JUPITER MEDICAL CENTER

**Institute for Metabolic and Bariatric Surgery**
1002 S. Old Dixie Highway • Suite 203 • Jupiter, FL 33458
Phone: 561-741-5695 • Fax: 561-741-5697

## Health Information Form

I am interested in: [ ] Gastric Bypass [ ] Adjustable Gastric Banding [ ] Sleeve Gastrectomy

| | | | | |
|---|---|---|---|---|
| Name: Last, First MI | Date of Birth | Race | Gender | Marital Status M D S W |
| Address | Home Phone | | E-Mail | |
| City, State, Zip | Work Phone | | Cell Phone | |
| Employer | Social Security No. | | | Age |
| Employer Address | Occupation / Retired From? | | | Primary Language |
| City, State, Zip | May we leave messages on your answering machine? Yes No | | | |
| Religious Preference | Primary Care Physician: | | | |
| Emergency Contact Relationship | Emergency Contact Number | | | |
| Pharmacy Name | Pharmacy Address | | | |

Insurance Information: Please provide a copy of your Health Insurance card and Driver's License. If you do not have Health Insurance or do not intend to use Health Insurance benefits for rendered services, please write "None".

| Primary Insurance | Secondary Insurance |
|---|---|
| Address | Address |
| Customer Service Phone Number | Customer Service Phone Number |
| Policy or ID Number | Policy or ID Number |
| Group Number | Group Number |
| Subscriber's Name & Relationship to Pt. | Subscriber's Name & Relationship to Pt. |

How did you hear about us?_____

I authorize the release of medical records necessary to process claims for health insurance benefits and request that payments be made directly to my physician for services rendered. A copy of this authorization is as valid as the original. I acknowledge that my submission of this form is no guarantee that I will be accepted as a patient. I also understand that you **do not finance co-pays and deductibles**, which must be paid in full when invoiced. I acknowledge receipt of the Notice of Privacy Practices and have read and understand it. I authorize the office to obtain or access medication history files.

COMMUNICATIONS REGARDING MY ACCOUNTS: Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

Signature:_____ Date: _____

**Patient Name:** _____

| Height: | Weight: | BMI: |
|---|---|---|
| Weight Problems date to: Childhood Adolescence Young Adult Pregnancy Adulthood | | |
| Waist Circumference: | Hip Circumference: | |
| Highest Weight in Past Five Years: | Lowest Weight in Past Five Years: | |

## Dietary History

Approximate age when you first seriously dieted: _____

Indicate all diets and diet programs you have used:

| Jenny Craig | Nutri-System | Weight Watchers | Opti/Medi-Fast | Fen/Phen/Redux |
|---|---|---|---|---|
| Xenical | Meridia | Adipex | Tenuate | T.O.P.S. |
| South Beach | OA | Acupuncture | Hypnosis | |

Have you completed or are you currently enrolled in a six consecutive month physician supervised weight loss program, which includes behavioral, nutritional and exercise components? YES NO

**Past Medical History:** Are you now or have you ever been treated for any of the following?

| | | | |
|---|---|---|---|
| [ ] Coronary Artery Disease | I25.83 | [ ]Aortic Valve Disease | I06.9 |
| [ ]Mitral Valve Disease | I34.9 | [ ] Heart Valve Replaced? | Z95.4 |
| [ ]Elevated Cholesterol/Triglycerides | E78.0 | [ ]High Blood Pressure | I10 |
| [ ]Type II Diabetes | E11.9 | [ ]Asthma | J45.909 |
| [ ]Shortness of Breath | R06.02 | [ ]Sleep Apnea Syndrome | G47.30 |
| [ ]Emphysema | J43.9 | [ ]Do you use home oxygen? | Y N |
| [ ]COPD | J44.9 | [ ]Use of CPAP? | Y N |
| [ ]Heartburn | R12 | [ ]Low Back Pain | M54.5 |
| [ ]Hiatal Hernia | K44.9 | [ ]Chronic Fatigue Syndrome | R53.82 |
| [ ]Leak of Urine w/ cough/sneeze | R39.81 | [ ]Anxiety Disorder | F41.1 |
| [ ]Low Thyroid Function | E03.9 | [ ]Depression | F33.9 |
| [ ]Fibromyalgia | m79.7 | [ ]BiPolar Disorder | F31.81 |
| [ ]Personal History of Breast Cancer | Z85.3 | [ ]Personal History of Colon Cancer | Z85.038 |
| [ ]Hepatitis C | Z22.52 | [ ] Irritable Bowel Disease | F45.8 |
| [ ]Gout | M10.00 | [ ] Esophageal Reflux | K21.9 |
| [ ]Osteoarthritis | M15.0 | | |

