NEW PATIENT REGISTRATION FORM

NAME: _____

DATE OF BIRTH: _____

DRIVER LICENSE# _____ OR FL ID CARD# _____

SOCIAL SECURITY NUMBER _____-_____-_____

ADDRESS: _____

_____

_____

HOME PHONE _____

CELL PHONE _____

EMAIL ADDRESS _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE

ARE YOU EMPLOYED ☐ YES ☐ NO YOUR OCCUPATION _____

EMPLOYER NAME _____

ARE YOU COVERED UNDER MEDICARE OR MEDICARE ADVANTAGE ☐ YES ☐ NO

MEDICARE CARD ID# _____

ARE YOU COVERED UNDER SOMEONE ELSE INSURANCE ☐ YES ☐ NO

IF YES, NAME _____

ADDRESS _____ D.O.B _____

_____

RELATIONSHIP, (spouse, child, parent) _____

INSURANCE NAME _____

INSURANCE ID# _____

LIST THE MEDICATIONS YOU ARE TAKING

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

WHO WAS YOUR PREVIOUS PRIMARY CARE DOCTOR?

NAME _____

ADDRESS: _____, CITY_____, ST___

WHO ARE YOUR OTHER DOCTORS OR SPECIALIST CURRENTLY PROVIDING CARE FOR YOU?

List the Name of your Specialty Doctors and Reason You Are Seeing Them:

_____, For What Problem_____

_____, For What Problem_____

_____, For What Problem_____

_____, For What Problem_____

_____, For What Problem_____

PREVIOUS HISTORY OF SURGERY ☐ YES ☐ NO

List Type of Surgery and Dates

_____ DATE _____

_____ DATE _____

_____ DATE _____

_____ DATE _____

SOCIAL HISTORY

DO USE TOBACCO PRODUCTS ☐ YES ☐ NO

IF YES, WHICH TOBACCO USED

☐ CIGARETTES ☐ CIGARS ☐ CHEWING TOBACCO ☐ PIPE ☐ E-CIGARETTES

AND HOW MUCH ? _____ PACKS PER DAY _____ PER WEEK

DO YOU CONSUME ALCOHOL ☐ YES ☐ NO

IF YES, WHAT TYPE? ☐ BEER ☐ WINE ☐ LIQUOR ☐ OTHER

IF YES, HOW OFTEN? ☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY

FAMILY HISTORY

ARE YOU ADOPTED ☐ YES ☐ NO

MOTHER

IS YOUR MOTHER LIVING ☐ YES ☐ NO Current Age _____

IF NO, CAUSE OF DEATH_____ AGE AT DEATH____

FATHER

IS YOUR FATHER LIVING ☐ YES ☐ NO Current Age _____

IF NO, CAUSE OF DEATH_____ AGE AT DEATH____

BROTHERS- HOW MANY LIVING ____ HOW MANY DECEASED _____

1ST BROTHER WHO IS DECEASED AGE___ CAUSE OF DEATH_____

2ND BROTHER WHO IS DECEASED AGE___ CAUSE OF DEATH _____

3RD BROTHER WHO IS DECEASED AGE ___ CAUSE OF DEATH _____

4th BROTHER WHO IS DECEASED AGE ___ CAUSE OF DEATH _____

SISTERS- HOW MANY LIVING ____ HOW MANY DECEASED _____

1ST SISTER WHO IS DECEASED AGE____ CAUSE OF DEATH _____

2ND SISTER WHO IS DECEASED AGE____ CAUSE OF DEATH _____

3RD SISTER WHO IS DECEASED AGE ____ CAUSE OF DEATH _____

4 th SISTER WHO IS DECEASED AGE ____ CAUSE OF DEATH _____

YOUR MEDICAL HISTORY

CANCER

☐ BRAIN CANCER, DATE DIAGNOSED _____
☐ LUNG CANCER, DATE DIAGNOSED _____
☐ THROAT CANCER, DATE DIAGNOSED _____
☐ BREAST CANCER, DATE DIAGNOSED _____
☐ PROSTATE CANCER, DATE DIAGNOSED _____
☐ OVARIAN CANCER, DATE DIAGNOSED _____
☐ UTERINE CANCER, DATE DIAGNOSED _____
☐ GALLBLADDER CANCER, DATE DIAGNOSED _____
☐ SKIN CANCER, DATE DIAGNOSED _____
☐ THYROID CANCER, DATE DIAGNOSED _____
☐ PANCREATIC CANCER, DATE DIAGNOSED _____
☐ RENAL CANCER, DATE DIAGNOSED _____
☐ OTHER_____, DATE DIAGNOSED _____

