Palm
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Consent for Medical Treatment and Care

As a patient, you have the right to be fully informed about your condition and the recommended surgical, medical, or diagnostic procedures, so you can make an informed decision about undergoing any suggested treatments. At this time, no specific treatment plan has been recommended. This consent form is solely to obtain your permission for the necessary evaluations to determine the appropriate treatment for any identified conditions.

By signing this form, you grant us permission to perform reasonable and necessary medical examinations, testing, and treatment. This consent is considered ongoing and will remain in effect until revoked in writing, even after a diagnosis has been made and treatment recommended. You have the right to discontinue services at any time.

We encourage you to discuss your treatment plan with your physician and ask questions about the purpose, potential risks and benefits of any tests ordered for you. If you have any concerns regarding a recommended test or treatment, we strongly encourage you to bring them to the attention of your healthcare provider.

I, the patient, voluntarily request a physician or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and any other necessary healthcare providers, to perform reasonable and necessary medical examinations, testing, and treatment for my condition. If additional testing or interventional procedures are recommended, I understand that I will be asked to read and sign additional consent forms before the procedure(s).

I certify that I have read and fully understand the above statements and voluntarily and willingly consent to its contents.

Patient Name (PRINT): _____

Signature: _____

Date: _____

If Personal Representative, please PRINT Name: Relationship to Patient

(PRINT): _____

Witness Signature: _____

Date: _____

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Informed Consent to Photograph

I hereby give consent for Palm Medical Centers or its staff to take and/or display photographs of my face and smile. These photographs will be used for identification purposes within the office and may be stored on the office's Electronic Medical Records. The doctors, office, and staff will ensure that my personal information, such as my name, age, and date of birth, is protected and not displayed.

Patient Name (PRINT}: _____

Signature: _____

Date: _____

If Personal Representative, please PRINT Name: _____

Relationship to Patient (PRINT} _____

Witness Signature: _____

Date: _____

Notice of Privacy Practices

November 6, 2018

This Notice explains how Palm Medical Centers fulfills our commitment to respect the privacy and confidentiality of your Protected Health Information (PHI) and how we may use and disclose your information. This Notice also tells you about your rights under federal and state laws. This notice applies to all records held by Palm Medical Centers, regardless of whether the record is written, electronic, or in any other form. We are required by law to provide you with this Notice and maintain the privacy of your PHI. All healthcare providers, employees, and business associates of Palm Medical Centers are required to follow the privacy practices required by law and described in this Notice.

Protected Health Information (PHI) refers to:

- Information about your health, such as medical conditions and diagnostic test results

- Information about health care services and treatments you have received or may receive in the future
- Information about your health care benefits under an insurance plan
- Geographic information, such as where you live or work
- Demographic information, such as your race, gender, ethnicity, or marital status
- Unique identifiers, such as your social security number, date of birth, phone number, address, or driver's license number
- Full-face photographs

We may use and disclose your Protected Health Information for:

Your medical treatment - We may use or disclose your PHI to provide, coordinate, or manage your medical treatment or services. We may disclose information about you to doctors, nurses, technicians, or other personnel involved in your medical care. With your written consent, we may disclose your information to individuals and entities outside of Palm Medical Centers involved in your continuing medical treatment after you leave our care, such as other healthcare providers, home health agencies, and transportation companies.

Payment: We may share your protected health information with insurance companies, third parties, and other service providers to receive payment for the services we provide to you. This may include sharing information with doctors, facilities, ambulance companies, and subcontractors who have treated or provided services to you. Insurance companies and other third parties may require your social security number and date of birth for verification and payment purposes.

Healthcare Operations: We may use your protected health information to support our business practices and improve the quality of your care. For instance, we may use it to review your treatment and services and to evaluate our staff's performance. We may also share your information with our staff for review and training purposes.

Appointment Reminders: We may use and share your protected health information to contact you and remind you of appointments for treatment or medical care. This may include reminders from entities where testing is performed.

Business Associates: We may share your protected health information with business associates such as billing companies or medical transcription services. These associates are required by law to keep your information confidential.

