

BRADENTON EAST INTEGRATIVE MEDICINE

NEW PATIENT DEMOGRAPHIC FORM

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Race: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Current Address: \_\_\_\_\_

\_\_\_\_\_

Mailing Address : if different than above

\_\_\_\_\_

\_\_\_\_\_

Do you live alone or with others? \_\_\_\_\_

Other Household members: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Work Number: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

(Please provide copy of insurance card to front desk)

Preferred Pharmacy: \_\_\_\_\_

How did you find us? \_\_\_\_\_

Who was your previous (or current) Primary Care Physician? \_\_\_\_\_

Phone #: \_\_\_\_\_

SURGICAL HISTORY/HOSPITALIZATIONS

_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

SOCIAL HISTORY

What is your Marital Status?  Single  Married  Divorced  widowed  Other Long term partnership

What is your Occupation (if retired, from what occupation are you retired)?

\_\_\_\_\_

Do you use Tobacco (smoke or chew)?  Yes  No If yes, then how much and for how long?

\_\_\_\_\_

If no, then do you have a history of tobacco use?  Yes  No

If yes, then for many years did you smoke? \_\_\_\_\_ How long ago did you quit? \_\_\_\_\_

Do you use Alcohol?  Yes  No If yes, then how often and how much?

\_\_\_\_\_

Do you use Drugs?  Yes  No If yes, then how often and how much?

\_\_\_\_\_

Do you currently follow a Specific Diet or Nutritional program?  Yes  No

\_\_\_\_\_

Do you Cook?  Yes  No

Do you Grocery Shop?  Yes  No

Do you Read Food Labels?  Yes  No

How many Servings of Fruits/Vegetables do you have per day (do not include fruit juice, potatoes, or processed foods)? \_\_\_\_\_

How many times per week do you Eat Out (include: breakfast, lunch, dinner, and dessert/snacks)?

Do you Exercise?  Yes  No What type and How often?

WHAT IS YOUR CURRENT LEVEL OF STRESS?  none  mild  moderate  severe

What are your Hobbies/Interests? \_\_\_\_\_

Do you currently have or have you had any Environmental Exposures to chemicals/toxins/radiation?

Are you sensitive to any Environmental Chemicals (e.g. perfumes/colognes, auto exhaust, MSG, etc)?

### FAMILY HISTORY

Father:  alive; age \_\_\_\_\_  deceased; age \_\_\_\_\_ Medical problems \_\_\_\_\_

Mother:  alive; age \_\_\_\_\_  deceased; age \_\_\_\_\_ Medical problems \_\_\_\_\_

Brothers: Medical problems \_\_\_\_\_

Sisters: Medical problems \_\_\_\_\_

Other medical problems that run in the family?  Diabetes  Heart Problems  Cancer  Stroke  
 Hypertension  High Cholesterol  Thyroid problems  Osteoarthritis  Autoimmune Diseases  
(for example: Rheumatoid Arthritis, Lupus, Crohn's Disease, etc.)  Emotional Disorders  Alcoholism

Genetic Disorders / Please list: \_\_\_\_\_

## PAST MEDICAL HISTORY

Check all that apply:

- Abuse:     Physical     Emotional     Sexual    (Treatment: \_\_\_\_\_)
- Abnormal Heart Rhythm     Fibroids     Lupus
- Anemia     Fibromyalgia     Lyme disease
- Anxiety     Food allergies or intolerances     Kidney Disease
- Asthma     Headaches/Migraines     Osteoarthritis     Osteoporosis
- Autoimmune Disease     Heart Attack     Parkinson's Disease
- Bipolar Disorder     Heart Disease     Premenstrual Syndrome
- Bowel or Bladder Incontinence     High Blood Pressure     Prostatitis / Prostate Disease
- Broken Bones \_\_\_\_\_     High Cholesterol     Pulmonary Embolism (clot in lung)
- Cancer (what kind/when? \_\_\_\_\_)     Psoriasis
- Crohn's Disease     Hepatitis     Rheumatoid Arthritis
- Deep Vein Thrombosis (clot)     HIV/AIDS     Seizures
- Dementia / Memory Disorder     Impotence     Sleep Apnea
- Depression     Infertility     Stomach Ulcers
- Diabetes     Insulin resistance or Borderline Diabetes     Stroke
- Emphysema or Chronic Bronchitis (COPD)     Irritable Bowel Syndrome     Thyroid Disease
- Endometriosis     Insomnia or other Sleep disturbance     Ulcerative Colitis
- Other \_\_\_\_\_
- Have you ever had elevated calcium levels? If yes, then when?  Yes  No  
Do you recall the level? How can we obtain this result?  
\_\_\_\_\_