BEHAVIORAL

☐ ANXIETY, DATE DIAGNOSED _____
☐ ATTENTION DEFICIT DISORDER, DATE DIAGNOSED _____
☐ BIPOLAR DISORDER, DATE DIAGNOSED _____
☐ DEPRESSION, DATE DIAGNOSED _____
☐ DRUG ABUSE, DATE DIAGNOSED _____
☐ INSOMNIA, DATE DIAGNOSED _____
☐ PANIC ATTACK, DATE DIAGNOSED _____
☐ POST TRAUMATIC STRESS DISORDER, DATE DIAGNOSED _____
☐ SCHIZOPHRENIA, DATE DIAGNOSED _____
☐ OTHER_____, DATE DIAGNOSED _____

ENDOCRINE

☐ DIABETES TYPE I, DATE DIAGNOSED _____
☐ DIABETES TYPE II, DATE DIAGNOSED _____
☐ DIABETIC KETOACIDOSIS, DATE DIAGNOSED _____
☐ HYPERTHYROIDISM, DATE DIAGNOSED _____
☐ HYPOTHYROIDISM, DATE DIAGNOSED _____
☐ GRAVES DISEASE, DATE DIAGNOSED _____
☐ OTHER_____, DATE DIAGNOSED _____

EYES

☐ CATARACTS DATE DIAGNOSED _____
☐ GLAUCOMA, DATE DIAGNOSED _____
☐ CONJUNCTIVITIS, DATE DIAGNOSED _____
☐ BLINDNESS, DATE DIAGNOSED _____
☐ OTHER_____ DATE DIAGNOSED _____

RESPIRATORY

☐ ASTHMA, DATE DIAGNOSED _____
☐ BRONCHITIS, DATE DIAGNOSED _____
☐ COPD, DATE DIAGNOSED _____
☐ EMPHYSEMA, DATE DIAGNOSED _____
☐ PNEUMONIA, DATE DIAGNOSED _____
☐ SLEEP APNEA, DATE DIAGNOSED _____
☐ TUBERCOLSOSIS, DATE DIAGNOSED _____
☐ OTHER_____, DATE DIAGNOSED _____

CARDIOVASCULAR

☐ ANGINA, DATE DIAGNOSED _____
☐ ATRIAL FILBRILLATION, DATE DIAGNOSED _____
☐ CAROTID ARTERY DISEASE, DATE DIAGNOSED _____
☐ CONGESTED HEART FAILURE, DATE DIAGNOSED _____
☐ CORONARY ARTERY DISEASE, DATE DIAGNOSED _____
☐ CAROTID ARTERY DISEASE, DATE DIAGNOSED _____
☐ DEEP VEIN THROMBOSIS, DATE DIAGNOSED _____
☐ HEART BLOCKAGE, DATE DIAGNOSED _____
☐ HIGH CHOLESTEROL (HYPERLIPDEMIA), DATE DIAGNOSED _____
☐ HIGH BLOOD PRESSURE (HYPERTENSION), DATE DIAGNOSED _____
☐ STROKE, DATE DIAGNOSED _____
☐ OTHER_____, DATE DIAGNOSED _____

GASTROENTEROLGY

☐ CIRROHSIS, DATE DIAGNOSED _____
☐ CELIAC DISEASE, DATE DIAGNOSED _____
☐ COLON POLYPS, DATE DIAGNOSED _____
☐ CONSTIPATION, DATE DIAGNOSED _____
☐ DIVERTICULITIS, DATE DIAGNOSED _____
☐ GALLBLADDER DISEASE, DATE DIAGNOSED _____
☐ GERD, DATE DIAGNOSED _____
☐ HEMORRHOIDS, DATE DIAGNOSED _____
☐ HERNIA, DATE DIAGNOSED _____
☐ HEPATITS, DATE DIAGNOSED _____
☐ PANCREATITS, DATE DIAGNOSED _____
☐ PEPTIC ULCER DISEASE, DATE DIAGNOSED _____
☐ OTHER_____, DATE DIAGNOSED _____