Patient Name:_____

**Surgical History** Please list any and all operations you have had in your entire life, **including Cosmetic or Plastic Surgery.** Please add any not specifically requested.

| Operation | Year(s) | Operation | Year(s) |
|---|---|---|---|
| [ ] Tonsillectomy/Adenoidectomy | | [ ] Appendectomy | |
| [ ] Laparoscopic Gallbladder | | [ ] Open Incision Gallbladder | |
| [ ] Total Abdominal Hysterectomy | | [ ] Vaginal Hysterectomy | |
| [ ] Coronary Bypass (CABG) | | [ ] Carotid Endarterectomy | |
| [ ] Colon / Large Intestine Surgery | | [ ] Prostate Surgery | |
| [ ] Breast Biopsy L R Both | | [ ] Mastectomy L R Both | |
| [ ] Breast Enlargement | | [ ] Breast Reduction | |
| [ ] Liposuction | | [ ] "Tummy Tuck" | |
| [ ] Hernia Repair | | [ ] Spleen Removal | |
| [ ] Hip Replacement L R Both | | [ ] Knee Replacement L R Both | |
| [ ] Heart Valve Replacement | | | |
| | | | |
| | | | |
| | | | |

**Allergies** [ ] I have no known drug allergies • OR • [ ] I am allergic to the following DRUGS:

| | |
|---|---|
| | |
| | |
| | Latex Allergy? Yes No |

## Medications AND Supplements AND Over The Counter Drugs

| Medication | Dose and Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Patient Name:** _____

## Social History

Occupation: _____

If you are Disabled, why? _____

Who Lives at home with you? Alone • Spouse • Family • Domestic Partner • Roommate

Do you exercise? No Yes If so, What type and how often?

Do you use any of the following?

| Substance | Amount | How Often | How Many Years |
|---|---|---|---|
| Alcohol | | | |
| Tobacco | | | |
| Street Drugs/Type | | | |
| Caffeine | | | |

**Personal Physicians:** Please provide phone AND fax number.

| Specialty | Physician Name | Phone Number/ Fax Number |
|---|---|---|
| Primary Care | | |
| Cardiologist | | |
| Pulmonologist | | |
| Mental Health | | |
| Other | | |

**Family Medical History:** Which of the following diseases "run in your family".

| Disease | Family Member | Disease | Family Member |
|---|---|---|---|
| [ ] Heart Disease | | [ ] High Blood Pressure | |
| [ ] High Cholesterol | | [ ] Obesity | |
| [ ] Diabetes | | [ ] Lung Disease | |
| [ ] Anesthesia Problems | | [ ] Kidney Disease | |
| [ ] Breast Cancer | | [ ] Colon Cancer | |
| [ ] Bleeding Problems | | | |

**Patient Name:** _____

**Review of Systems:** Please circle all symptoms that you frequently experience

1. General: Fever Chills Malaise Weight Gain Weight Loss Decreased Appetite Increased Appetite Weakness
2. Eyes: Visual Changes Eye Pain
3. Ears/Nose/Throat: Sore Throat Ear pain Ringing in the Ears Hoarseness
4. Cardiovascular: Palpitations Chest pain
5. Respiratory: Shortness of Breath Cough Blood in Sputum
6. Gastrointestinal: Nausea Vomiting Constipation Diarrhea Bowel Changes Rectal Pain Rectal Bleeding Cirrhosis Hiatal Hernia Ulcer Disease Abdominal Pain Bloating
7. GenitoUrinary: Painful Urination Flank Pain Frequency Loss of Libido Erectile Dysfunction Painful Intercourse Incontinence Vaginal Discharge Bloody Urine Getting up at Night to Urinate Heavy Periods Frequent periods Menopause Hot Flashes
8. Musculoskeletal: Back Pain Joint Pain Muscle Pain Unable to walk without Assistance
9. Skin: Rash Itching Easy Bruising
10. Neurological: Numbness Confusion Headache Dizziness
11. Psychiatric: Hallucinations Anxiety Depression Suicidal Homicidal
12. Endocrine: Heat Intolerance Frequent Urination Frequent Thirst
13. Hematology / Lymphatic: Anemia Easy Bruising Bleeding Gums Swollen Nodes

## NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices and have read and understand it.

Patient Signature: _____ Date: _____

Upon completion, please mail to:

**Institute for Metabolic and Bariatric Surgery**
**1002 S. Old Dixie highway, STE 203**
**Jupiter, FL 33458**

Or Fax To:
**561-741-5697**

## ANNUAL QUESTIONNAIRE

Patient Name: _____ Date: _____

1. Have you had a Pneumonia Vaccination? ☐ Yes ☐ No If yes, When: _____
2. Have you had a Flu Vaccination? ☐ Yes ☐ No If yes, When: _____
3. Do you have little interest or pleasure in doing things? ☐ Yes ☐ No
4. Are you feeling down, depressed or hopeless? ☐ Yes ☐ No

**IF "NO" TO QUESTIONS 3 and 4, SKIP TO QUESTION #5**

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

| | Not at all<br>0 | Several Days<br>1 | More than Half the days<br>2 | Everyday<br>3 |
|---|---|---|---|---|
| Trouble falling or staying asleep or sleeping too much? | | | | |
| Feeling tired or having little energy? | | | | |
| Poor appetite or overeating? | | | | |
| Feeling bad about yourself, or that you are a failure, or have let yourself or your family down | | | | |
| Trouble concentrating on things, such as reading the newspaper or watching television. | | | | |
| Moving or speaking so slowly that other people could have noticed. Or the opposite? Being so fidgety or restless that you have been moving around a lot more than usual. | | | | |
| Thoughts that you would be better off dead and/or of hurting yourself in some way. | | | | |

**TOTAL SCORE** _____

1-4 Minimal Depression
5-9 Mild Depression
10-14 Moderate Depression
15-19 Moderately Severe Depression
20-27 Severe Depression

5. Have you fallen in the past year (If 65 or older please answer)? ☐ Yes ☐ No

If yes, please complete:

☐ 1 fall with injury in the past year
☐ 1 fall without injury in the past year
☐ 2 or more falls with injury in the past year
☐ 2 or more falls without injury in the past year

# Jupiter Medical Specialists, LLC

Jefferson Vaughan, M.D.

## PATIENT REFERRAL FORM

Patient Name: _____ Date: _____

Who referred you to our practice? _____

How did hear about us if other than doctor's office? (Please check off all that apply)

- ☐ Referral from a family member/friend (Name:_____)
- ☐ Insurance Plan, Plan Directory Listing and/or Plan Website _____
- ☐ Newspaper Ad (Which newspaper?) _____
- ☐ Yellow pages_____
- ☐ Online _____
- ☐ Seminar or Lecture_____
- ☐ Other (Please explain: _____

**EFFECTIVE SEPTEMBER 23, 2013**

**JUPITER MEDICAL SPECIALISTS, LLC**
**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 at P.O. Box 452587, Sunrise, FL 33345 or 954-838-2767.

PURPOSE OF THIS NOTICE.

This notice describes the ways in which we may use and disclose medical information about you. This notice also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

OUR LEGAL REQUIREMENTS.

We are required by law to:

- Make sure that medical information that identifies you is kept private in compliance with the applicable law;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you;
- Follow the terms of the notice that currently is in effect;
- Change the notice only in accordance with federal rules; and
- Provide our internal complaint process for privacy issues to you.

WHO WILL FOLLOW OUR PRIVACY PRACTICES

This notice describes the practices of Jupiter Medical Specialists, LLC and all of its subsidiaries (collectively, "Jupiter") and that of:

- Jupiter's employees, staff and other Jupiter personnel.

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services that we provide to you. We need this record to provide you with medical care and to comply with certain legal requirements. This notice applies to all of the records of your care we generate from which you can be individually identified. This notice also applies to other health information about you, such as information we collect with your authorization during research studies that do not involve treatment. Your personal doctor and other entities providing products or services to you may have different policies or notices regarding their use and disclosure of your medical information. We will notify you if we become aware that there has been a loss of your medical information in a manner that could compromise the privacy of your information.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

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 about you or your care. Usually, this includes medical and billing records.

  To inspect and copy medical information about you or your care, you must submit your request in writing to our Privacy Office; P.O. Box 452587; Sunrise, FL 33345. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. If we keep your medical records in an electronic format, information you can request a copy of your records in an electronic format and we will provide it to you in that format if it is a form and format readily producible by us.

  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 the denial be reviewed. Another licensed health care professional chosen by us 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 of the review.

- **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us.

To request an amendment, your request must be made in writing and submitted to our Privacy Office; P.O. Box 452587; Sunrise, FL 33345. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason sufficient 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 us;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This accounting is a list of the disclosures we made of medical information about you, except disclosures made for treatment, payment and Jupiter's health care operations ("TPO Accounting"). You may have a right to a TPO Accounting in the future, in which case we will amend this Notice, including the effective date of your right to a TPO Accounting. Any TPO Accounting will be for a period of no longer than a three year time period.

