Print and fill out pages 1-9 and bring to your appointment.

Pages 10 and 11 are for you to keep.

Dr. Scott Friedberg
Board Certified Family Physician

6611 W. Boynton Beach Blvd.
Boynton Beach, FL 33437

NEW PATIENT REGISTRATION

Name: _____ **Date of Birth:** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Home phone: ( ) _____ **Work phone:** ( ) _____

Mobile phone: ( ) _____

Email address: _____

Social Security Number: _____

Age: _____ **Sex:** M / F **Marital Status:** _____

Emergency Contact: _____ **Phone:** ( ) _____

Employer: _____ **Occupation:** _____

How did you hear about us/who referred you to our office? _____

Signature: _____

Dr. Scott Friedberg
Board Certified Family Physician
Health History
(Confidential)

Name_____ Today's Date_____

Age_____ Birth Date_____ Date of Last Physical Examination_____

What is the reason for your visit? _____

Symptoms: (Please put an "X" on the line next to any symptoms you currently have or have had in the past year.)

General
__Chills
__Depression
__Dizziness
__Fainting
__Fever
__Forgetfulness
__Headache
__Loss of Sleep
__Loss of Weight
__Nervousness
__Numbness
__Sweats

Muscle/Joint/Bone
Pain, weakness, numbness in:
__Arms __Hips
__Back __Legs
__Feet __Neck
__Hands __Shoulders

Genito-Urinary
__Blood in Urine
__Frequent Urination
__Lack of Bladder Control
__Painful Urination

Gastrointestinal
__Appetite Poor
__Bloating
__Bowel Changes
__Constipation
__Diarrhea
__Excessive Hunger
__Excessive Thirst
__Gas
__Hemorrhoids
__Indigestion
__Nausea
__Rectal Bleeding
__Stomach Pain
__Vomiting
__Vomiting Blood

Cardiovascular
__Chest Pain
__High Blood Pressure
__Irregular Heart Beat
__Low Blood Pressure
__Poor Circulation
__Rapid Heart Beat
__Swelling of Ankles
__Varicose Veins

Eye, Ear, Nose, Throat
__Bleeding Gums
__Blurred Vision
__Crossed Eyes
__Difficulty Swallowing
__Double Vision
__Earache
__Ear Discharge
__Hay Fever
__Hoarseness
__Loss of Hearing
__Nosebleed
__Persistent Cough
__Ringing in Ears
__Sinus Problems
__Vision-Flashes
__Vision-Halos

Skin
__Bruise Easily
__Hives
__Itching
__Change in Moles
__Rash
__Scars
__Sore that won't Heal

Men Only
__Breast Lump
__Erection Difficulties
__Lump in Testicles
__Penis Discharge
__Sore on Penis
__Other

Women Only
__Abnormal Pap Smear
__Bleeding Between Periods
__Breast Lump
__Extreme Menstrual Pain
__Hot Flashes
__Nipple Discharge
__Painful Intercourse
__Vaginal Discharge
__Other

Date of Last Menstrual Period:
_____
Date of Last Pap Smear:
_____
Have you had a Mammogram?
Y/N If yes, Date: _____
Are you Pregnant? Y/N
Number of Children_____

Conditions: (Please put an "X" on the line next to any conditions you currently have or have had in the past.)

__AIDS
__Alcoholism
__Anemia
__Anorexia
__Appendicitis
__Arthritis
__Asthma
__Bleeding Disorders
__Breast Lump
__Bronchitis
__Bulimia
__Cancer
__Cataracts
__Chemical Dependency
__Chicken Pox
__Diabetes
__Emphysema
__Epilepsy
__Glaucoma
__Goiter
__Gonorrhea
__Gout
__Heart Disease
__Hepatitis
__Hernia
__Herpes
__High Cholesterol
__HIV Positive
__Kidney Disease
__Liver Disease
__Measles
__Migraine Headaches
__Miscarriage
__Mononucleosis
__Multiple Sclerosis
__Mumps
__Pacemaker
__Pneumonia
__Polio
__Prostate Problem
__Psychiatric Care
__Rheumatic Fever
__Scarlet Fever
__Stroke
__Suicide Attempt
__Thyroid Problems
__Tonsillitis
__Tuberculosis
__Typhoid Fever
__Ulcers
__Vaginal Infections
__Venereal Disease

Medications: (List medications you are currently taking.)

_____

_____

_____

Pharmacy Name/Phone Number:

Allergies: (To medications or substances.)

_____

_____

_____

Family History: (Fill in information about your family.)