MUSCULOSKELETAL

☐ BACK PAIN, DATE DIAGNOSED _____
☐ NECK PAIN, DATE DIAGNOSED _____
☐ COSTOCHONDRITIS, DATE DIAGNOSED _____
☐ LUMBAR DISC DISEASE, DATE DIAGNOSED _____
☐ OSTEOARTHRITIS, DATE DIAGNOSED _____
☐ CERVICAL DISC DISEASE, DATE DIAGNOSED _____
☐ OSTEOPOROSIS, DATE DIAGNOSED _____
☐ MUSCULAR DYSTROPHY, DATE DIAGNOSED _____

Patient: <if:patient_name_fl ^ endif> D.O.B: <if:patient_dob ^ endif>

☐ ROTATOR CUFF SYNDROME, DATE DIAGNOSED _____
☐ SCOLIOSIS DATE DIAGNOSED _____
☐ SPINAL STENOSIS, DATE DIAGNOSED _____
☐ ROTATOR CUFF SYNDROME, DATE DIAGNOSED _____
☐ OTHER_____, DATE DIAGNOSED _____

NEUROLOGY
☐ ALZHEIMER DISEASE, DATE DIAGNOSED _____
☐ ENCEPHALITIS, DATE DIAGNOSED _____
☐ CEREBRAL PALSY, DATE DIAGNOSED _____
☐ MULTIPLE SCLEROSIS, DATE DIAGNOSED _____
☐ NEUROPATHY, DATE DIAGNOSED _____
☐ PERIPHERAL NERVE DISEASE, DATE DIAGNOSED _____
☐ SEIZURES, DATE DIAGNOSED _____
☐ OTHER_____, DATE DIAGNOSED _____

Sickle cell
Anemia

Other

TELL US ABOUT YOUR FAMILY MEDICAL HISTORY

Gastrointestinal: ☐ Anorexia ☐ Bulimia ☐ GERD (Gastroesophageal Reflux Disease
☐ Colitis ☐ Ulcer ☐ Stomach Cancer ☐ Pancreatitis
☐ Gall Bladder Disease ☐ Colorectal Cancer
☐ Inflammatory Bowel Disease ☐ Irritable Bowel
☐ Heartburn ☐ Hernia ☐ Colon Polyp

Behavioral: ☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Attention Deficit **Disorder**
☐ Alcohol Use ☐ Tobacco Use ☐ Substance Use ☐ Schizophrenia

Neurological: ☐ Brain Cancer ☐ Dementia ☐ Seizures ☐ Multiple Sclerosis
☐ Stroke ☐ Headaches ☐ Parkinson's Disease ☐ Alzheimer Disease

Cardiovascular: ☐ Hypertension ☐ Heart Attack ☐ Congestive Heart Failure
☐ Irregular Heartbeat ☐ Deep Vein Thrombosis ☐ High Cholesterol

Respiratory: ☐ COPD ☐ Emphysema ☐ Asthma ☐ Lung Cancer
☐ Tuberculosis ☐ Sleep Apnea

Endocrine: ☐ Diabetes ☐ Hyperthyroidism ☐ Liver Cancer ☐ Liver Disease
☐ Thyroid Cancer ☐ Graves ' Disease ☐ Hypothyroidism

Genitourinary: ☐ Renal Disease ☐ Renal Cancer ☐ Kidney Cancer ☐ Kidney Stones
☐ Renal Failure ☐ Bladder Cancer ☐ Prostate Disease

Musculoskeletal: ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Gout ☐ Arthritis
☐ Restless Leg Syndrome ☐ Fractures

HEENT: ☐ Glaucoma ☐ Cataracts ☐ Hearing Loss
☐ Oral Cancer

☐ **No Family History of Disease or Illness**

CENTURY CLINICAL FAMILY MEDICINE
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Required by the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164)

_____ _____
Patient's Full Name Patient's Social Security Number

_____ _____
Street Address Patient's Date of Birth

_____ _____ _____
City State, Zip Code Home Phone Cell Phone

I hereby authorize Century Clinical Family Medicine LLC to use or disclose the protected health information it has about me.

