



Dear New Patient,

We would like to take this opportunity to welcome you as a patient and to thank you for choosing Pulmonary and Sleep Institute of Citrus Hills, a Respire Health Corp. It is our goal to assist you with all of your pulmonary and sleep apnea needs. We wish to make your visits informative and your appointment pleasant and rewarding.

I encourage you to make a list of any questions you may have. You will find we are dedicated to excellence in patient care. During your consultation we will review your medical history, perform a physical exam and discuss your goals for procedures.

Please bring these items with you:

- **List of Medications**
- **Chest X-Ray, CT Chest report – with disc (your physician will need to see the images)**
- **Pulmonary Function Test (PFT)**
- **Sleep study report**
- **Copies of Medical Records from referring physician**
- **Picture ID and Insurance card(s)**

If our office does not receive this information, it may effect your appointment time and ultimately cause your appointment to be rescheduled.

Also, if your insurance requires authorization #, please be sure your Primary Care Physician has obtained one for you or your appointment will be rescheduled.

We kindly ask that you provide twenty-four hours' notice for appointment cancellation.

I look forward to participating in your health care needs.

Lee Gonzalez, M.D.
Pulmonary and Sleep Medicine

2484 N Essex Ave
Hernando, FL 34442

700 SE 5th Terr Suite 2
Crystal River, FL 34429

(Tel) 352-249-5338 (Fax) 352-249-5340

www.respirecare.org



Patient

Registration

NAME:		Date of Birth:
Address		Home Phone: () -
City:	State:	Zip Code:
Cell Phone: () -		
Email Address:		Primary Language: English Spanish Other
Employer:	Occupation:	Work Phone: () -
Marital Status: Single Married Divorced Widowed Prefer Not to Say		
Spouse's Name:		Date of Birth:
Race: (circle) Black/ African American Asian White/Caucasian Other Refuse to Answer		
Ethnicity: (circle) Hispanic/Latino Not Hispanic/Latino		
Advanced Care Plan: <input type="checkbox"/> None <input type="checkbox"/> DNR (Do Not Resuscitate) <input type="checkbox"/> DNI (Do Not Intubate)		
Emergency Contact:		Relationship
Address:		Phone Number
Primary Care Physician:		Referring Physician
Pharmacy		Phone Number:
DME		Phone Number:
Primary Insurance:		ID Number:
Group Number:	Insurance Phone Number:	
Subscriber	Date of Birth:	Phone Number:
Secondary Insurance:		ID Number:
Group Number	Insurance Phone Number:	
Subscriber:	Date of Birth:	Phone Number:
How did you hear about Pulmonary and Sleep Institute of Citrus Hills/Crystal River?		
Ad	Friend	Doctor
Google	Newspaper	Other: _____

WE ARE PARTICIPATING WITH MEDICARE. IF YOU HAVE A SUPPLEMENTAL INSURANCE THAT CROSSES OVER FROM MEDICARE AND PAYS THE DOCTOR, THEN WE WILL NOT COLLECT THE 20%. IF IT DOES NOT CROSS OVER OR YOU HAVE NO SECONDARY INSURANCE, THEN WE WILL COLLECT THE 20% PLUS DEDUCTIBLE AT THE TIME OF SERVICE. PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO YOUR APPOINTMENT. AN INSURANCE RECEIPT WILL BE GIVEN TO YOU TO SEND TO YOUR INSURANCE COMPANY. THIS OFFICE WILL FILE FOR PROCEDURES AND HOSPITALIZATION.

I GUARANTEE Respire Pulmonary and Sleep Medicine PAYMENT for ALL CHARGES FOR THE ABOVE NAMED PATIENT IN ACCORDANCE WITH THEIR REGULATION AND CHARGES. IN THE EVENT THAT Respire Pulmonary and Sleep Medicine CHOOSES TO BILL MY INSURANCE COMPANY, I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO THEM ALL MEDICAL BENEFITS DUE ME UNDER THIS POLICY, IF THE SERVICES ARE NOT COVERED BY MEDICARE OR THE OTHER INSURANCE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND AND AGREE THAT ANY OUTSTANDING BILLS WILL BE MY RESPONSIBILITY.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIMS TO MEDICARE OR ANY OTHER INSURANCE OF WHICH I AM A BENEFICIARY; I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS FROM AN OUTSIDE FACILITY THAT MAY BE REQUESTED TO THE OFFICE.

