

NEW PATIENT INFORMATION 2022



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

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 **.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

PRINT PATIENT NAME

SIGNATURE/PARENT/GUARDIAN

___/___/___
DATE

PATIENT ACCOUNT NUMBER _____ (OFFICE USE ONLY)

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: ___ / ___ / ___

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

PATIENT RESEARCH QUESTIONNAIRE



We are very interested in developing new drugs for the treatment of allergic diseases. We participate in many research studies with several pharmaceutical companies that are prepared to bring to market new treatments for allergic diseases. Some studies give patients time and travel per diem. If you are interested in participating in one of our clinical trials in the future, please fill out this form.

Date _____ Name _____

Name of Parent/Legal Guardian (if under 18 yrs of age) _____

Date of Birth / /	Gender (Check One) M F	Ethnic Group
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Address	City / State	Zip Code
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E-mail	Home Phone	Work Phone
--------	------------	------------

Do you have asthma?	When did it start?
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Do you have any allergies?	What type of allergies?
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Do you experience sinus symptoms? (congestion, infections, etc)	How often?	Do you have or ever had hives?
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Other medical conditions _____

Are you a smoker?	Ever Smoked?	If yes, when did you quit smoking?
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Are you allergic to aspirin or any other pain relievers? _____

Tell us what other medications you are allergic to (if any) _____

Are you currently on allergy shots?	Since when?
-------------------------------------	-------------

May we call you if your profile meets our research study criteria to see if you are interested in participating in clinical trials?
 Yes to this phone _____ No _____

Thank you for taking the time to fill out this questionnaire

For more information, visit: Florida-Allergy.com

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 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

Jaime Landman, M.D.*
Zevy Landman, M.D.*
Ileana M. Rodicio, M.D.*
Frank J. Martell, M.D.*
Philip C. Mirmelli, M.D.*
Sharlene J. Llanes, M.D.*
Walter M. Ryan III, D.O.*
Adriana M. Bonansea-Frances, M.D., PhD.



1.877.4.255.3749 Florida-Allergy.com

Kfir Shamir, M.D.*
Barry J. Mark, M.D.*
Tamar N. Rubin, M.D.*
Inessa R. Bachove, D.O.*
Stacy M. Nassau, M.D.*
Ornella Papadias Feria, M.D.
Jose E. Rojas Camayo, M.D.
*Board Certified in Allergy & Immunology

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,

A handwritten signature in black ink, appearing to read "Cari Cruet".

Cari Cruet
Chief Operating Officer

Jaime Landman, M.D.*
 Zevy Landman, M.D.*
 Ileana M. Rodicio, M.D.*
 Frank J. Martell, M.D.*
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 *Board Certified in Allergy & Immunology

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.

AVENTURA (305) 932.3252	BOCA RATON (561) 392.8832	CORAL GABLES (305) 445.9422	CORAL SPRINGS (954) 344.8100	FORT LAUDERDALE (954) 772.3366	HIALEAH/MIAMI LAKES (305) 362.7762	HOLLYWOOD/EMERALD HILLS (954) 981.9180	HOMESTEAD (305) 245.1100	KENDALL (305) 279.3366	KENDALL REGIONAL (305) 223.8919
MIAMI BEACH (305) 538.8339	NORTH MIAMI BEACH (305) 945.4131	PALMETTO BAY (305) 255.4868	PALM BEACH GARDENS (561) 227.1456	PEMBROKE PINES (954) 437.3600	PLANTATION (954) 472.4848	WELLINGTON (561) 227.0630	WEST KENDALL (305) 388.0078	WESTON (954) 389.2599	

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.

AVENTURA (305) 932.3252	BOCA RATON (561) 392.8832	CORAL GABLES (305) 445.9422	CORAL SPRINGS (954) 344.8100	FORT LAUDERDALE (954) 772.3366	HIALEAH/MIAMI LAKES (305) 362.7762	HOLLYWOOD/EMERALD HILLS (954) 981.9180	HOMESTEAD (305) 245.1100	KENDALL (305) 279.3366	KENDALL REGIONAL (305) 223.8919
MIAMI BEACH (305) 538.8339	NORTH MIAMI BEACH (305) 945.4131	PALMETTO BAY (305) 255.4868	PALM BEACH GARDENS (561) 227.1456	PEMBROKE PINES (954) 437.3600	PLANTATION (954) 472.4848	WELLINGTON (561) 227.0630	WEST KENDALL (305) 388.0078	WESTON (954) 389.2599	

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 Stacy M. Nassau, M.D.*
 Ornella Papadias Fera, M.D.
 Jose E. Rojas Camayo, M.D.
 *Board Certified in Allergy & Immunology

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.

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

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