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Treatment Options and Other Health-related Benefits: We may use your information to contact you about treatment options and other health-related benefits provided by Palm Medical Centers that may be of interest to you. We will not use your information for marketing activities (other than face-to-face communications) without your authorization.

Individuals Involved in Your Care: Unless you object, we may release your protected health information to individuals involved in your medical care or payment, such as family members or others. Parents and legal guardians are authorized representatives for minors unless minors are legally permitted to make their own medical decisions. You must notify us in writing if you do not want information released to those involved in your care.

Disaster Relief Efforts: We may share your protected health information with organizations assisting in disaster relief efforts to notify your family or significant others of your condition, status, and location.

Research: Researchers may contact you about participating in research studies after obtaining your authorization or approval from an Institutional Review Board (IRB). IRBs are committees that protect the rights and welfare of research participants. Enrollment in most studies requires your informed consent, which is obtained after you have been informed about the study and sign an authorization or consent form approved by an IRB. In some cases, federal law allows us to use your protected health information for research without your authorization, with approval from an IRB or other special review board. This will not affect your treatment or welfare and your information will remain protected.

Legal Proceedings, Lawsuits, and Other Legal Actions: We may share your protected health information with courts, attorneys, and court employees when we receive a court order, subpoena, discovery request, warrant, or summons, and when required by law during other lawful judicial or administrative proceedings

Law Enforcement: We may disclose your protected health information as authorized or required by law or in response to a valid judicial order or subpoena:

- To identify or locate a suspect, fugitive, material witness, or missing person
- In criminal investigations
- To protect victims of abuse, neglect, and domestic violence
- If a death is suspected to be the result of criminal conduct
- To prevent a serious health or safety threat
- If you are an inmate in a correctional institution or under the custody of a law enforcement official, we may release your protected health information to the institution or official.

Workers' Compensation: We may share your protected health information for Workers' Compensation or similar programs that provide benefits for work-related injuries or illnesses.

Special Government Functions: If you are a member of the armed forces, we may share your protected health information with military authorities to allow them to carry out their duties under the law. We may also disclose your information if it relates to national security and intelligence functions.

Regulatory Agencies: We may disclose your protected health information to local, state, or federal government authorities responsible for medical oversight, as authorized by law. This includes licensing, auditing, and accrediting entities and agencies that administer public health programs such as Medicare and Medicaid.

Coroners, Medical Examiners, and Funeral Directors: We may release your protected health information to coroners or medical examiners as necessary to identify a deceased person or determine the cause of death. We may also release protected health information to funeral directors for the performance of their duties.

Organ Donation: If you are an organ donor, we may release your protected health information to organizations that handle organ, eye, or tissue transplants, including donation banks.

Public Health Risks: As required by law, we may disclose your protected health information to public health authorities for purposes related to:

- Preventing or controlling diseases, injuries, or disabilities
- Reporting vital events such as births and deaths
- Reporting child abuse or neglect
- Reporting domestic violence
- Reporting reactions to medications or problems with medical products
- Notifying patients of recalls, repairs, or replacements of products they may be using
- Notifying a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease
- Reporting to your employer findings concerning work-related illnesses or injuries so the workplace can be monitored for safety.

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Other Uses and Disclosures Not Covered in this Notice:

Other uses and disclosures of your protected health information, not described in this Notice or permitted by law, will only be made with your written authorization. We will obtain your authorization for most uses and disclosures of psychotherapy notes. If you give us authorization to use or disclose your protected health information, you may revoke it in writing at any time. Please note that we cannot retract any disclosures already made with your prior authorization.

Your Rights Concerning Your Protected Health Information: Unless otherwise required by law, your medical health record is the property of the Palm Medical Centers or facility that compiled it. You have the following rights regarding your protected health information:

Right to Receive a Copy of this Notice: You will be provided with a hard copy of this notice at the time of first service. You may also request a copy at any time. The center reserves the right to change or update its practices regarding protected health information. If changes are made, a revised notice will be provided.

Right to Ask to See and Obtain a Copy of Your Records and Protected Health Information: You have the right to request to see and obtain a copy of the protected health information used for decision making about your care. Your request must be made in writing. The center may deny access in certain limited circumstances, and a written explanation will be provided if this occurs. If your request is denied in whole or in part, you may request a review of the denial.

