 – ON-GOING ACCESS TO THIS NOTICE OF PRIVACY PRACTICES

FCAAC posts the most recent version of this Notice on its website at: Florida-allergy.com. Also, upon written request to any of FCAAC's privacy officers, FCAAC will send you by mail or electronically a copy of the most recent version of its Notice. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact FCAAC's privacy officers at the following address or telephone number:

FCAAC'S Privacy Officers
Geidy Rodriguez, Director of Office Operations.
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