Please Arrive 30 min early for your appointment

Dear New Patient,

The Providers and staff would like to Welcome and thank you for choosing and trusting Diabetes Alliance of Tampa Bay with your health care needs. Our goal is to make your visits as pleasant and informative as possible.

We are asking you to **complete** the enclosed new patient packet, please bring in completed at the time of your first visit.

Once you have been established you can conveniently be able to access information about future appointments, prescriptions, message the office and account billing summaries through our patient portal.

If you were previously treated at another clinic or facility for the same care you will be receiving from our clinic, it is very important to provide us with your records before your initial appointment. We realize that not every patient will have their medical records available by the first visit. However, the quality of one's visit is enhanced when we have the ability to review your health records prior to your visit.

As a part of the patient information packet please know that payments, all applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your visit. We encourage you to visit our website at www.luciagillingmd.com for information about our providers and the services we provide.

Thank you for choosing and trusting our providers and staff with your healthcare and we look forward to your first visit.

3914 Flatiron Loop #101
Wesley Chapel, FL 33544

(813) 915-6811
(813) 907-0494 fax
luciagillingmd@gmail.com

PATIENT REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
					Single / Mar / Div / Sep / Wid

Social Security Number	Birth Date:	Age	Sex:		Spouse Name
	/ /		❑ M	❑ F	

Race:	Ethnicity:	Preferred Language:

Street address:			City
State	Zip Code	Home Phone	Cell Phone
		( )	( )

Occupation:	Employer:	Employer phone :
		( )

Pharmacy Phone Number	Email Address
( )	

Whom Referred you	May we leave a message on your answering machine?

INSURANCE INFORMATION

Name of Insured	Birth date:	Address (if different):	Home phone (if different):
	/ /		( )

Date Employed:	Insurance Company:

Subscriber's name if not Patient:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:
		/ /		

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone.:	Work phone:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*

diabetes alliance of tampa bay

HEALTH HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**

PATIENT MEDICAL HISTORY

Central Nervous System	**Year Diagnosed**
☐ Headache	
☐ Migraine	
☐ Seizures	
☐ Stroke	

Eyes, Ears, Nose & Throat	**Year Diagnosed**
☐ Glaucoma	
☐ Seasonal Allergies	

Respiratory	**Year Diagnosed**
☐ Asthma	
☐ Chronic Obstructive Pulmonary Disease	
☐ Emphysema	
☐ Sleep Apnea	
☐ Tuberculosis	

Cardiovascular	**Year Diagnosed**
☐ Arrhythmia / A. Fib	
☐ CAD/ blockage	
☐ Congestive Heart Failure	
☐ High Cholesterol	
☐ Hypertension	
☐ Mitral Valve Prolapse	
☐ Murmur	
☐ Valvular Disease	

Gastrointestinal	**Year Diagnosed**
☐ Crohns / Ulcerative Colitis	
☐ Gastric / Peptic Ulcers	
☐ GERD	
☐ Hepatitis	
☐ Irritable Bowl Syndrome	

Endocrinology	**Year Diagnosed**
☐ Diabetes Mellitus	
☐ Hyperthyroid	
☐ Hypothyroid	
☐ PCOS	
☐ Thyroid nodule	

Genito-Urinary / Gynecological	**Year Diagnosed**
☐ Anemia	
☐ Cancer:	
☐ Other Blood Disorder	

Hematology	
☐ Infertility	
☐ Polycystic Ovaries	
☐ Prostate Enlargement	
☐ Proteinuria	

Rheumatology	**Year Diagnosed**
☐ Gout	
☐ Osteoarthritis	
☐ Osteoporosis	
☐ Rheumatoid Arthritis	

Renal	**Year Diagnosed**
☐ Kidney Stones	
☐ Other	
☐ Proteinuria	
☐ Renal Failure / Insufficiency	

Other Medical Conditions	**Year Diagnosed**
☐	
☐	
☐	
☐	
☐	

Surgeries

Year	Surgery

SOCIAL HISTORY

Tobacco Use	☐ No- I do not smoke and have never smoked		
	☐ Yes- I previously smoked but no longer smoke	Total # of years smoking?	
	☐ Yes- I am currently Smoking	Total # of packs per Day	
Alcohol Use	☐ Never ☐ In the Past ☐ Rarely ☐ Weekly ☐ Daily		
Illicit Drug Use	☐ Never ☐ In the Past ☐ Rarely ☐ Weekly ☐ Daily		
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Occupation	☐ Employed ☐ Not Employed ☐ Student ☐ Retired		

WOMAN ONLY

Date of Last Menstruation:	Period Every _____ Days	Duration of Period:
Have you had a D&C ☐ Yes ☐ No	Hysterectomy ☐ Yes ☐ No	Cesarean ☐ Yes ☐ No