*SHOULD INFORMATION ABOUT ALCOHOL, SUBSTANCE ABUSE, HIV/AIDS, OR PSYCHOTHERAPY NOTES BE REQUESTED FOR DISCLOSURE FROM YOUR RECORDS, DO YOU AGREE TO RELEASE THIS INFORMATION? *(please initial choice)*

_____ **YES, DISCLOSE THIS INFORMATION**

_____ **NO, DO NOT DISCLOSE THIS INFORMATION**

In addition to the authorization for release of my Protected Health Information, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s)

Name: _____ Relationship _____ Phone _____
Name: _____ Relationship _____ Phone _____
Name: _____ Relationship _____ Phone _____

1. EXPIRATION DATE: *This authorization expires one (1) year from the date of signature unless a different expiration date or expiration event is noted here:* _____
2. REVOCATION: I understand that I have the right to revoke this authorization in writing any time, however, I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that Century Clinical Family Medicine LLC shall not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. I understand the revocation will not apply to my insurance plan or CMS when the law provides my insurer with the right to contest a claim under my policy. Written notice shall be directed to: Privacy Officer, Century Clinical Family Medicine LLC, 1410 LPGA Blvd, Ste 136, Daytona Beach, Florida 32117
3. CONDITION: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

_____ _____ _____
Signature of Patient Date of Signature Date of Birth or SSN

_____ _____ _____
Signature of Guardian or Date of Signature Description of Authority

Patient: <if:patient_name_fl ^ endif> D.O.B: <if:patient_dob ^ endif>

CENTURY CLINICAL FAMILY MEDICINE LLC

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS TO CENTURY CLINICAL, PER ORS 192.525

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization
I hereby give authorization to:

_____
(Doctor's Office, Clinic, Hospital, Specialist, Other)

_____
(Street Address)

_____
City, State, Zip

_____
(Phone No.)

_____
(Fax Number)

To release and disclose to:

Century Clinical Family Medicine LLC and or its Providers
1410 LPGA Blvd, Ste 136
Daytona Beach, Florida 32117
Phone: (386)274-4750
Fax: (386)274-2499
Secure Upload the Records at http://centuryclinical.leapfile.net
Recipient Email to upload to: records@centuryclinical.com

For: _____ _____ _____
Patient Name Date of Birth Social Security Number

Information to be Used or Disclosed:

☐ Entire Medical Records
☐ Home Health Records
☐ Physical Therapy Records
☐ Specialist Consult Notes
☐ Hospital Records & Progress Notes
☐ Pathology Reports
☐ Most Recent 5 Year History
☐ Emergency & Urgent Care
☐ Diagnostic Imaging
☐ Clinician Office Chart Notes

PROTECTED & SPECIAL PRIVILEDGED HEALTH INFORMATION

I acknowledge and understand that certain information cannot be released without specific authorization as required by Federal and State Law. By initialing below, I authorize the additional or specific release of the following protected or sensitive information:

_____ HIV/AIDS related records (incl lab results)
_____ Drug/Alcohol Abuse Treatment records
_____ Genetic or DNA testing
_____ Behavioral/Mental Health records
_____ Domestic Abuse or Sexual Violence

Expiration Date:

This authorization expires 1 year from date written below unless a different expiration date or expiration event is noted here _____ or revoked or terminated by the patient or other authorized signer or representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Century Clinical Family Medicine. You should contact the Office Manager or Compliance Officer to terminate this authorization. The only exception is when action has already been taken in reliance on the authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by Century Clinical Family Medicine to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____
Date

_____
Signature of Patient or Authorized Representative

_____
Relationship of Patient Representative By Law (if not signed by patient)

Patient: <if:patient_name_fl ^ endif> D.O.B: <if:patient_dob ^ endif>

CENTURY CLINICAL FAMILY MEDICINE LLC

CONSENT TO CARE

I present myself to Century Clinical Family Medicine LLC for medical care. I hereby authorize and consent to such care, including any tests, examinations, diagnostic procedure, surgical and medical treatment, or other care which my healthcare provider fees is necessary and beneficial to me. No guarantees have been made to me about the outcome of the care.

