HIPAA 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.**
Effective date of this notice is **January 24, 2021,** and will remain in effect until it is amended or replaced by us.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. **Tell us what you want us to do, and we will follow your instructions.** In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care

- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we ***never*** share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

- We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
  Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
  Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
  Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
  Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
  For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.
- Effective date of this notice is **January 24, 2021,** and will remain in effect until it is amended or replaced by us.

Privacy Officer: Sheena Shah
Phone: 863-732-7246 (PAIN)
Fax: 863-256-2520
Email: Info@tpscflorida.com
Address: 2310 North Blvd W, Suite A, Davenport FL 33837

Consent to Medical Treatment:

Total Pain & Spine Care of Florida maintains personnel and facilities in order to assist my physicians in providing me with medical care, and I authorize Total Pain & Spine Care of Florida providers and personnel to perform on me the care ordered by my physicians. I consent to receive services by telemedicine (using Interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring or other communications benefiting a patient) if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so, I choose to receive services even if my insurance plan may not cover or continue to cover specific service, including the specific services rendered during the admission. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to the recognized standards of medical practice, and I acknowledge that Total Pain & Spine Care of Florida and its personnel are not responsible for providing me this information. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of examinations and or treatments provided by Total Pain & Spine Care of Florida.

Consent to Recording or Filming
I authorize Total Pain & Spine Care of Florida, the attending physician, or other Total Pain & Spine Care of Florida authorized persons to record, photograph or film me for treatment, quality improvement or education purposes. Such recording, filming or photographs will be released only as permitted by law or authorized by me.

Assignment of Insurance Benefits. Patient Financial Responsibility and Credit Report Authorizations:
I guarantee payment of all charges made for or on account of the patient. I assign my right and my insurance benefits payments or other payment sources directly to Total Pain & Spine Care of Florida and/or the physicians providing services in conjunction with Total Pain & Spine Care of Florida. This assignment includes, but is not limited to, radiology reading, pathology services, emergency room visits or EKG readings. I understand I will receive separate bills for certain Total Pain & Spine Care of Florida and physician services. I understand I am financially responsible to Total Pain & Spine Care of Florida and physicians for charges not covered by this insurance assignment, I further understand Total Pain & Spine Care of Florida can obtain my credit report for collection purposes and I am responsible for any collections, attorney fees and costs. I have provided all Medicare information and insurance cards to Total Pain & Spine Care of Florida. I agree that in the event benefits paid under this assignment or any other amounts paid by me/us or my/our behalf exceeds the amount due Total Pain & Spine Care of Florida, my physicians, or those entitles for services in connection with this treatment, and such excess amount may be applied to any other indebtedness that l, my spouse, or any child for whom I am financially responsible, may have with Total Pain & Spine Care of Florida or any other facility entity related to Total Pain & Spine Care of Florida.

Authorization to Disclose Information and Privacy Act:
I authorize Total Pain & Spine Care of Florida, and its affiliates to use or disclose my protected health information for the purposes of treatment, payment or healthcare operations. This consent shall cover any of my protected health information that Total Pain & Spine Care of Florida may maintain or receive. I authorize the release of medical and related information about my treatment to the Professional Standards Review Organization responsible for reviewing the medical care furnished to me. This authorization will expire six years from the date shown below; however, I reserve the right to revoke this authorization at any time by contacting Total Pain & Spine Care of Florida at 863-732-7246.

Authorization to Release Medical Information:
I authorize Total Pain & Spine Care of Florida and my physicians to disclose any medical information related to my services or treatment to my insurance company, governmental or charitable agencies and their agents, my employer and professional review organizations with whom I may have insurance coverage or who may be assisting in the payment of my bill and my medical care. I also authorize Total Pain & Spine Care of Florida and my physicians to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. In addition, I authorize Total Pain & Spine Care of Florida and my physicians to release any medical information necessary to prove Total Pain & Spine Care of Florida's damages in any legal proceeding brought about to enforce any unpaid balance on any of my accounts. This authorization will expire two (2) years from the date shown below, and I understand that I or my legal representative may revoke this authorization at any time, unless legal action has already been taken, or in In the event of my death, the release of medical information is necessary to verify any charges incurred by me.

Authorization to Release Medicare and Medicaid Information:
I certify that the information provided by me in applying for payment under Titles V, Will and/or XIX 01 the Social Security Act is correct. I understand that health care services paid for under Medicare, Medicaid and Maternal and Child Health programs are subject to review by professional organizations, which may recommend denial of payment if my medical condition does not warrant continued Total Pain & Spine Care of Florida care. I authorize Total Pain & Spine Care of Florida to assist me in the processing of any benefits application, including Medical Assistance, Aid to Families with Dependent Children, or Special Assistance, initiated for the patient within six months of the date of this authorization. Total Pain & Spine Care of Florida may have access to and copy any records or information to which I would be entitled. The doctrine of informed consent has been explained to me, I acknowledge that this consent is voluntary and that it may be revoked by me at any time except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one year from the date of authorization, or until final determination of any benefits application as described above, whichever is later.

For Underinsured Patients or Uninsured Patients:
I authorize Total Pain & Spine Care of Florida and its affiliates, to use or disclose my protected healthcare information for the purpose of helping me find to find a healthcare provider and/or locate a payment source for my visit.

Release of Responsibility/Liability For Valuables:
I understand that Total Pain & Spine Care of Florida has a policy for safekeeping of patient valuables requiring all money, credit cards and/or items of value including jewelry to be given to a family member to hold or leave at home. If I choose not to deposit such items of value with my family member, I absolve Total Pain & Spine Care of Florida from responsibility for their loss, damage of disappearance.

Payment Guaranty: (Patient and/or responsible party/parties) agree to pay all charges for services rendered by Total Pain & Spine Care of Florida and my physicians or other providers during treatment related to services provided by Total Pain & Spine Care of Florida. This guaranty includes charges not covered by my insurance regardless of the reason insurance coverage is denied. I agree to pay the reasonable cost of the attorney services in addition to the unpaid charges. I consent and authorize Total Pain & Spine Care of Florida and its agents or subcontractors to contact outside sources including for the purpose related to my account, including evaluating and assessing my credit worthiness, my charity eligibility and the viability of collecting any amounts due for treatments I receive, whether at this time or on subsequent visits. I understand and agree that Total Pain & Spine Care of Florida may assign my accounts as it deems necessary for the purposes of collecting any amounts I owe, including to collection agencies and attorneys. I consent and authorize Total Pain & Spine Care of Florida and third-party agents of Total Pain & Spine Care of Florida to contact me at any telephone associated with me, including a wireless number, and to use pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.
I affirm that my signature on this form indicates that I have disclosed any and all current Insurance coverage/s that may pay for this visit. Further, any failure on my part to Identify my insurance/s may result in additional charges for which I win be responsible. My signature also indicates that if I have no insurance coverage J will cooperate and participate in any efforts to help me qualify for any applicable coverage. Failure to do so may render me ineligible for any financial assistance discounts.
I have read the request and authorization in Its entirety and agree to be bound by all the terms and conditions herein.
Witness my (our) hand(s) and seal(s) below,

____. ____

Patient Responsible Party(ies)

____ ____

Witness Relationship to Patient

I have been provided access to Total Pain & Spine Care of Florida Notice of Privacy Practices

____

Patient (or authorized representative) Date Time

Patient unable/unwilling to sign___________ Reason ____

Total Pain & Spine Care of Florida Representative____

Date/Time ____