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FAMILY HEALTH HISTORY			
ARE YOU ADOPTED ☐ YES ☐ NO IF YOU ARE ADOPTED, YOU DO NOT NEED TO COMPLETE THE FOLLOWING			
	SIGNIFICANT HEALTH PROBLEMS MATERNAL SIDE		SIGNIFICANT HEALTH PROBLEMS PATERNAL SIDE
Mother		**Father**	
Grandmother *Maternal*		**Grandmother** *Paternal*	
Grandfather *Maternal*		**Grandfather** *Paternal*	
Other		**Other**	
Other		**Other**	

DO YOU HAVE THE FOLLOWING SYMPTOMS?			
Skin	☐ Acne ☐ Blemish ☐ Discoloration ☐ Easy Bruising / Bleeding ☐ Excess Facial Hair ☐ Rash ☐ Vitiligo	**Gastrointestinal**	☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Distress from greasy foods ☐ Gallbladder Problem ☐ Heartburn ☐ Hiatal Hernia ☐ Liver Trouble ☐ Nausea ☐ Pancreatitis ☐ Stomach Pain ☐ Ulcers ☐ Vomiting
General	☐ Fatigue ☐ Fever ☐ Loss of Appetite ☐ Loss of Sleep ☐ Recent Weight Gain ☐ Recent Wight Loss ☐ Smoking	**Genitourinary**	☐ Blood in urine ☐ Enlarged Prostate ☐ Frequent urinary tract infection ☐ Frequent urination ☐ Incontinence ☐ Kidney Stones ☐ Loss of Libido ☐ Pain in Pelvis ☐ Painful urination ☐ Sexual Difficulty
EYES, EARS, NOSE & THROAT	☐ Blind Spot ☐ Blurred Vision ☐ Double Vision ☐ Dry Gritty Eyes ☐ Ear Noises ☐ Hearing Loss ☐ Mouth Sores ☐ Hoarseness ☐ Sore Throat	**Musculoskeletal**	☐ Osteoarthritis ☐ Compression Fracture ☐ Muscle Weakness ☐ Muscle Pain ☐ Join Pain ☐ Bone Pain ☐ Gout ☐ Head Injury ☐ Broken Bones ☐ Sciatica
Cardiovascular	☐ Heart Attack ☐ Irregular Heartbeat ☐ Pain down left arm ☐ Pain over Heart ☐ Pressure over chest ☐ Sleep with Pillows # _____ ☐ SOB with activity ☐ Swelling of ankles	**Neurological**	☐ Anxiety ☐ Difficulty Walking ☐ Fainting ☐ Headaches ☐ Light headed / dizzy ☐ Loss of Coordination ☐ Memory Loss ☐ Numbness ☐ Tingling ☐ Tremors ☐ Weakness
Respiratory	☐ Coughing ☐ Coughing up blood ☐ Difficulty Breathing	**Endocrine**	☐ Diabetes ☐ Goiter ☐ Too Hot ☐ Too Cold ☐ Hair Changes ☐ Dry Skin ☐ Increased Thirst ☐ Increased Hunger

PATIENT NAME:_____ **DATE:**_____

WRITE OUT your prescribed drugs, over-the-counter-drugs, vitamins, and herbal supplements below			
Name of Drug, Viatmin, Herb, or over-the-counter-drugs	**Strength**	**Frequency Taken**	**Date Started Medications**

Allergies to Medicine	**Reaction you Had**

Allergies to Food	**Reaction you Had**

Allergies to Environment	**Reaction You Had**
☐ Animal Dander	
☐ Dust	
☐ Grasses	
☐ Latex	
☐ Mold	
☐ Pollen	
☐ Stainless Steel	
☐ Talc	
☐ Tape	
☐ Topical Iodine	

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this

Offices “Notice of Privacy Practices”.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

_____Individual refused to sign

_____Communications barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (Please Specify)

_____

3914 Flatiron Loop# 101, Wesley Chapel, FL 33544
Phone: 813-915-6811 Fax: 813-907-0494

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please release all requested records for the patient listed below

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

Patient Signature: _____ Date Signed: _____

FINANCIAL AGREEMENT

Dear Patient,

Thank you for choosing Diabetes Alliance of Tampa Bay, Dr. Gilling MD, PA. as your endocrine healthcare provider. We are committed to the success of your treatment, as well as, providing you the best possible endocrine care. Please understand that payment of your bill is considered a part of your treatment. All patients must complete our registration form, provide their insurance card and driver's license / ID cared before seeing Dr. Gilling. The following is a statement of our Financial Agreement, which we require you to read and sign prior to any treatment. ***Full Payment is Due at the Time of Service Unless Other Arrangements Have Been Made. We accept Cash, Visa, MasterCard, American Express and checks***

Regarding Medicare

We are a Medicare Provider therefore; we do accept assignment on Medicare. When possible, your claim will be filed to Medicare and any supplement insurance that routinely pays the doctor for her services. For those patients that have a supplement that does not routinely pay the doctor, or if you do not have supplemental policy, we will require 20% of the total bill to be paid at the time of service. If there is a remaining balance after your insurance pays, then a bill will be sent to you, for your payment of the final balance.