Have you had laboratory tests to check your Vitamin D levels?  Yes  No

ARE YOU CURRENTLY ON ANY BLOOD THINNERS?  Yes  No

Have you ever taken quinolone antibiotics (Cipro, Levofloxin)? If so, when?  Yes  No \_\_\_\_\_

### Chronic Musculoskeletal Pain :

- Shoulder     Neck     Knee
- Elbow     Mid-back     Ankle/foot
- Wrist/hand     Low back     other: \_\_\_\_\_

## REVIEW OF SYSTEMS/SYMPTOMS

(Check any symptoms or findings that you have experienced recently)

CONSTITUTIONAL  weight change  fatigue  fever  night sweats  general weakness

EYES  vision problems  double vision  yellowing of the eyes

ENT  hearing problems  dizziness  sinus trouble  sore throat  ringing ears  bleeding gums  
 periodontal disease

CARDIOVASC  shortness of breath  chest pain  leg swelling  increased blood pressure  
 palpitations

RESPIRATORY  cough  coughing up blood  wheezing  asthma  other difficulty breathing  
 snoring  gasping for air during sleep  fall asleep during the day

GASTROINTESTINAL  trouble swallowing  heartburn  nausea  vomiting  diarrhea  blood or  
black tarry stools  abdominal pain  gas  bloating

GENITOURINARY  pain with urination, blood in urine  urgency  incontinence  increased urination  
 sexual dysfunction  nocturia (frequent urination at night)

MUSCULOSKELETAL  joint pain  joint stiffness  muscle cramps  muscle twitching  muscle  
weakness  loss of motion  tendonitis  swelling of finger or other joints  redness of joints

SKIN/HAIR/NAILS  rash  lumps/masses  itchy  dryness  hair changes  nail changes  
 yellowing of the skin

NEUROLOGICAL  fainting  blackouts  seizures  paralysis  weakness  numbness  memory  
loss  numbness in a saddle distribution (inner legs and groin)  headaches

PSYCHOLOGICAL  nervousness  tension  mood changes  depression  anxiety

ENDOCRINE  decreased libido  heat or cold intolerance  excessive thirst  increased hunger  
 increased craving for sweets or carbs  low blood pressure  hot flashes

HEMATOLOGY/ONCOLOGY  easy bruising  bleeding (difficulty clotting)  venous thrombosis (clots)  
 current or history of cancer

**ALLERGIES (to medications, supplements, foods or environmental agents)**

Medication: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

Food: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

Food: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

Food: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

Other: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

**MEDICATIONS/BOTANICAL HERBS/SUPPLEMENTS LIST**

<u>NAME</u>	<u>DOSAGE</u>	<u>HOW OFTEN TAKEN</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____

## IMMUNIZATION HISTORY

Please provide the dates of the most recent vaccination for the following  
(or record as n/a if you have never been vaccinated):

1. Pneumonia \_\_\_\_\_
2. DTAP \_\_\_\_\_
3. HEPATITIS A \_\_\_\_\_
4. HEPATITIS B \_\_\_\_\_
5. SHINGLES \_\_\_\_\_
6. HPV / GUARDASIL \_\_\_\_\_
7. MENINGITIS \_\_\_\_\_
8. MMR \_\_\_\_\_
9. POLIO \_\_\_\_\_
10. Other please list \_\_\_\_\_

HIPPA DISCLOSURE AGREEMENT

Bradenton East Integrative Medicine, P.A

Patient Authorization for Disclosure of Information

Do we have permission to?

Leave the following information on your home answering machine or voice mail?