CONSENT TO E-PRESCRIBING & MEDICATION HISTORY

I give permission to Century Clinical Family Medicine LLC as part of my electronic health record to access my pharmacy benefits data electronically. Century Clinical Family Medicine LLC will transmit my prescriptions and will obtain the history of all of my past and current prescriptions to: determine my pharmacy benefits, check whether prescribed medication is covered (in formulary) under my plan, display therapeutic alternatives with preference rank (if applicable) within a drug class, assist in reviewing my medication compliance, retrieve historic list of all medications prescribed for me by all providers, and determine if my health plan allows electronic prescribing to Mail Order pharmacies.

CONSENT TO ASSIGNMENT OF BENEFITS AND GURANTEE OF PAYMENT FOR SERVICES

I request payment of authorized insurance benefits (health, casualty, or other) including Medicare or Medicaid benefits, due for any services furnished by Century Clinical Family Medicine LLC or its providers be made to the provider in accordance to its billing practice. I assign the benefits payable for services to the provider or organization furnishing the services or authorize such provider or organization to submit claim to my insurance company for payment. I understand I am responsible for, and agree to pay, upon presentation or demand, any charges that are my responsibility not covered or not paid by any applicable insurance. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for all professional services rendered.

I understand that Century Clinical Family Medicine and or its providers may refer me to other specialty healthcare provider associated with coordination of care and information regarding my condition will be made available. Written consent must be given if information is to be provided to anyone else.

Verbal information regarding my condition may be given to: _____ relationship _____

I have read all of the information on this form and have answered the questions. I hereby certify that all information is true and correct to the best of my knowledge. I will notify Century Clinical Family Medicine LLC of any changes in my health status or the above information

Signature: _____ Date:_____

SIGNING AS (please check one) ____ PATIENT ____ PARENT/GUARDIAN _____PR

If signed by other than the patient, state the reason the patient was unable to sign

_____

RELATIONSHIP TO PATIENT: _____

Patient: <if:patient_name_fl ^ endif> D.O.B: <if:patient_dob ^ endif>

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices for Century Clinical Family Medicine LLC, detailing how my information may be used and disclosed as permitted under federal and state law.

I authorize Century Clinical Family Medicine LLC to maintain the following individuals as my **"Emergency Contact(s)**" and to discuss my medical information in an emergency.

Name: _____ Relationship to you_____ Phone No._____

Name: _____ Relationship to you_____ Phone No._____

Name: _____ Relationship to you_____ Phone No._____

For Office Use ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because: ☐ Individual refused to sign ☐ Communication barriers prohibited obtaining acknowledgment ☐ An emergency situation prevented us from obtaining acknowledgment ☐ Other (Please specify):

CENTURY CLINICAL FAMILY MEDICINE, LLC.
1410 LPGA BLVD., SUITE 136
DAYTONA BEACH, FLORIDA 32117

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.

A. We Have A Legal Duty to Protect Health Information About You

We at the office of Century Clinical Family Medicine, LLC are committed to treating and using personal health information about you responsibly and with the utmost respect for your privacy. In addition to this moral and ethical obligation, there is also a legal obligation to do the same. We are required by law to protect the privacy of health information about you and that can be identified with you, which we call "protected health information," or "PHI" for short. We must give you notice of our legal duties and privacy practices concerning PHI:

- We must protect PHI that we have created or received about: your past, present, or future health condition; health care we provide to you; or payment for your health care.
- We must notify you about how we protect PHI about you.
- We must explain how, when and why we use and/or disclose PHI about you.
- We may only use and/or disclose PHI as we have described in this Notice.

This Notice describes the types of uses and disclosures that we may make and gives you some examples. In addition, we may make other uses and disclosures, which occur as a byproduct of the permitted uses and disclosures described in this Notice. If we participate in an "organized health care arrangement" (defined in subsection B.3 below), the providers participating in the "organized health care arrangement" will share PHI with each other, as necessary to carry out treatment, payment or health care operations (defined below) relating to the "organized health care arrangement".

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain by first:

- Posting the revised notice in our offices and on our website (www.centuryclinical.com); and
- Making copies of the revised notice available upon request.

B. We May Use and Disclose PHI About You Without Your Authorization in the Following Circumstances

1. We may use and disclose PHI about you to provide <u>health care treatment to you</u>.

We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.

> ***EXAMPLE***: We may share medical information about you with another health care provider. For example, if you are referred to another doctor, that doctor will need to know if you are allergic to any medications. Similarly, your doctor may share PHI about you with a pharmacy when calling in a prescription.