SIGNED (Patient or Authorized Representative): _____ DATE: ____ / ____ / ____

WITNESS: _____

PATIENT HISTORY FORM

Patient Name:	Today's Date:
Date of Birth:	Sex: Male Female
Referring Physician:	Primary Care Physician:
Advanced Care Plan: <input type="checkbox"/> None <input type="checkbox"/> DNR (Do Not Resuscitate) <input type="checkbox"/> DNI (Do Not Intubate)	
How did you hear about this clinic?	
Briefly describe your present symptoms:	
Please list the names of other practitioners you have seen for this problem:	

Family History		
Mother	Living or Deceased	Medical Conditions:
Father	Living or Deceased	Medical Conditions:

PAST MEDICAL HISTORY			
Do you now or have you ever had:			
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Goiter <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Leukemia <input type="checkbox"/> Psoriasis <input type="checkbox"/> Angina <input type="checkbox"/> Heart problems _____ <input type="checkbox"/> Heart murmur _____ <input type="checkbox"/> Sleep Apnea </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> COPD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy (seizures) <input type="checkbox"/> Cataracts <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stones <input type="checkbox"/> GERD (Acid Reflux) <input type="checkbox"/> Hiatal Hernia </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Anemia <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach or peptic ulcer <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Gout </td> </tr> </table>	<input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Goiter <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Leukemia <input type="checkbox"/> Psoriasis <input type="checkbox"/> Angina <input type="checkbox"/> Heart problems _____ <input type="checkbox"/> Heart murmur _____ <input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> COPD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy (seizures) <input type="checkbox"/> Cataracts <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stones <input type="checkbox"/> GERD (Acid Reflux) <input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Anemia <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach or peptic ulcer <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Gout
<input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Goiter <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Leukemia <input type="checkbox"/> Psoriasis <input type="checkbox"/> Angina <input type="checkbox"/> Heart problems _____ <input type="checkbox"/> Heart murmur _____ <input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> COPD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy (seizures) <input type="checkbox"/> Cataracts <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stones <input type="checkbox"/> GERD (Acid Reflux) <input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Anemia <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach or peptic ulcer <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Gout	
Other medical conditions (please list):			
<hr/> <hr/>			

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL

- Recent weight gain; how much _____
- Recent weight loss: how much _____
- Fatigue
- Weakness
- Fever
- Night sweats
- Change in Appetite

MUSCLE/JOINTS/BONES

- Numbness
 - Joint pain
 - Muscle weakness
 - Joint swelling
- Where?

EARS, NOSE, THROAT

- Ringing in ears
- Loss of hearing
- Pain in jaw
- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Snoring
- Post Nasal Drip

EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

HEART

- Chest pain
- Palpitations
- Rapid Heart Rate
- Irregular Heartbeat
- Swollen legs or feet

NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

SKIN

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

KIDNEY/URINE/BLADDER

- Frequent or painful urination
- Blood in urine
- Difficulty urinating
- Discharge

LUNGS

- Shortness of Breath
 - Cough
 - Wheezing
 - Sputum Production
- Color?

BLOOD

- Anemia
- Clots

PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts
- Paranoia
- Mood swings
- Anxiety
- Risky behavior

Women Only:

- Abnormal Pap smear
- Irregular periods
- Bleeding between periods
- PMS

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

SUBSTANCE USE AND EXPOSURE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes <input type="checkbox"/> No <input type="checkbox"/>
TOBACCO					Yes <input type="checkbox"/> No <input type="checkbox"/>
CANNABIS: Marijuana, hashish, hash oil					Yes <input type="checkbox"/> No <input type="checkbox"/>
STIMULANTS: Cocaine, crack					Yes <input type="checkbox"/> No <input type="checkbox"/>
STIMULANTS: Methamphetamine—speed, ice, crank					Yes <input type="checkbox"/> No <input type="checkbox"/>
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes <input type="checkbox"/> No <input type="checkbox"/>
HEROIN					Yes <input type="checkbox"/> No <input type="checkbox"/>
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes <input type="checkbox"/> No <input type="checkbox"/>
OTHER: specify) _____ _____ _____					Yes <input type="checkbox"/> No <input type="checkbox"/>

Vaccination Status	
Vaccine Name	Date of vaccination
Pneumonia	
Influenza	
Shingles	
Covid-19	

Pulmonary and Sleep Institute of Citrus Hills and Crystal River

Financial Policy

Welcome and thank you for choosing our practice! We believe that establishing a written financial policy is mutually beneficial for all parties. If you have any questions regarding our policies, our staff will be happy to assist you.