Relation	Age	State of Health	Age at Death	Cause of Death
Father	___	_____	_____	_____
Mother	___	_____	_____	_____
Brother(s)	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____
Sister(s)	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____

Please put an "X" on the line if your blood relatives had any of the following:

Disease	Relationship to you:
__Arthritis, Gout	_____
__Asthma, Hay Fever	_____
__Cancer	_____
__Chemical Dependency	_____
__Diabetes	_____
__Heart Disease, Strokes	_____
__Kidney Disease	_____
__Tuberculosis	_____
Other:	

Hospitalizations:

Year: Hospital: Reason for Hospitalization and Outcome:

_____

_____

_____

_____

Health Habits: Please put an "X" next to the substances you use and describe how much you use:

__Caffeine_____

__Tobacco_____

__Drugs_____

Other:_____

Serious Illness/Injuries: Date: Outcome:

_____

_____

_____

Occupational Concerns:

Please put an "X" if your work exposes you to the following:

__Stress
__Hazardous Substances
__Heavy Lifting
Other: _____

Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Friedberg or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: Date:

DR. SCOTT FRIEDBERG
BOARD CERTIFIED FAMILY PHYSICIAN

6611 W. BOYNTON BEACH BLVD.
BOYNTON BEACH, FL 33437

GENERAL CONSENT FORM
CONSENT FOR TREATMENT

I, _____ HEREBY AUTHORIZE SCOTT FRIEDBERG, D.O., P.A., THE ATTENDING PHYSICIAN, OR THE PHYSICIAN DESIGNATED BY HIM, AND OTHER CENTER EMPLOYEES, TO EXAMINE AND TREAT ME. I ALSO AUTHORIZE SUCH TREATMENT AND PROCEDURES, AS DEEMED NECESSARY BY THE PHYSICIAN, INCLUDING BUT NOT LIMITED TO, THE TAKING OF X-RAYS, MEDICATIONS, BLOOD SAMPLES, URINE SAMPLES AND OTHER THERAPIES AS DEEMED NECESSARY. I AM AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE OR IMPLIED TO ME AS TO THE RESULTS THAT MAY BE OBTAINED BY EXAMINATION AND TREATMENT.

I HEREBY CERTIFY THAT I UNDERSTAND THE ABOVE AUTHORIZATION.

X_____ _____

PATIENT'S SIGNATURE — PERSON AUTHORIZED TO CONSENT (IF DIFFERENT THAN PATIENT)

X_____

DATE

Dr. Scott Friedberg
Board Certified Family Physician

6611 W. Boynton Beach Blvd.
Boynton Beach, FL 33437

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name _____ DOB _____

I understand and agree that it is my responsibility, and not the sole responsibility of Scott Friedberg, D.O., P.A., to know if my insurance company (if applicable) will pay for my medical services.

I understand and agree that I am financially responsible for any and all charges my insurance company (if applicable) does not pay for, and that I get billed for.

I understand that Scott Friedberg, D.O., P.A. is a private Family Practice that offers a variety of medical services. I understand that I am responsible for any co-payment, co-insurance, or deductible that I may have at the time services are rendered.

I understand and agree that Scott Friedberg, D.O., P.A. will submit a claim to my insurance company (if applicable) on my behalf, but cannot guarantee reimbursement or be held responsible for any policy restrictions or benefit limitations or exclusions my insurance company may apply. I further understand that I am responsible for my portion of any unpaid balance.

Patient or responsible party's signature _____

Patient or responsible party's name _____ Date _____

DR. SCOTT FRIEDBERG
BOARD CERTIFIED FAMILY PHYSICIAN

6611 W. BOYNTON BEACH BLVD.
BOYNTON BEACH, FL 33437

AUTHORIZATION FOR THE USE OF OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

FULL NAME_____DATE OF BIRTH_____

THIS IS AN AUTHORIZATION UNDER THE PRIVACY RULES OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 [CFR 164.508]. I AUTHORIZE SCOTT FRIEDBERG, D.O., P.A., MY PHYSICIAN, AND/OR ADMINISTRATIVE AND CLINICAL STAFF TO (CHECK ALL THAT APPLY):
____USE THE FOLLOWING PROTECTED HEALTH INFORMATION, AND/OR
____DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION TO THE FOLLOWING LISTED ENTITY AND/OR PERSON(S):
*
_____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:
*
_____

THIS PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED FOR THE FOLLOWING PURPOSE:
[*LIST SPECIFIC PURPOSES HERE. "AT THE REQUEST OF THE INDIVIDUAL" IS ACCEPTABLE IF THE REQUEST IS MADE BY THE PATIENT, AND THE PATIENT DOES NOT WANT TO STATE SPECIFIC PURPOSE.*]
*_____

_____

THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECT UNTIL: (1) _____ [*EXPIRATION DATE*] OR (2)_____ [*EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE*] AT WHICH TIME THIS AUTHORIZATION TO USE OR DISCLOSE THIS PROTECTED HEALTH INFORMATION EXPIRES.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIME BY SENDING SUCH WRITTEN NOTIFICATION TO THE PRACTICE'S PRIVACY OFFICER AT THIS OFFICE. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE TO THE EXTENT THAT SCOTT FRIEDBERG, D.O., P.A. HAS RELIED ON THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION OR IF MY AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE AND THE INSURER HAS A LEGAL RIGHT TO CONTEST A CLAIM.