Appointment Information	Y	N
Medical information	Y	N
Billing information	Y	N
Contact you at work	Y	N

List family members of friends or personal care givers that you give permission to receive the following information about you:

Appointments: \_\_\_\_\_

Medical or health information: \_\_\_\_\_

Billing/Payments: \_\_\_\_\_

I understand that is the person or entity receiving authorized information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Bradenton East Integrative Medicine in writing.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

I Have received a copy of the "Notice of Privacy Practices" to review and acknowledge that I may request a copy.

Patient signature \_\_\_\_\_ Date \_\_ / \_\_ / \_\_





INSURANCE COMPANY: \_\_\_\_\_

NAME \_\_\_\_\_

INSURANCE ID# \_\_\_\_\_

GROUP# \_\_\_\_\_

KNOW YOUR INSURANCE – Your insurance is a contract between you and your insurance company.

We want to inform you that your health insurance benefits may or may not cover specific services depending on your policy. These services may include but are not limited to routine physical exams, ultrasound testing, massage, acupuncture, and laboratory services.

If your coverage denies this claim, you will be financially responsible.

\_\_\_\_\_  
Signature

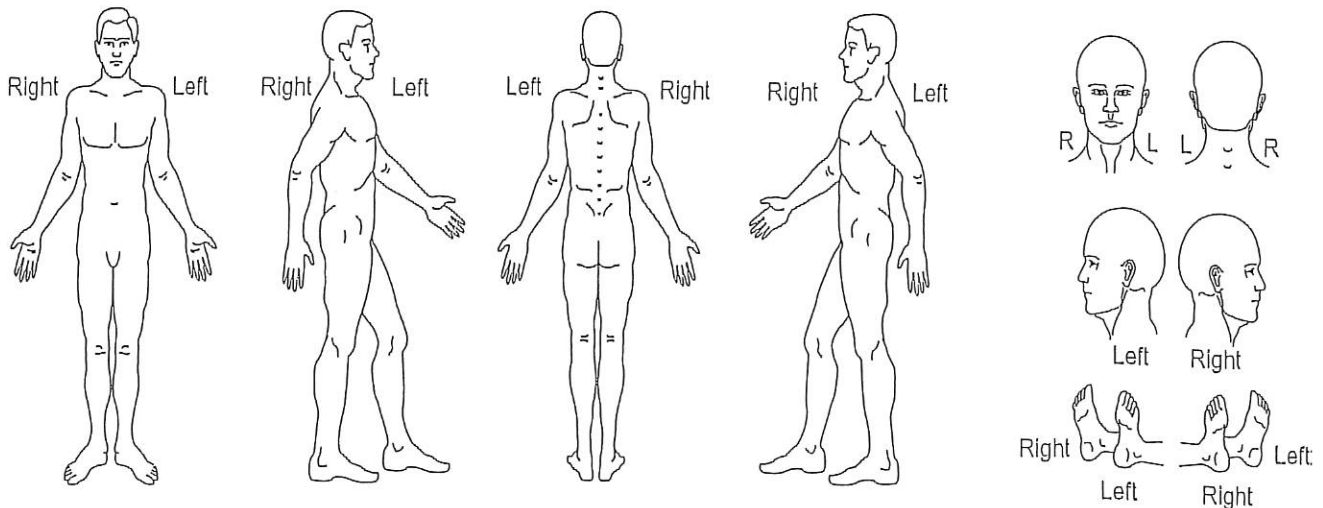
\_\_\_\_\_  
Please print name

# MUSCULOSKELETAL DIVISION

- 1) REFERRED BY: \_\_\_\_\_  
2) PRIMARY CARE PHYSICIAN: \_\_\_\_\_ Last Visit: \_\_\_\_\_  
3) DO YOU SEE A PAIN MANAGEMENT PHYSICIAN:  Yes  No  
NAME: \_\_\_\_\_ LAST VISIT: \_\_\_\_\_  
4) REASON FOR THIS VISIT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE MARK THE AREAS ON THE DIAGRAM WHERE YOU ARE EXPERIENCING DIFFICULTY:



- 5) IS THIS THE RESULT OF AN INJURY OR ACCIDENT? IS THIS A WORKER'S COMPENSATION OR AUTOMOBILE INSURANCE RELATED CASE? (if Yes, please provide background information)

\_\_\_\_\_  
-  
\_\_\_\_\_

PRIMARY AREA YOU WOULD LIKE TO DISCUSS TODAY: (please check one)

- Neck/Upper back     Mid-back/Lower Back     Shoulder     Elbow  
 Wrist     Hand     Hip     Knee     Ankle     Foot

Comments: \_\_\_\_\_

6) THE FOLLOWING QUESTIONS PERTAIN TO THE PRIMARY AREA YOU'VE CHECKED IN QUESTION 4 ABOVE :

a. When and how did this problem start?

\_\_\_\_\_

b. How would you describe the character of your pain or complaint (check all that apply):

- Aching    Tightness/Stiffness    Numbness/Tingling    Cramping    Stabbing  
 Sharp    Shooting    Pressure    Burning    Weakness

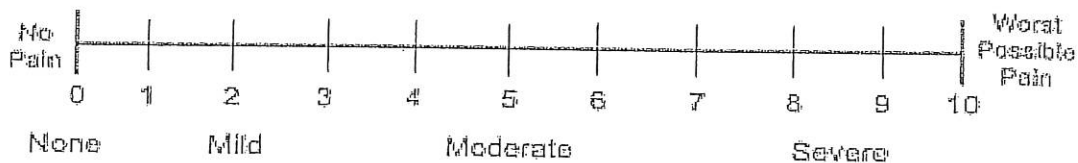
If your chief complaint today is for knee pain, then please check the following (if they apply):

- Knee Popping    Knee Clicking    Knee Catching    Knee Instability

c. Does this pain/complaint radiate to any other locations? (if yes, describe the pattern)

\_\_\_\_\_

d. How severe is the pain/complaint currently on a scale of 0 (no pain) to 10 (worst possible pain)? [please circle the appropriate number on the scale below]



Comments: \_\_\_\_\_

What is the pain on average throughout the day on a scale of 0 – 10? \_\_\_\_\_

e. Is this pain/complaint constant?    Yes    No

i. How much of the day is your discomfort or pain present?

- Less than 1 hour    4 hours    6 hours    12 hours    18 hours    24 hours

f. How has this pain/complaint changed over time?

- getting better    getting worse    no change

g. What activities is this pain/complaint affecting?

\_\_\_\_\_

h. What makes this pain/complaint worse?

\_\_\_\_\_

i. Does it get worse with bending the area? (For neck or low back pain, is it worse with bending forward, backwards, or with turning?)

\_\_\_\_\_

ii. Does it get worse with sneezing or coughing?  Yes  No

i. What makes this pain/complaint better?

\_\_\_\_\_

i. Is it better at certain times of day?

\_\_\_\_\_

ii. Is it better with  rest or  motion? Are there certain positions that ease the problem?

\_\_\_\_\_

\_\_\_\_\_

## 7) PRIOR TREATMENT

a. Have you taken any Medications/Botanical Herbs/Supplements for this problem?

1. Please list:

<u>Name</u>	<u>Dose</u>	<u>Length of Time Taken</u>	<u>Helpful (Not at all/Mildly/Moderately/Very)</u>
-------------	-------------	-----------------------------	--

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

b. ARE YOU CURRENTLY ON ANY ONGOING STEROID THERAPY ?  Yes  No

c. Have you had Physical Therapy for this problem?  Yes  No When?

\_\_\_\_\_ For how long?

\_\_\_\_\_

d. Have you had Manual Adjustments (e.g. Chiropractic or Osteopathic) for this problem?

Yes  No When? \_\_\_\_\_ For how long?

\_\_\_\_\_

e. Have you had Acupuncture for this problem?  Yes  No When?

\_\_\_\_\_ For how long?

\_\_\_\_\_

f. Have you had Massage for this problem?  Yes  No When?

\_\_\_\_\_ For how long?

\_\_\_\_\_

g. Have you had any Injections for this problem?  Yes  No When?