We participate with most insurance plans. However, each insurance plan has different benefits as well as different financial obligations. Therefore you, as the patient, are responsible for verifying these benefits with your insurance company. We will file your insurance, as a courtesy to you, but you are responsible for any unpaid balances.

Please review the following guidelines:

- **Payment is required at the time of service.** This may include your co-pay, co-insurance, deductible, and any other unpaid balances.
- Be prepared to show your insurance card, prescription card, and photo ID at **each visit**.
- You are required to bring **all medications**, or current list of medications, at **each visit**.
- You may be charged a **\$50 no-show fee** for any missed appointments that are not cancelled/rescheduled with a 24 hour notice. This is the patient's responsibility to pay.
- We charge a **\$30 fee**, payable in advance from the patient, for any forms or detailed letters that are completed by our office. We ask that you complete your portion of the form along with stamped envelope and submit those to our office as soon as possible. Please allow up to two weeks for completion of forms.
- There will be a **\$36 NSF fee** for all returned checks.
- **We urge you to keep your account current. If your account becomes delinquent, your account will be referred to an outside agency for collections.** At that point, you will not be able to make an appointment with our office. You will then be responsible for your balance and the 20% collection fee. Please contact our business office with payment arrangements prior to this to keep our account in good standing. Continued non-payment on your account may result in discharge from Pulmonary Group.

Insurance Policies:

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within sixty (60) days from the date-of-service, we may look to you for payment in full. We strongly suggest you monitor your account with us by closely following the balance as it ages beyond 30 days, at which time we recommend calling your insurance carrier and request a "claim status report".
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for complete charge. Payment is due upon receipt of statement from our office.
- It is your responsibility to understand your healthcare benefit coverage. If you are unsure of your benefit coverage, we encourage you to contact your health insurance prior to your appointment as ultimately you will be responsible for unpaid balances by your insurance carrier.

We appreciate the opportunity to be involved in your healthcare. If you have any questions regarding your account or need to make payment arrangements, you may contact our business office at (352) 249-5338. We are open Monday – Thursday 9:00 am – 5:00 pm.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays, co-insurance, and deductibles are my responsibility, and I will pay them at each visit. I agree to notify you of any changes in my health insurance coverage.

Patient Signature

Date

2484 N Essex Ave
Hernando, FL 34442

www.respirecare.org

(352) 249-5338 (phone)
(352) 249-5340 (fax)

700 SE 5th Terr Suite 2
Crystal River, FL 34429

Pulmonary and Sleep Institute of Citrus Hills and Crystal River

Respire Health Corp

Notice of Privacy Practice

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.

1. Introduction

Pulmonary and Sleep Institute of Citrus Hills/Crystal River is required by law to maintain the privacy and security of health information and provide individuals with notice of its legal duties and privacy practices with respect to health information. Pulmonary and Sleep Institute of Citrus Hills/Crystal River is required to abide by the terms of this Notice currently in effect. Pulmonary and Sleep Institute of Citrus Hills/Crystal River reserves the right to change the terms of this Notice at any time and to make new Notice provisions effective for all health information that it maintains. Upon your request, we will provide you with a current copy of this Notice.

This Notice of Privacy Practices outlines our practices and legal duties to maintain the confidentiality of your protected health information (“PHI”) under the privacy and security regulations mandated by the Health Insurance Portability and Accountability Act (“HIPPA”) and further expanded by the Health Information Technology for Economic Clinical Health Act (“HITECH”).

PHI includes demographic information that can be used to identify you such as your name, address, and telephone number; information concerning your past, present, or future physical or mental health condition; information concerning the provision of health care to you; and information concerning the past, present, or future payments for health care. Your PHI may be maintained by us electronically and/or on paper.

This Notice describes uses and disclosures of PHI to which you have consented, that you may be asked to authorize in the future, and that are permitted or required by state or federal law. Also, it advises you of your right to access and control your PHI.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorization you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with Pulmonary and Sleep Institute of Citrus Hills. If you have any questions about Pulmonary and Sleep Institute of Citrus Hills/Crystal River Notice of Privacy Practices, please contact Lee Gonzalez 352-249-5338.