2. We may use and disclose PHI about you <u>to obtain payment for services</u>.

Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services provided to you by us or by another provider. Before you receive scheduled services, we may share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services. We may also share portions of medical information about you with the following:

- A billing company;
- Collection departments or agencies, or attorneys assisting us with collections;
- Insurance companies, health plans and their agents which provide you coverage;
- Hospital departments that review the care you received to check that it and the costs associated with it were appropriate for your illness or injury; and
- Consumer reporting agencies (e.g., credit bureaus).

> ***EXAMPLE:*** Let's say you have a broken leg. We may need to give your health plan(s) information about your condition, supplies used (such as plaster for your cast or crutches), and services you received (such as x-rays or surgery). The information is given to our billing department and your health plan so we can be paid or you can be reimbursed. If this care was provided in the hospital, we may also send the same information to our hospital department that reviews our care of your illness or injury.

3. We may use and disclose PHI about you for <u>health care operations</u>.

We may use and disclose PHI in performing business activities, which we call "health care operations". These "health care operations" allow us to improve the quality of care we provide and reduce health care costs. We may also disclose PHI for the "health care operations" of any "organized health care arrangement" in which we participate. An example of an "organized health care arrangement" is the care provided by a hospital and the physicians who see patients at the hospital. In addition, we may disclose PHI about you for the "health care operations" of other providers involved in your care to improve the quality, efficiency and costs of their care or to evaluate and improve the performance of their providers. Examples of the way we may use or disclose PHI about you for "health care operations" include the following:

- *Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.* For example, we may use PHI about you to develop ways to assist our health care providers and staff in deciding what medical treatment should be provided to others.

- *Improving health care and lowering costs for groups of people who have similar health problems and to help manage and coordinate the care for these groups of people.* We may use PHI to identify groups of people with similar health problems to give them information, for instance, about treatment alternatives, classes, or new procedures.

- *Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you.*

- *Providing training programs for students, trainees, health care providers or non-health care professionals (for example, billing clerks or assistants, etc.) to help them practice or improve their skills.*

- *Cooperating with outside organizations that assess the quality of the care we and others provide.* These organizations might include government agencies or accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations.

- *Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities in a particular field or specialty.* For example, we may use or disclose PHI so that one of our nurses may become certified as having expertise in a specific field of nursing, such as pediatric nursing.

- *Assisting various people who review our activities.* For example, PHI may be seen by doctors reviewing the services provided to you, and by accountants, lawyers, and others who assist us in complying with applicable laws.

- *Conducting business management and general administrative activities related to our organization and the services it provides*.

- *Resolving grievances within our organization.*

- *Reviewing activities and using or disclosing PHI in the event that we sell our business, property or give control of our business or property to someone else.*

- *Complying with this Notice and with applicable laws.*

4. We may use and disclose PHI under other circumstances without your authorization or an opportunity to agree or object.

We may use and/or disclose PHI about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:

- *When the use and/or disclosure is required by law.* For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.

- *When the use and/or disclosure is necessary for public health activities.* For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

- *When the disclosure relates to victims of abuse, neglect or domestic violence.*

- *When the use and/or disclosure is for health oversight activities.* For example, we may disclose PHI about you to a state or federal health oversight agency that is authorized by law to oversee our operations.

- *When the disclosure is for judicial and administrative proceedings.* For example, we may disclose PHI about you in response to an order of a court or administrative tribunal.

- *When the disclosure is for law enforcement purposes.* For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.

- *When the use and/or disclosure relates to decedents.* For example, we may disclose PHI about you to a coroner or medical examiner for the purposes of identifying you should you die.

- *When the use and/or disclosure relates to organ, eye or tissue donation purposes.*

- *When the use and/or disclosure relates to medical research.* Under certain circumstances, we may disclose PHI about you for medical research.

- *When the use and/or disclosure is to avert a serious threat to health or safety.* For example, we may disclose PHI about you to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

- *When the use and/or disclosure relates to specialized government functions.* For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.

- *When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations.* For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

5. You can object to certain uses and disclosures.

Unless you object, we may use or disclose PHI about you in the following circumstances:

- As a patient in the hospital, your name, room number, and general condition (critical, serious, etc.) may be shared in the hospital's directory with clergy and with people who ask for you by name.