Right to Ask for an Amendment or Addendum: If you believe your protected health information is incorrect or incomplete, you may request an amendment. Your request must be in writing and include supporting documentation. The center may deny the request if the information was not created by the center, if it is not part of the center's protected health information, or if the information is deemed accurate and complete. If the request is denied, a written explanation will be provided, and documentation of the request and decision will be included in your medical record.

Right to Ask for an Accounting of Disclosures: You have the right to request a list of individuals or entities that have received your protected health information from the center. Your request must be in writing and specify the dates of the requested disclosures. This list will not include disclosures made to you, authorized parties, for your care, treatment, payment, or health care operations, or disclosures incident to permitted use or disclosure under law, such as government and regulatory agencies, national security, or intelligence services, or to correctional institutions or law enforcement officials.

Right to Revoke Certain Authorizations and/or Request Restrictions: You have the right to revoke previously authorized consents or request restrictions or limits on your protected health information. The center may consider your request but is not obligated to agree. You also have the right to request restrictions on protected health information disclosed to someone you authorized for your care or payment. Your request for restriction or revocation must be made in writing.

Right to Confidential Communications: You have the right to request that we communicate with you about medical matters in a confidential manner of your choosing. For example, you can ask that we contact you only at home, through a personal or business phone, email, or regular mail. Your request must be made in writing. You do not need to provide a reason for your request, and we will comply with all reasonable requests. However, if we are unable to contact you using your requested means, we may contact you using other information you have provided us.

Right to Receive Notice of a Breach: You have the right to be notified in the event of a breach of the privacy of your protected health information by Palm Medical Centers or its business associates. You will be notified as soon as reasonably possible, but no later than 60 days after the discovery of the breach. The notice will provide you with the date of discovery, a description of the type of information involved, the steps we are taking to investigate and mitigate the situation and contact information for you to ask questions and obtain additional information.

Right to File a Privacy-Related Complaint: If you believe that your privacy rights have not been followed as mandated by federal and/or state law or as explained in this notice, you may file a written complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. The complaint must be in writing, describe the subject matter of the complaint, and name the individual(s) or organization that you believe violated your privacy. You will not be subjected to retaliation or denied any health care services if you file a complaint. The contact information for both the Palm Medical Centers' Compliance Department and the U.S. Department of Health and Human Services is provided.

Palm Medical Centers
Compliance Officer
2600 Douglas Road, Suite 308,
Coral Gables, Florida 33134
Phone: (800) 996-0098

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www.PalmMedicalCenters.com

US Department of Health and Human Services
Office of the Secretary
200 Independence Avenue,
SW Washington, DC 2020J
Phone: (202) 619-0257 Toll Free: l-877-696-6775
www.usa.go

Notice of Privacy Practices Signature and Acknowledgement

I hereby acknowledge that I have read, understand, and received a copy of the Palm Medical Centers Notice of Privacy Practices.

Patient Name (PRINT): _____ Patient Date of Birth: _____

_____ _____

Patient Signature Date

I am the parent, legal guardian, or authorized representative of _____ (patient name). I hereby acknowledge that I have read, understand, and received a copy of Palm Medical Centers Notice of Privacy Practices.

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Name of Parent, Legal Guardian, or Authorized Representative (PRINT):_____

Relationship to Patient _____

_____ _____

Patient Signature Date

_____

First Name Last Name

Thank you for choosing Palm Medical Centers as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality of healthcare. We request that you read and sign this form to acknowledge your understanding of our patient financial policies, which are an essential aspect of your medical care and treatment.

PATIENT FINANCIAL RESPONSIBILITIES:

I understand that it is my responsibility to know the terms of my insurance, and in compliance with those terms, I agree to the following:

- I am fully responsible for the payment of my medical treatment and care as a recipient of healthcare services.
- I am responsible for paying copayments, coinsurance, deductibles, and any other procedures or treatments not covered by my insurance plan. I agree to pay copayments and deductibles at the time of service.
- If I do not have medical insurance, Palm Medical Centers will provide me with a fee schedule for self-pay patients. I understand that full payment is due at the time of service, unless otherwise arranged or mandated by law.
- If I have a high deductible policy or coinsurance, I agree to pay an estimated charge of $30.00 in advance for my office visit and understand that other charges may apply. I also agree to pay my outstanding balances as they become due.