2. Safeguarding Your PHI

We have in place appropriate administrative, technical, and physical safeguards to protect and secure the privacy and security of your PHI. We train our employees on the regulations and policies that are in place to protect the privacy and security of your PHI. Medical records are maintained in secure area within our practice and electronic medical record systems are monitored and updated to address security risks in compliance with the HIPAA Security Rule. Only employees who have legitimate “need to know” are permitted access to your medical records and PHI. Our employees understand their legal and ethical obligations to protect your PHI and that violation of this Notice of Privacy Practices may result in disciplinary action.

3. Uses and Disclosures of PHI

As part of your registration materials, we will request your written consent for our practice to use and disclose your PHI for the following types of activities:

- **Treatment:** Treatment means the provision, coordination, or management of your health care and related services by Pulmonary and Sleep Institute of Citrus Hills/Crystal River and health care providers involved in your care. It includes the coordination or management of health care by a provider with a third-party insurance carrier, communication with lab or imaging providers for test results, consultation between our clinical staff and other health care providers relating to your care or our referral of you to a specialist physician or facility.
- **Payment:** Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims management, and collection activities. Payment also may include your insurance carrier's efforts in determining eligibility, claims processing, assessing medical necessity, and utilization review. Payment may also include activities carried out on our behalf by one or more of our collection agencies or agents in order to secure payment on delinquent bills.
- **Health Care Operations:** Health care operations mean the legitimate business activities of our practice. These activities may include quality assessment and improvement activities; fraud and abuse compliance; business planning and development; and business management and general administrative activities. These can also include our telephoning you to remind you of appointments or using a translation service if we need to communicate with you in person, or on the telephone in a language other than English.
- When we involve third parties in our business activities, we will have them sign a Business Associate Agreement obligating them to safeguard your PHI according to the same legal standards we follow.

4. Electronic Exchange of PHI

We may transfer your PHI to other treating health care providers electronically. We may also transmit your information to your insurance carrier electronically.

5. Uses and Disclosures of PHI Requiring Your Written Authorization

Uses and disclosures of your PHI made for purposes of psychotherapy, marketing and disclosures that constitute a sale of PHI will be made only with your written authorization.

Other uses and disclosures of your PHI will be made only with your specific written authorization. This allows you to request that Pulmonary and Sleep Institute of Citrus Hills disclose limited PHI to specified individuals or companies for defined purpose and timeframe. For example, you may wish to authorize disclosures to individuals who are not involved in treatment, payment, or healthcare operations, such as a family member or a school physical education program. If you wish to make disclosures in these situations, we will ask you to sign an authorization allowing us to disclose this PHI to the designated parties.

If Pulmonary and Sleep Institute of Citrus Hills/Crystal River intends to engage in fundraising, you have the right to opt out of receiving such communications. If you authorize us to use or disclose your PHI for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose your PHI for the reasons contained within your authorization. However, we cannot take back, disclosures already made with your permission.

6. Uses and Disclosure of PHI Permitted or Required by Law

In some circumstances, we may be legally permitted or required to use disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization in certain situations, including but not limited to:

- **Emergencies:** If you are incapacitated and require emergency medical treatment, we will use and disclose your PHI to ensure you receive the necessary medical services. We will attempt to obtain your consent as soon as practical following your treatment.
- **Others Involved in Your Healthcare:** Upon your verbal authorization, we may disclose to a family member, close friend, or other person you designate only that PHI that directly relates to that individual's involvement in your health care and treatment. We may also need to use PHI to notify a family member, personal representative, or someone else responsible for your care of your location and general condition.
- **Communication Barriers:** If we try but cannot obtain your consent to use or disclose your PHI because of substantial communication barriers and your physician, using his or her professional judgment, infers that you consent to such use or disclosure, or the physician determines that a limited disclosure is in your best interests, we may permit such use or disclosure.
- **Required by Law:** We may disclose your PHI to the extent that its use or disclosure is required law. This disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Public Health/ Regulatory Activities:** We may disclose your PHI to an authorized public health authority to prevent or control disease, injury, or disability or to comply with state child or adult or adult abuse or neglect law. We are obligated to report suspicion of abuse and neglect to appropriate regulatory agencies.
- **Food and Drug Administration:** We may disclose your PHI to a person company as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviation as well as to track product usage, enable product recalls, make repairs or replacements or to conduct post-marketing surveillance.
- **Health Oversight Activities:** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, and other activities necessary for the appropriate oversight of the health care systems and government benefit programs such as Medicare and Medicaid.
- **Judicial and Administrative Proceeding:** We may only disclose your PHI in the course of any judicial or administrative proceeding in response to a court order expressly directing disclosure, or in accordance with specific statutory obligations compelling to us to do so, or with your permission.
- **Law Enforcement Activities:** We may disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, missing person, or complying with a court order or other law enforcement purpose. Under some limited circumstance we will request your authorization prior to permitting disclosure.
- **Coroners and Medical Examiners:** We may disclose your PHI to a law enforcement official for purpose such as identifying a deceased person, determining a cause of death, or other lawful purpose.
- **Funeral Director and Organ Donation Organizations:** We may disclose your PHI to enable a funeral director to carry out his or her lawful duties PHI may also be disclosed to organ banks for cadaveric organ, eye, bone, tissue and other donation purposes.