  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Office; P.O. Box 452587; Sunrise, FL 33345. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. 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 use or disclose about you for treatment, payment or health care operations. You 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, like a family member or friend. We are not required to agree to your request, except as stated at the end of this paragraph. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. In the event that you pay out of pocket for the entire cost of a service, you have a right to request that we not disclose this service to your health plan for payment or health care operations purposes. We must comply with that request, unless the disclosure to your health plan is required by law.

  To request restrictions, you must make your request in writing to our Privacy Office; P.O. Box 452587; Sunrise, FL 33345. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **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.

  To request confidential communications, you must make your request in writing to our Privacy Office; P.O. Box 452587; Sunrise, FL 33345. 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 to be contacted.

- **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.

  To obtain a paper copy of this notice, contact our Privacy Officer at P.O. Box 452587; Sunrise, FL 33345.

## HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we are permitted to use and disclose medical information as a health care provider, although certain of these categories may not apply to our business and we may not actually use or disclose your medical information for such purposes. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose information will fall within one of the general categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to physicians, nurses and their office personnel, medical technicians, residents, medical students, labs, hospitals, and other facilities and their staff. For example, your health care provider may disclose your medical information for treatment purposes when referring you to another health care provider. We

also may disclose medical information about you to people who may be involved in your medical care after you have received our products and services, such as social workers or home health agencies. We may also use electronic health records to obtain information about you or to provide your medical information to other physicians and health care facilities to help make treatment decisions and reduce unnecessary cost. When using these electronic records we may have access to treatment and services provided by other health care providers.

- **For Payment.** We may use and disclose medical information about you so that the treatment and services we provide you may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about products and services we provided to you so your health plan will pay us or reimburse you for the products and services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- **For Health Care Operations**. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to run our company and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to our compliance department, attorneys, auditors, business planners and managers, health care educators and trainers, peer review committees and general administrators for review and learning purposes and in order to assist in the defense of any claim, lawsuit, proceeding or investigation. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or services.

- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your location and condition and that you are receiving products and services from us. In addition, we may disclose medical information about you to any entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research**. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one product or service to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave our premises. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

- **As Required By Law**. We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS.

- **Military and Veterans**. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Activities**. We may disclose medical information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to notify 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 medical 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.
- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you 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 medical information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct occurring on our premises; and
  - In emergency circumstances 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 medical 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 may also release medical information about our patients to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities**. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others**. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be 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) for the safety and security of the correctional institution.
- **Organ and Tissue Donation**. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Sale of Business Assets**. We reserve the right to transfer medical information about you to a third party in conjunction with the sale of our company or certain assets belonging to our company.

CHANGES TO THIS NOTICE.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in your physician's office (or at the facility where you are being treated). The notice will contain on the first page, in the top right-hand corner, the effective date. If we do change this notice, we will

repost a copy of the current notice, but we will not redistribute this notice to you.

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Office at P.O. Box 452587; Sunrise, FL 33345 or at 954-838-2767. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not generally covered by the examples given in this notice or the laws that apply to us will be made only with your written authorization. For example, we will obtain your authorization before we would release your psychotherapy notes. Similarly, we will obtain your authorization before we would use or disclose your medical information for marketing products to you. We will not sell your medical information unless you authorize us to do so. If you authorize us to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

## Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practices are available on the company's website and paper copies are out and available in the office and that I can take one of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

Patient: _____ Date: _____
(Print Name)

Patient Signature: _____

or

Patient's Representative: _____ Date: _____

Relationship to Patient:_____

**Jupiter Medical Center**
Jupiter, FL 33458

MR#:

DOB: / /

For and in consideration of the hospital services and supplies rendered, or to be rendered by Jupiter Medical Center (hereinafter referred to as "JMC") to the patient named above, I agree as follows:

I. **CONSENT TO TREATMENT:** The undersigned, as the patient or as the guardian or representative of the patient, consents to any emergency, medical, surgical, diagnostic or therapeutic treatment, x-ray examination, laboratory procedure, anesthesia or hospital service rendered to the patient under the general or special instructions of a licensed physician or other health care practitioner who is authorized by law to issue said instructions.

II. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby irrevocably assign and transfer to JMC all rights, title and interest to any and all benefits payable for the hospital services and supplies. I specifically instruct my PIP carriers to pay JMC'S claim up to policy limits prior to honoring any wage claim by me or any claim by any other provider. The undersigned hereby directs all payors that may be liable for the hospital services and supplies to pay directly to JMC all benefits due as a result of their liability by reason of the hospital services and supplies. I will pay JMC all charges not paid by payers, which are not subject to a contractual write off. I will authorize JMC to complete any forms necessary to secure payment from payers including but not limited to the filing of an appeal of an ERISA claim. I authorize JMC to endorse any and all checks; drafts or other instruments payable to me for the hospital services and supplies as though I had signed said check, draft or instrument. The undersigned does herewith authorize and instruct all payors, healthcare providers, third party administrators and utilization review companies to release any and all information relating to the patient to JMC regarding payment, treatment and operations.

III. **AGREEMENT TO PAY CHARGES:** I agree on behalf of myself, as patient or guarantor, to pay JMC'S bill in full and to not contest JMC'S charges so long as they are based upon JMC'S current charge listings at the time of service. I also agree that all charges connected with the hospital services and supplies that are not covered by any payer or not subject to any contractual limitation between payor and hospital only are due and payable at the time of discharge or discontinuation of treatment. All other charges will be due upon demand. I agree to pay all attorneys fees, including appellate attorney's fees, court costs and/or collection agency fees associated with the collection process.

IV. **PATIENT INFORMATION DISCLOSURE FOR TREATMENT, OPERATIONS AND PAYMENT:** The undersigned, as the patient or as the guardian or authorized representative of the patient, authorizes JMC to release any and all information regarding the hospital services and supplies including but not limited to copies of medical records, for the purpose of treatment, operations or payment to any payor or other entity or person deemed necessary by JMC. This includes authorization to release information pertaining to psychiatric and/or psychological care (but not psychotherapy notes), alcohol and/or substance abuse and serologic test results including HIV.

V. **MEDICARE AND MEDICAID BENEFITS:** I certify that the information given by me in applying for payment under Medicare is correct (including the answers given by me in response to the questions of the Medicare Secondary Payer (MSP) questionnaire). I request payment of authorized Medical benefits on my behalf for services furnished to me by or in Jupiter Medical Center, including physician services. I authorize any holder of medical and other information about me to release to Medicare and it's agents my information needed to determine these benefits or benefits for related services.

VI. **RELEASE OF LIABILITY AND RESPONSIBILITY FOR PERSONAL VALUABLES:** I understand that I am responsible for all articles and personal property (money, documents, radios, jewelry, dentures, eyeglasses, hearing aids, etc.) and/or clothing which I retain in my possession (on my person or in my room) and for any other articles and/or clothing which may be brought to me while I am a patient in JMC. I hereby release JMC, physician(s) and employees from any claim for loss, damage to or complete destruction of such property, which is not deposited with the hospital for safekeeping in the hospital safe.

VII. **NOTICE OF PRIVACY PRACTICES:** I hereby acknowledge that I have received a copy of the " Notice of Privacy Practices"

VIII. **INDEPENDENT CONTRACTOR:** I acknowledge that the physicians operating and practicing in this hospital are not agents or employees of the hospital. These physicians include but are not limited to the following groups of physicians: Emergency Physicians, Anesthesiologists, Pathologists, Radiologists, Staff and/or Contract Physicians.

IX. **STUDENT HEALTH CARE PROVIDERS:** I understand that I have the right to refuse to have a student health care provider such as a student nurse, respiratory therapist, and pharmacy intern or radiology technology student participating in my care. I understand that by signing this form I am consenting to the supervised care rendered by such health care providers.

X. **DIAGNOSTIC PHOTOGRAPHY AUTHORIZATION:** I authorize radiographic films, x-rays, mammograms and other diagnostic films including still, movie or television photography to be taken of me during my hospital stay and consent to the use of such films for medical, scientific or educational purposes.

XI. A fax and/or photostatic copy of this document shall be considered as effective and valid as the original.

XII. **WORKERS COMPENSATION:** According to Florida Statute section 440.105(7): "Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s.817.234."

XIII. **ADVANCE DIRECTIVE QUESTIONS**

1. Do you have an Advance Directive ☐ yes ☐ no ☐ Unable to respond
2. If yes, is it on file ☐ yes ☐ no. If no, copy requested ☐ yes ☐ no
3. If no Advance Directive, copy given ☐ yes ☐ declined

XIV. **Tobacco-Free Environment:** I understand that Jupiter Medical Center is a tobacco-free environment and that I may not use tobacco products on hospital premises or adjacent property.

**ACKNOWLEDGEMENT**

The undersigned certifies that he/she has read and understood the foregoing and agrees to its terms:

DATE _____ PATIENT _____ PARENT OR LEGAL GUARDIAN (if patient is a minor) _____

RELATIONSHIP _____ GUARANTOR _____ WITNESS _____