Del Sol Medical Center Inc.
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.

Del Sol Medical Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment -
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Del Sol Medical Center."*
>
> *"It is our policy to provide a substitute health care provider, authorized by Del Sol Medical Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment -
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Del Sol Medical Center for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation -
We may disclose your health information, as necessary, to comply with State Workers' Compensation Laws.

Emergencies -
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

> *"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation, or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Del Sol Medical Center sponsored fund-raising events."*

Change of Ownership
In the event that Del Sol Medical Center is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Del Sol Medical Center is not required to agree to the restriction that you have requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that Del Sol Medical Center amend your protected health information. Please be advised, however, that Del Sol Medical Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Del Sol Medical Center.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
[Insert practice name] reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Del Sol Medical Center is required by law to comply with this Notice.

Del Sol Medical Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our office.

Complaints
Complaints about your Privacy rights, or how Del Sol Medical Center has handled your health information should be directed to our office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

Del Sol Medical Center

Confidential Patient Information

Patient's Name_____ DOB_____ Sex____Male____Female

SS Number_____ Marital Status S M D W

Name of Spouse_____ DOB_____ SS#_____

Mailing Address:_____ Other Address:_____

City:_____ City:_____

State:_____ Zip:_____ State:_____ Zip:_____

Phone:_____ Cell:_____ E-mail:_____

Race/Ethnicity:____ White____African American____Hispanic____Asian Other_____

Preferred Language_____ I prefer appointment reminders in ____English____Spanish

Person to notify in case of emergency:_____ phone_____

Employment Status:____ Full time____ Part time____ Unemployed____Self Employed____ Retired

Patient's Employer:_____Phone Number_____ Occupation:_____

Insurance Information

Primary Insurance:_____ Group Number:_____

Address:_____ Policy ID # :_____

_____ Policyholder:_____

Phone Number:_____ Relationship to Patient:_____

Secondary Insurance:_____ Group Number:_____

Address:_____ Policy Number:_____

_____ Policyholder:_____

Phone Number:_____ Relationship to Patient:_____

Release of Information

Lifetime Medicare Part B Signature Authorization for services starting on:_____

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of Del Sol Medical Center, any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original and request payment of all medical insurance benefits either to me or the party who accepts assignment.

Signature:_____

Commercial Insurance signature authorization for services on:_____

I authorize the release of medical information necessary to process this claim. I authorize payment of medical benefits to Del Sol Medical Center for services rendered.

Signature:_____

FINANCIAL POLICY

This is an agreement between Del Sol Medical Center Inc. and the patient named on this form. The account established and assigned to the patient named below in which charges are made and payments are applied.

Patient Name: _____ Date of Birth: _____

The words "you", "your", and "yours", mean and refer to, the patient named on this form. The words "we", "us", and "our" refer to Del Sol Medical Center Inc.

PAYMENT POLICY: Payment co-payments and deductibles are due and payable in full at the time services are provided.

PATIENTS WITH INSURANCE: We bill most insurance primary and secondary carriers for you if paperwork is provided to us. Your agreement with your insurance carrier is private; we do not regularly investigate why a carrier has not paid or why payment was less than anticipated. If an insurance carrier has not paid within 60 days from submission, you are responsible for full payment.

MEDICARE PATIENTS: We will bill Medicare and secondary insurance carriers on your behalf but this is not a guarantee of payment. Your insurance company will make the final determination of your eligible benefits. You acknowledge that you understand the insurance coverage is an agreement by and between you and your insurance company. You are therefore accepting responsibility for the charges your insurance company does not pay. You are responsible for your annual Medicare deductible and the 20% Patient responsibility. You are responsible for any services that Medicare does not cover. You are responsible for any services your secondary insurance does not cover.

SELF-PAY: If you are paying for services yourself (self-pay), then an approximated amount for the anticipated services is due at time of service. Any remaining balance will be billed to you.

SURGERY FEES: All co-pays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Your carrier may require prior authorization.

NON-COVERED SERVICES: Any care not paid for by your existing insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES/ MOTOR VEHICLE ACCIDENTS: This office does not bill for automobile accidents, other liability or lawsuit-related cases , therefore you are responsible for payment at the time of service. Patients must submit bills to their insurance company. We do not accept letters of protection from attorneys.