- **Research:** We may disclose your PHI for certain medical or scientific research where approved by an institutional review board and where the researchers have a protocol to ensure the privacy and security of your PHI.
- **Serious Threats to Health or Safety:** We may disclose your PHI to prevent or lesion serious and imminent threat to the health or safety of a person or the public.
- **Military and National Security Activities.** We may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military authorities to assure proper execution of military missions. We also may describe your PHI to certain federal officials for lawful intelligence and other national security activities.
- **Worker's Compensation:** We may disclose your PHI as authorized to comply with worker's compensation laws.
- **Inmates of a Correctional Facility:** We may use or disclose PHI if you are an inmate of a correctional facility and our practice created or received your PHI in the course of providing care to you while in custody.
- **US Department of Health and Human Services:** We must disclose your PHI to you upon request and to the Secretary of the United States Department of Health Services to investigate or determine our compliance with privacy and security laws.
- **Disaster Relief Activities:** We may disclose your PHI to local, state or federal agencies engaged in disaster relief and to private disaster relief assistance organizations (such as the Red Cross if authorized to assist in disaster relief efforts).

7. Your Rights Regarding PHI

- **Right to Request Restrictions for Certain of Uses and Disclosures.** You have the right to request that we not use or disclose your PHI unless such a use or disclosure is required by law. Such a request must be in writing and include the specific PHI you wish to restrict as well as the individual(s) who should not receive the restricted PHI. If we agree to your request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. However, we are not required to agree to your requested restriction except in the case of restricting disclosure of PHI to a health plan as described below.

If you request a restriction on certain uses and disclosures of your PHI to a health plan for a particular health care item or service where said health care item or service where said health care item or service is paid for out of pocket and in full, we will abide by your request. Such a request must be made into the practice Privacy Officer. Your request must describe in a clear and concise fashion the health care item or service you wish restricted.

- **Right to Access:** You have the right to inspect and obtain a copy of your PHI. You may request copies of your PHI in either paper or electronic form. In very limited circumstances, we may deny access to your PHI. To request access to your PHI, please submit a request in writing to the practice Privacy Officer including whether you want your copy in electronic or paper form. We will respond to your request as soon as possible, but no later than 30 days from the date of your request. If access is denied you will receive a denial to your request as soon as possible, but no later than 30 days from the date of your request. If access is denied you will receive a denial letter within days. If access is denied, an appeals process may be available in certain cases. We have the right to charge a letter within 30 days. If access is denied, an appeals process may be available in certain cases. We have the right to charge a reasonable fee for providing copies of your PHI (and for electronic media, if applicable). Furthermore, you may request that a copy of your PHI be transmitted directly to a third party provided such request is made in writing, signed by you and clearly identifies the designated third party and location to send your PHI.
- **Right to Confidential Communications:** You have the right to request to receive communication of PHI by alternative means or at alternative locations. For example, you may wish your bill to be sent an address other than your home. Such requests must be made in writing to the practice Privacy Officer. We will not require an explanation of your reasons for the request, and will accommodate reasonable requests.

- **Right to Amend:** You have the right to request that we amend your PHI. Your request must be in writing. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for amendment, you have the right to submit a written statement disagreeing with the denial. Pulmonary and Sleep Institute of Citrus Hills has the right to submit a rebuttal statement. A record of any disagreement regarding amendments will become part of your medical record and may be included in subsequent disclosures of your PHI.
- **Right to an Accounting of Disclosures:** Subject to certain limitations, you have the right to a written accounting of disclosures by us of your PHI for not more than 6 years prior to the date of your request. Your right to an accounting applies to disclosures other than those made for purposes of treatment, payment, or health care operations. Please make your request in writing to the practice Privacy Officer. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. We will provide you with one accounting every 12 months free of charge. We will charge a reasonable fee based upon our costs for any subsequent accounting requests.
- **Right to Notice of Breach.** You have a right to receive notice if there has been a breach of your unsecured PHI.