\_\_\_\_\_ What kind? \_\_\_\_\_ For how long/How many times?

\_\_\_\_\_

h. Have you had any other treatment interventions for this problem?  Yes  No  
When? \_\_\_\_\_ For how long/How many times?

\_\_\_\_\_

8) What are your goals for treatment?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9) HAVE YOU RECEIVED ANY SPECIAL TESTING OR PROCEDURES FOR THIS PROBLEM? (PLEASE BRING COPIES OF REPORTS OR HAVE SENT TO US)

<u>TEST</u>	<u>DATE</u>	<u>LOCATION</u>	<u>RESULTS (in your own words is ok)</u>
XRAY	_____	_____	_____
CAT SCAN (CT)	_____	_____	_____
MRI	_____	_____	_____
ULTRASOUND	_____	_____	_____
EMG/NERVE CONDUCTION	_____	_____	_____
OTHER (please specify )	_____	_____	_____

# BRADENTON EAST INTEGRATIVE MEDICINE

## NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this Notice please contact our Privacy Officer who is **HEATHER JOHNSON**

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. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**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.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

### **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. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

**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.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**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.

## **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

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

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

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. Please contact our Privacy Officer if you have questions about access to your medical record.

**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. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **submitting the request in writing to the privacy officer (Heather Johnson) for review with your physician.**

**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, **Heather Johnson** at (941)727-1243 **or beim6120@gmail.com** for further information about the complaint process.

This notice was published and becomes effective on **9/1/2013**.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Bradenton East Integrative Medicine with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date

**REQUEST TO RELEASE MEDICAL RECORDS TO:  
BRADENTON EAST INTEGRATIVE MEDICINE, PA  
8614 EAST STATE ROAD 70 SUITE 200 BRADENTON, FL 34202  
941-727-1243  
FAX: 941-751-9039**

KAREN BRAINARD, MD \_\_\_\_\_ ROBIN JAMES, ARNP \_\_\_\_\_  
 JAMES LEIBER, DO \_\_\_\_\_ KINGA PORTER, DO \_\_\_\_\_  
 MICHAEL AMOROSO, MD \_\_\_\_\_ MARIA GALIMIDI, DPM \_\_\_\_\_

**FROM:** \_\_\_\_\_  
 NAME OF HEALTHCARE PROVIDER/PHYSICIAN/FACILITY

\_\_\_\_\_  
 STREET ADDRESS

\_\_\_\_\_  
 CITY, STATE & ZIP

PHONE ( ) \_\_\_\_\_ FAX ( ) \_\_\_\_\_

\_\_\_\_\_  
 PRINT PATIENT'S FULL NAME

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 DATE OF BIRTH SOCIAL SECURITY NUMBER

\_\_\_\_\_  
 SIGNATURE OF PATIENT OR GUARDIAN \_\_\_\_\_  
 DATE

**I HEREBY AUTHORIZE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION  
 ABOUT ME AS DESCRIBED BELOW FOR THE PURPOSE OF CONTINUITY OF CARE**

\_\_\_\_\_ COMPLETE MEDICAL RECORDS \_\_\_\_\_ LAB TESTS  
 \_\_\_\_\_ X-RAYS \_\_\_\_\_ EKG/ECG/CARDIAC STUDIES  
 \_\_\_\_\_ CONSULT REPORTS

I UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES, AND TREATMENT FOR ALCOHOL AND DRUG ABUSE OR SELF-PAID SERVICES. YOU ARE HEREBY SPECIFICALLY AUTHORIZED TO RELEASE ALL INFORMATION OR MEDICAL RECORDS RELATING TO SUCH DIAGNOSIS, TESTING, OR TREATMENT, UNLESS SPECIFICALLY EXCLUDED BELOW:

\_\_\_\_\_

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF SIGNING.  
 THE PATIENT MAY REVOKE THIS AUTHORIZATION AT ANYTIME UPON WRITTEN REQUEST.  
 I ACKNOWLEDGE THAT THE DISCLOSED INFORMATION MAY NO LONGER BE PROTECTED BY THE PRIVACY PRACTICES OF THIS PRACTICE.