I UNDERSTAND THE INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE DISCLOSED BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

MY PHYSICIAN WILL NOT CONDITION MY TREATMENT, PAYMENT, ENROLLMENT IN A HEALTH PLAN OR ELIGIBILITY FOR BENEFITS (*IF APPLICABLE*) ON WHETHER I PROVIDE AUTHORIZATION FOR THE REQUESTED USE OR DISCLOSURES EXCEPT: (1) IF MY TREATMENT IS RELATED TO RESEARCH, OR (2) HEALTH CARE SERVICES ARE PROVIDED TO ME SOLELY FOR THE PURPOSE OF CREATING PROTECTED HEALTH INFORMATION FOR DISCLOSURE TO A THIRD PARTY. I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

X_____	X_____	X_____
SIGNATURE OF PATIENT OR REPRESENTATIVE	PRINT	DATE

DR. SCOTT FRIEDBERG
BOARD CERTIFIED FAMILY PHYSICIAN

6611 W. BOYNTON BEACH BLVD.
BOYNTON BEACH, FL 33437

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HEREBY GIVE CONSENT TO SCOTT FRIEDBERG, D.O., P.A. AND ALL HEALTH CARE PROVIDERS FURNISHING CARE WITHIN THE PRACTICE TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

MY "PROTECTED HEALTH INFORMATION" MEANS MY HEALTH INFORMATION, INCLUDING MY DEMOGRAPHIC INFORMATION, COLLECTED FROM ME AND CREATED OR RECEIVED BY MY PHYSICIAN, ANOTHER HEALTH CARE PROVIDER, A HEALTH PLAN, MY EMPLOYER OR A HEALTH CARE CLEARINGHOUSE.

THIS PROTECTED HEALTH INFORMATION RELATES TO MY PAST, PRESENT OR FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITIONS AND IDENTIFIES ME, OR THERE IS A REASONABLE BASIS TO BELIEVE THE INFORMATION MAY IDENTIFY ME.

PLEASE BE ADVISED THAT OUR NOTICE OF PRIVACY PRACTICES PROVIDES MORE DETAILED INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION. YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU SIGN THIS CONSENT.

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES. YOU MAY OBTAIN A COPY OF THE CURRENT NOTICE BY CONTACTING OUR PRIVACY OFFICER AT (561) 369-2428 OR BY MAIL AT THE ABOVE ADDRESS.

YOU HAVE THE RIGHT TO REQUEST US TO RESTRICT HOW WE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. WE ARE NOT REQUIRED TO GRANT YOUR REQUEST, BUT IF WE DO, THE RESTRICTIONS WILL BE BINDING ON US.

YOU MAY REVOKE THIS CONSENT AT ANY TIME. YOUR REVOCATION MUST BE IN WRITING SIGNED BY YOU OR ON YOUR BEHALF, AND DELIVERED TO THIS OFFICE. YOU MAY DELIVER YOUR REVOCATION BY ANY MEANS YOU CHOOSE BUT IT WILL BE EFFECTIVE ONLY WHEN WE ACTUALLY RECEIVE THE REVOCATION. YOUR REVOCATION WILL NOT BE EFFECTIVE TO THE EXTENT THAT WE OR OTHERS HAVE ACTED IN RELIANCE UPON THIS CONSENT.

SIGN X_____PRINT X_____ DATE X_____

IF YOU ARE SIGNING AS PATIENT'S REPRESENTATIVE:
PRINT YOUR NAME_____ RELATIONSHIP_____

DR. SCOTT FRIEDBERG
BOARD CERTIFIED FAMILY PHYSICIAN

6611 W. BOYNTON BEACH BLVD.
BOYNTON BEACH, FL 33437

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND HAD AN OPPORTUNITY TO ASK QUESTIONS CONCERNING SCOTT FRIEDBERG, D.O., P.A.'S NOTICE OF PRIVACY PRACTICES.

X_____
PATIENT'S OR REPRESENTATIVE'S SIGNATURE

X_____
DATE

X_____
PRINT

_____
RELATIONSHIP TO PATIENT (IF SIGNED BY REPRESENTATIVE)

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
A patient has the right to a prompt and reasonable response to questions and requests.
A patient has the right to know who is providing medical services and who is responsible for his or her care.
A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
A patient has the right to know what rules and regulations apply to his or her conduct.
A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
A patient has the right to refuse any treatment, except as otherwise provided by law.
A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
A patient is responsible for following the treatment plan recommended by the health care provider.
A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Signature_____ Date_____

DR. SCOTT FRIEDBERG
NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

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

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities. We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

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

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

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

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

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

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

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

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

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

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

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their

duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

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

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

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

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

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

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

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

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

2. YOUR RIGHTS

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

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (561) 369-2428 for further information about the complaint process or write to us at 6611 W. Boynton Beach Blvd., Boynton Beach, FL 33437.

This notice was published and becomes effective on **April, 2011**