Regarding Private Insurances

If you are a member of an insurance company that we are a participating provider with, as a courtesy to you, we will file the claim directly with the insurance company. The amount of benefits you are entitled to depends solely on what your specific insurance company and plan offers to its members. Some insurance plans cover as little as 30% and some cover as much as 100% of your medical care. You will be responsible for your co-pays, your deductibles, your co-insurance percentages, and services that are not covered under your specific contract.

Miscellaneous Policies

All accounts must be paid upon receipt of our bill. If after 60 days, the balance is not paid in full; your account will be sent to our collection agency for the balance plus a 50% collection fee. Returned checks are subject to a $25.00 processing fee.

We understand that emergencies happen and that the 24 hour notice is not always possible, but please call as soona s you realize that you will not be able to make the appointment. If you do not cancel your appointment, a $25.00 charge will be incurred.

I, the undersigned, authorize payment of medical benefits directly to Dr. Lucia Gilling, M.D.,PA and to release information including the diagnosis and the records of any such medical care. I am also giving D.r Gilling all rights to inquire on my behalf on any medical reviews relating to my medical benefits, either assigned or non-assigned. I have read the Financial Agreement, I understand and agree

Signature of patient_____**Date:** _____

CANCELLATION AND NO SHOW APPOINTMENT POLICY

Our practice philosophy is to provide comprehensive patient care by reserving dedicated blocks of time for each patient. Therefore, if you are not able to keep your appointment, we request that you call as soon as possible to let us know. This will allow us to provide more timely care to other patients who could be scheduled into your reserved time slot. We realize this is not always possible and the practice will consider each individual case. Providing such notice allows the clinic time to offer other persons the opportunity to see our providers, thus using the time more efficiently.

At least 24 hours' notice is required for the cancellation of all appointments. If an established patient fails to provide notice twice, it will be necessary to charge you , A $25 fee that will be added to your account if 24 hours' notice is not received prior to a missed appointment. Insurance will not pay for this charge.

LATE APPOINTMENT POLICY

If you are going to be more than 15 minutes late for your scheduled appointment time, we request that you call our office at 813-915-6811. We will do everything possible to accommodate the delay schedule permitting, though there may be times where we cannot accommodate the delay due to previously scheduled patient appointments and we may need to reschedule or modify your appointment. We work diligently to stay on schedule and ask that you arrive 15 minutes prior to your schedule appointment to allow time to work you up and get you in the room on time.

I have read and understood this policy, and accept the responsibility of its terms.

_____ _____

Patient Signature Date

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS.

I understand that as part of my healthcare, diabetes alliance originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices Sheet* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their noticed and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not require to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

Notification of Family Members: Please share information with: _____

_____

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

Signature of Patient or Legal Representative Date:

HIPAA Notice of Privacy Practices

Effective Date: 09/13/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the way we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services and received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment of Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not re move or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law: We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing servic es on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provided benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summon s or similar process;(2) limited information to identify or locate a suspect, fugitive, a material witness, or missing person;(3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5)about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care;(2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your 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.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WIRTTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to *Diabetes Alliance of Tampa Bay.* We may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request and amendment for as long as the information is kept by or for our office. To reque4st and amendment, you must make your request, in writing, to *Diabetes Alliance of Tampa Bay.*

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to *Diabetes Alliance of Tampa Bay.*

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to *Diabetes Alliance of Tampa Bay.* We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket " in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to *Diabetes Alliance of Tampa Bay.* Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We wiLl post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact *Diabetes Alliance of Tampa Bay.* All complaints must be made in writing.

You will not be penalized for filing a complaint.

NOTICE OF INFORMATION PRACTICES

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please read carefully.

- LUCIA GILLING, M.D.,PA may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; and collection agencies. Healthcare operations includes, but is not limited to, internal quality control and assurance including auditing of records.
- LUCIA GILLING, M.D.,PA is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders
- This office will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
- This office may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health related benefits and services that may be of interest to the individual patient.
- We will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.
- This office reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information of the patient. Copies may also be obtained at any time at our offices
- We will provide each patient with a copy of any revisions of it's Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
- Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and or phone number: 3914 Flatiron Loop #101, Wesley Chapel, Florida 33544. All complaints will be addressed and results will be reported to the Corporate Compliance Officer.
- It is our policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standard.
- The name, title and telephone number of a person in the office to contact for further information: Office Manager
- The effective date of this Notice is 11-11-2011

PATIENT RIGHTS

This describes your rights and obligations of this practice regarding the use and disclosure of your medical information. You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer. Ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies, i.e. tapes, disks, etc. associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

Right to Amend: If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request and amendment for as long as the Practice maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that support your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- *Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;*
- *Is not part of the medical information kept by or for the Practice;*
- *Is no part of the information which you would be permitted to inspect and copy; or*
- *Is inaccurate and incomplete.*

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others.

To request this list, you must submit your request in writing. Your request must state a time period no longer than six (6) years back and may not include dates before April 14, 2003 (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we sue or disclose about you for treatment, payment or health care operations. YUou also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is excepted form the consent requirement or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request in writing. In your request, you indicate:

-What information you want to limit;
-Whether you want to limit our use, disclosure or both;
- To whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc)

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

To request confidential communications, you must a make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

Right to Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.