- Using our best judgment, we may share with a family member, relative, friend or other person identified by you, PHI directly related to that person's involvement in your care or payment for your care.

- We may share with a public or private agency (for example, American Red Cross) PHI about you for disaster relief purposes. Even if you object, we may still share the PHI about you, if necessary for the emergency circumstances.

If you would like to object to our use or disclosure of PHI about you in the above or other specific circumstances, please call or write our office using the contact information at the end of this Notice.

6. We may contact you to provide appointment reminders.

We may use and/or disclose PHI to contact you to provide a reminder to you about an appointment you have for treatment or medical care.

7. We may contact you with information about treatment, services, products or health care providers.

We may use and/or disclose PHI to manage or coordinate your healthcare. This may include telling you about treatments, services, products and/or other healthcare providers. We may also use and/or disclose PHI to give you gifts of a small value.

EXAMPLE: If you are diagnosed with diabetes, we may tell you about nutritional and other counseling services that may be of interest to you.

8. Newborn photography.

It has become customary for our practice to take digital pictures of newborn babies and celebrate their births by putting a photograph on the practice's website (www.centuryclinical.com). This is done as a complimentary service so that the friends and family of the parents can view the picture soon after delivery. In addition to the picture, other PHI will be used on the website, such as the baby's name, weight, and time of birth. You can opt out of this service at anytime and will be given the opportunity to do so verbally prior to any picture or information being posted. The amount of time that the picture will remain on the website is at the discretion of the practice, though you can request its removal in writing at any time.

ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose PHI about you. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing by our office. If you cancel your authorization in writing, we will not disclose PHI about you after we receive your cancellation, except for disclosures, which were being processed before we received your cancellation.

C. You Have Several Rights Regarding PHI About You

1. You have the right to request restrictions on uses and disclosures of PHI about you.

You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection B.4 of the previous section of this Notice. You may request a restriction in writing at the address listed below.

2. You have the right to request different ways to communicate with you.

You have the right to request how and where we contact you about PHI. For example, you may request that we contact you at your work address or phone number or by email. Your request must be in writing. We must accommodate reasonable requests, but, when appropriate, may condition that accommodation on your providing us with information regarding how payment, if any, will be handled and your specification of an alternative address or other method of contact. You may request alternative communications by writing to the address listed below.

3. You have the right to see and copy PHI about you.

You have the right to request to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. You may request to see and receive a copy of PHI by requesting this in writing at the address listed below.

4. You have the right to request amendment of PHI about you.

You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amendment. You may request an amendment of PHI by writing to the address listed below.

5. You have the right to a listing of disclosures we have made.

If you ask us in writing, you have the right to receive a written list of certain of our disclosures of PHI about you. You may ask for disclosures made up to six (6) years before your request (not including disclosures made prior to April 14, 2003). We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For health care operations
- Made to or requested by you, or that you authorized
- Occurring as a byproduct of permitted uses and disclosures
- Made to individuals involved in your care, for directory or notification purposes, or for other purposes described in subsection B.5 above
- Allowed by law when the use and/or disclosure relates to certain specialized government functions or relates to correctional institutions and in other law enforcement custodial situations (please see subsection B.4 above) and
- As part of a limited set of information which does not contain certain information which would identify you

The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If, under permitted circumstances, PHI about you has been disclosed for certain types of research projects, the list may include different types of information.

If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee. You may request a listing of disclosures by writing to the address listed below.

6. You have the right to a copy of this Notice.

You have the right to request a paper copy of this Notice at any time by contacting our office. We will provide a copy of this Notice no later than the date you first receive service from us (except for emergency services, and then we will provide the Notice to you as soon as possible).

D. You May File A Complaint About Our Privacy Practices

If you think we have violated your privacy rights, or you want to complain to us about our privacy practices, please contact our Privacy Officer Thomas Gaskin, in the following manner:

Century Clinical Family Medicine, LLC
1410 LPGA Blvd., Suite 136
Daytona Beach, Florida 32117
Phone 386-274-4750
Fax 386-274-2499
Email info.@centuryclinical.com

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services.

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

If you file a complaint, we will not take any action against you or change our treatment of you in any way.

E. Effective Date of this Notice

This Notice of Privacy Practices is effective on November 15, 2009.