8. Complaint Procedure

- **Within our Practice:** If you have a complaint about the denial of any of the specific rights listed above, about our Notice of Privacy Practices, or about our compliance with state and federal privacy laws you may receive more information about the complaint

9. Effective Date: This Notice is effective as of January 01, 2021.

Legal Notice:

This sample Notice of Privacy Practices is provided to you serve as an example for creating your own documentation and agreements and is not be construed as legal advice. Any sample that you adapt for your organization should be carefully reviewed and modified as necessary to ensure that it accurately reflects your organization's privacy practices. Document and form approval should follow your standard operating procedure including, as applicable, consultation with legal consent.

Disclaimer of Liability:

The information contained herein is for informational purpose only and is provided on an "as is" basis. WVMI, Quality Insights of Delaware, and their employees make no representation concerning the suitability or accuracy of this information for any purpose. Neither WVMI, Quality Insights of Delaware, nor any of their employees makes any warranty, express or implied including warranties of merchantability and fitness for a particular purpose, or assumes any legal liability or responsibility for the accuracy, completeness, or usefulness of any information, apparatus, product or process disclosed, or represents that its use would not infringe privately owned rights and shall not be liable for damages whatsoever arising from the use of or reliance on any information contained herein.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Pulmonary and Sleep Institute of Citrus Hills/Crystal River Notice of Privacy practices containing a description of the uses and disclosures of my health information. I further understand that Pulmonary and Sleep Institute of Citrus Hills/Crystal River may update its Notice of Privacy Practice at any time and that I may receive and updated copy Pulmonary and Sleep Institute of Citrus Hills/Crystal River Notice of Privacy Practices by submitting a request in writing for a request in writing for a current copy of Pulmonary and Sleep Institute of Citrus Hills/Crystal River Notice of Privacy Practices.

Printed Patient Name

Patient Signature

Date

If completed by patient's personal representative, please print name and sign below.

Printed Patient Personal Representative Name

Relationship to Patient

Patient Personal Representative Signature

Date

For Pulmonary and Sleep Institute of Citrus Hills/Crystal River OFFICAL USE ONLY

Complete this form if unable to obtain signature of patient or patient's personal representative

Pulmonary and Sleep Institute of Citrus Hills/Crystal River made a good faith effort to obtain patient's written acknowledgement of the Notice of privacy Practices but was unable to do so for the reasons documented below:

Patient or patient's personal representative refused to sign

Other

Employee Name (printed)

Employee Signature

Date



Lee Gonzalez, MD
2484 N Essex Ave
Hernando, FL 34442
P: (352) 249-5338 | F: (352) 249-5340
E: info@respirecare.com

HIPAA AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Patient Name: _____ Date Of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I request and authorize medical records from the following facility:

I authorize to release information to the following:

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

To release healthcare information of the patient named above to:

**Pulmonary and Sleep Institute of Citrus Hills
Respire Health Corp.
2484 N Essex Ave
Hernando, FL 34442
P: 352-249-5338 | F:352-249-5340**

This request and authorization applies to health care information relating to the following treatment, condition, or dates:

CONDITIONS OF AUTHORIZATION:

I MAY REVOKE THIS AUTHORIZATION IN WRITING. IF I DO, IT WILL NOT AFFECT ANY PREVIOUS ACTIONS ALREADY TAKEN IN RELEANCE TO MY AUTHORIZATION. I MAY NOT BE ABLE TO REVOKE THIS AUTHORIZATION IF ITS PURPOSE WAS TO OBTAIN INSURANCE. I MAY REVOKE THIS AUTHORIZATION BY WRITING A LETTER AND MAILING IT CERTIFIED MAIL, RETURN RECEIPT REQUESTED, TO THE PRIVACY OFFICER AT THE HEALTHCARE PROVIDER LISTED ABOVE. INFORMATION USED OR DISCLOSED PUSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY FEDERAL PRIVACY REGULATIONS.

THIS AUTHORIZATION IS VALID FOR ONE (1) YEAR, FOR THE RELEASE OF THE INFORMATION ABOVE. ONLY RECORDS OF THIS FACILITY CAN LEGALLY BE RELEASED. ANY RECORDS FROM OTHER PHYSICIANS MUST BE OBTAINED FROM THEM.

Patient Signature & Date

Representative Signature & Date

Witness Signature & Date