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- I am required to provide Palm Medical Centers with complete and accurate billing information, including, but not limited to, my current insurance card, authorization numbers, and/or referral forms for each visit and/or procedure.
- I am responsible for all visits and procedures that are not properly authorized or for any charges incurred if the insurance information provided to Palm Medical Centers is not current or valid.
- By signing below, I hereby authorize Palm Medical Centers to release medical and other information acquired during my examination and/or treatment, including my protected health information (PHI), to my health plan and/or other healthcare providers, physicians, and/or entities required to participate in my medical care.

Assignment Of Benefits

- I authorize the assignment of my insurance benefits directly to Palm Medical Centers. Any insurance benefits received by Palm Medical Centers will be credited to my account in accordance with my insurance company's policy. I am responsible for any unpaid charges.
- I authorize the release of all information or documents related to obtaining my insurance benefits for claims submitted on my behalf and/or my dependents. I understand and agree that my signature on this document authorizes my physician and other authorized parties to submit claims for services rendered without obtaining my signature on each claim, and I will be bound by this signature as if I had signed each claim personally.

Patient balances are due immediately and are not contingent on receiving a statement. Insurance companies provide an Explanation of Benefits that details payments and patient balances. For your convenience, we accept payment in the form of Visa, MasterCard, Discover, American Express, Money Orders, Checks, and Cash. A $25.00 service charge will be applied for a returned check.

Accounts with no activity for 60 days may be referred for further collection action. If I default on my account and it is referred to a collection agency or attorney, I will be responsible for all costs associated with collecting the money owed, including interest, court costs, collection fees, and attorney fees. All advance collection fees incurred by the practice will be included in my final bill.

I have read and understand Palm Medical Centers' financial policy and agree to the terms outlined in the policy.

Printed name of Patient/ Parent/ Legal Guardian or Authorized Representative	Signature of Patient/ Parent I Legal Guardian or Authorized Representative

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Date

If Legal Guardian or Authorized Representative,
indicate Relationship to patient:
(Guardian or Authorized Representative must provide documentation of such status)

Printed Witness Name | Employee Title | Witness Signature | Date

Patient Authorization for Disclosure of Protected Health Information

Patient Name				Date of Birth			
Address:		City:		State:		Zip:	
E-mail Address:				Phone:			
I request that my protected health information (PHI) from							
Phone:		Fax:				be disclosed to:	
Recipient Name:							
Address:		City:		State:		Zip:	
E-mail Address:		Phone:				Fax:	

I authorize the following PHI to be released from my medical record{s): All records which include hospital discharges, pathology reports, test results (labs, radiology, EKG, Mammogram, etc.), Progress notes, Treatment plans, Immunization records, Psychological and Psychiatric evaluations from to or Other:

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment of alcohol, drug, or sexual abuse.

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State and federal law protects the following information, as defined in HI PAA at 45 CFR 164.501. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records		Yes		No	Dates:	
HIV/AIDS Testing and Results		Yes		No	Dates:	
Mental Health (Psychiatric & Psychological)		Yes		No	Dates:	
Psychotherapy Records		Yes		No	Dates:	

Purpose for requesting information: Legal Insurance Personal Continuation of Care Other:

By signing this authorization form, I understand that:

Requests for copies of medical records are subject to reproduction fees in accordance with federal and state laws and regulations.

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 2600 S. Douglas Road, Suite 308, Coral Gables, 33134. Revocation will not apply to information that has already been disclosed in response to this authorization. Unless otherwise revoked, this authorization will expire one year from date signed.
- I understand that these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that these records will not be release to entities other than those designated by myself, or my personal representative as provided by state or federal laws.

_____ _____

Patient or Authorized Representative Signature Date

_____

Print Name

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Patient Authorization for Disclosure of Health Information Rev. 05.10.2022

_____

Relationship to Patient