WORKER'S COMPENSATION: Del Sol Medical Center Inc. is not affiliated, nor are we contracted with. any worker's compensation carriers.

YEARLY HEALTH CHECKS: Preventive care checks may or may not be covered under your health insurance policy, even though your physician may require them.

MISSED APPOINTMENTS: In all fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. Failure to provide the minimum notice may result in a $ 30.00 "no show fee" for missed appointments charged to your account.

PATIENT BALENCES: if you have a Patient Balance on your account, you will be billed for the entire amount due. Your bill will show separately any previous balance, any new charges on your account as well as any payments or credits applied to your account during that billing cycle. Your bill may also show pending payments from your insurance company, if applicable. The patient balance will be clearly indicated. Unless you have made other arrangements for the payment of the patient balance, approved by Del Sol Medical Center Inc. and the billing company associated with them. The amount indicated as patient balance is due upon receipt. Your balance will be considered past due if payment is not received within the 30 days form the issue date printed on the statement. Del Sol Medical Center Inc. reserves the right to add any fees incurred for additional billing and/or collection services. For your convenience we accept Visa, MasterCard, American Express and Discover.

RETURNED CHECK FEE: A $ 25.00 returned check fee will be charged to your account for any checks that come back as non-sufficient funds (or any other reason) by your financial institution

If necessary, Del Sol Medical Center Inc. may set up a regular payment schedule for you. Del Sol Medical Center Inc. reserves the right to report your account to credit reporting agencies if your balance goes into a past due

status. Nonpayment of past due patient balance may result in Del Sol Medical Center Inc. inability to provide you with continued care.
You acknowledge your understanding that if your account is submitted to an attorney, collection agency, involved in court litigation, or reported to a credit agency the fact that you received treatment/services at our office may become a matter of public record.

Transferring of medical records must be in writing along with a Medical Records Release form.

By signing below you are acknowledging and agreeing that:
You understand that it is your responsibility to provide Del Sol Medical Center Inc. with all current and accurate billing information at the time of service and you will notify Del Sol Medical Center Inc. immediately if there are any changes to this information.
You are agreeing to the terms and conditions contained herein. You understand that any charges not covered by your insurance company along with any co-payments and deductibles, are your responsibility.

MEDICARE PATIENTS- I request payment of authorized Medicare benefits be made on my behalf to Del sol Medical Center Inc. for any services provided to me. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.

Patient's Name (Please Print):	**PROVIDER**
Patient's Signature:	
Patient's Medicare No.: Date:	

ASSIGNMENT OF INSURANCE BENEFITS- Patients with insurances please read and sign below.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Del Sol Medical Center Inc. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by above insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

I have read, understood, and agreed to the above financial policy for payment of professional fees.

Signature: _____ Date: _____

This notice is effective as of _____.
Date

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

By way of my signature, I provide Del Sol Medical Center with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

_____
Printed Patient's Name

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

Del Sol Medical Center

Consent to disclose medical Information

Patient Name: _____ Date of Birth_____

Please check one of the Following:

_____ I give permission to the employees of Del Sol Medical Center to disclose my protected Health information to me and the following Friends and family:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

OR

_____ I request that all my Protected Health Information be disclosed only to me and no other Family or Friends.

WHAT TYPE OF MESSAGE MAY LEAVE YOU?

Del Sol Medical Center would like to know what type of message we may leave on your voice mail / answering machine when contacting you. Del Sol Medical center will contact you at the phone number you have provided. When we contact you at the phone number provided to us by you:

May we leave a detailed message on your answering machine/voicemail? ____YES ____ NO

Del Sol Medical Center will always leave a message when contacting you for to remind you of an upcoming appointment at our office.

I understand I have the right to revoke this authorization in writing at any time by filling out Consent to disclose Medical Information Form. My treatment or payment for my treatment cannot be conditioned on signing this authorization. If I refuse to sign this authorization, I understand the information used or disclosed may be re- disclosed by the recipient and no longer protected by Federal and State privacy laws. I understand this authorization will not expire.

_____ _____

Signature of Patient or Representative Date

_____ _____

Print name if not signed by patient Relationship/ authority to act on behalf of Patient

If signed by other that the patient you must provide a copy of the document of authority that makes you the patient's personal representative and a copy of your identification.

Authorization for the release of Patient Protected Health Records

From: _____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____

Address

RE:

Patients Name:_____

Date of Birth:_____ Social Security Number:_____

To:_____

Name of Healthcare Provider/Physician/Facility

Ph 239) 217-4470 Fax 239) 217-4474

Del Sol Medical Center
2002 Del Prado Blvd.
~~Suite 100~~
Cape Coral Florida 33990

Address

I authorize and request the disclosure of all protected information for the purpose of continued medical care. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose the requested medical information including the following:

_____ Entire Medical Record

_____All Medical Records from Date_____ To_____

_____ Other_____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) Alcohol and drug abuse and Behavioral/ Psychiatric care.

I understand I have the right to revoke this authorization in writing at any time, except to the extent has been released in reliance upon this authorization. The information released in response to this authorization may be re-disclosed to other parties. My treatment or payment for my treatment cannot be conditioned on signing of this authorization. This authorization will remain in force for one year from the date of execution.

_____ _____

Signature of the patient/Guardian/Legal representative Date Signed

_____

Name and relationship of Legally Authorized Representative to Patient

Del Sol Medical Center **Date**_____ **Page 1**

Patient's Medical History

Last Name_____ First Name_____ MI_____

DOB_____ Last for digits of SSI_____

Reason for Todays Visit_____

Lifestyle and Social Visit

Marital Status S M D W Separated Seat belt use Y N

Occupation_____ Employer_____

Alcohol use Y # per day_____ N Caffeine use Y # per day_____ N

Tobacco use No Yes Type_____ Year started_____ if prior Year quit_____

Health Screening and Vaccinations

Mammogram_____ Flu Vaccine_____ Prostate exam PSA_____

Bone densitometry_____ Pneumonia Vaccine_____ Colonoscopy_____

Pap Smear_____ Tetanus Vaccine_____ Other_____

Drug Allergies_____

Active medications (including over the counter)

Name _____Dose _____Frequency_____

Name _____Dose _____Frequency_____

Name _____Dose _____Frequency_____

Name _____Dose _____Frequency_____

Name _____Dose _____Frequency_____

Name _____Dose _____Frequency_____

Review of Systems

Skin:

_____ Skin problems

_____ Skin Cancer

_____ Skin lesions

_____ Bruise easily

Head and Eyes:

_____ Concussion injury

_____ Migraines

_____ Glasses or contacts

_____ Glaucoma

_____ Cataracts

Last eye exam_____

Ears Nose Throat:

_____ Hearing difficulty

_____ Perforated eardrum

_____ Ringing in ears

_____ Sinus infection

_____ Allergies or hay fever

_____ Hoarseness change in voice

Cardiac:

_____ High blood pressure

_____ Chest pain MI

_____ Heart Murmur

_____ Palpitations

Gastrointestinal:

_____ Difficulty swallowing

_____ Stomach ulcers

_____ Hepatitis

_____ Pancreas liver or gallbladder problems

_____ Colon polyps rectal bleeding hemorrhoids

_____ Constipation or diarrhea

Urinary:

_____ Kidney disease

_____ Bladder Problems

_____ Urinary tract infection

_____ Frequent urination

_____ Difficulty urinating

_____ Kidney stones

Respiratory:

_____ Asthma or wheezing

_____ Shortness of breath

_____ Blood in the phlegm

_____ COPD Emphysema

_____ Snoring / Problems with sleep

_____ Excessive daytime sleepiness

_____ Chronic phlegm production

Neurologic:

_____ Insomnia

_____ Anxiety/ Depression

_____ Seizure or convulsions

_____ Stroke

_____ Weakness

_____ Numbness

_____ Tingling in the arms or legs

Endocrine:

_____ Diabetes

_____ Thyroid disorder

_____ Fatigue

_____ Weight loss or gain

_____ Frequent hunger or thirst

Musculoskeletal:

_____ Arthritis

_____ Muscle, bone or joint pain

_____ Joint swelling

_____ Joint stiffness AM or PM

_____ Muscle cramping

Hematologic:

_____ Anemia / Blood transfusion

_____ Bleeding abnormality

_____ Persistent swollen glands

Infectious Disease:

_____ Rheumatic fever

_____ Measles, Mumps, Chicken pox, Shingles

_____ Sexually transmitted diseases

Female:

Date of last menstrual period_____

Are you post menopause? YES NO

Abnormal vaginal bleeding? YES NO

Monthly self-breast exams? YES NO

Male:

Prostate problems? YES NO

Weak or slow urine stream? YES NO

Swelling or lumps on testicles? YES NO

Difficulty with erections? YES NO

Patient's Past Medical History

_____ Alcoholism

_____ Anemia

_____ Anxiety

_____ Arrhythmia/Atrial Fibrillation

_____ Asthma

_____ Autoimmune Disorder

_____ Bleeding disorders / Blood clots

_____ Cancer/ Type_____

_____ Chest pain / Angina / MI / CHF

_____ Chronic Bronchitis

_____ Cirrhosis / Liver Disease

_____ COPD / Emphysema

_____ Coronary Artery Disease / MI

_____ CVA / Stroke / Seizure

_____ Colon Polyp

_____ Dementia

_____ Diabetes Type 1 / Type 2

_____ Diverticulosis / Diverticulitis

_____ Fibromyalgia

_____ GI Bleed

_____ Depression

_____ GERD

_____ Gestational diabetes

_____ Hemochromatosis

_____ Hepatitis A B C

_____ Hyperlipidemia

_____ Hypertension

_____ Hypothyroidism / Hyperthyroidism

_____ Thyroid Disorder

_____ IBS / Crohn's Disease / colitis

_____ Kidney Disease / Stones

_____ Neurologic Disorders

_____ Obesity / Sleep Apnea

_____ Osteoarthritis / Osteoporosis

_____ Peripheral Vascular Disease

_____ Renal Insufficiency / Failure

_____ Rheumatoid Arthritis

_____ Varicose Veins / Phlebitis

_____ UTI-Recurrent

_____ Abnormal Pap smear

_____ Cervical Cancer

_____ Breast Disease / Breast Cancer

Patient's Family History

_____ Alcoholism

_____ Allergies

_____ Anemia

_____ Angina

_____ Anxiety

_____ Arthritis

_____ Asthma

_____ Bipolar Disorder

_____ Birth Defects

_____ Bleeding Disorder

_____ Blood Clots

_____ Cancer Type _____

_____ Colon polyps

_____ COPD

_____ Emphysema

_____ Dementia

_____ Depression

_____ Obesity

_____ Diabetes

_____ Endometriosis

_____ Esophageal reflux

_____ Growth/Development

_____ Headaches

_____ Heart Disease

_____ High Cholesterol

_____ Hypertension

_____ Kidney Disease

_____ Melanoma

_____ MI Female before age 65

_____ MI Male before age 65

_____ Migraines

_____ Osteoarthritis

_____ Osteoporosis

_____ Rheumatoid Arthritis

_____ Seizures/Stoke

_____ Sleep Apnea

_____ Thyroid Problems

Patient's Surgical History

_____ Abdominal Surgery

_____ Amputation _____

_____ AV Fistula

_____ Aortic-femoral Bypass

_____ Appendectomy

_____ Back Surgery_____

_____ Breast Surgery_____

_____ Bronchoscopy

_____ Bunionectomy L R

_____ CABG/ Cardiac Surgery

_____ Carotid endarterectomy

_____ Carpal Tunnel L R

_____ Cataract Extraction L R

_____ Cesarean Surgery

_____ Cholecystectomy

_____ Colon Resection

_____ Coronary Artery Stent

_____ Craniotomy

_____ Cystoscopy

_____ Gastric Bypass

_____ Hemorrhoidectomy

_____ Hip Replacement

_____ Hernia Repair_____

_____ Knee Surgery_____ L R

_____ Hysterectomy with BOS

_____ Laminectomy

_____ Mitral Valve Replacement

_____ Nephrectomy

_____ Pacemaker

_____ Parathyroidectomy

_____ Plastic surgery_____

_____ Pilonidal Cystectomy

_____ Pneumonectomy

_____ Removal Kidney Stone

_____ Rhinoplasty

_____ Rotator Cuff Repair L R

_____ Tonsillectomy

_____ Thyroidectomy

_____ Transplant_____

_____ Other_____