BIRJIS K. ALAM, MD PA

Patient Name: _____ DOB: _____ AGE: _____ SEX: _____ DATE: _____

Address: _____

Phone # (H): _____ (W): _____ (Cell): _____

Race: _____ Ethnicity: _____ Language: _____ Email Address: _____

Social Security #: _____ Spouse's Name: _____ Work Phone: _____

Insured Name: _____ DOB: _____ Social Security #: _____

Address: _____

Emergency Contact: _____ Relationship: _____ Ph #: _____

Whom may we thank for referring you to us: _____ Home:_____

Allergies/Adverse Reactions? O Yes O No If yes, please list:_____
_____

Please review the following questions and darken/check in the circles of the symptoms that apply to you only:

CONSTITUTIONAL

weight gain	O Yes	O No
loss of appetite	O Yes	O No
fever	O Yes	O No
weakness	O Yes	O No
weight loss	O Yes	O No
fatigue	O Yes	O No
night sweats	O Yes	O No

HEENT

Change in vision	O Yes	O No
hearing loss	O Yes	O No
diminished vision	O Yes	O No
pain in eyes or ears	O Yes	O No
discharge from ears	O Yes	O No
eye irritation or redness	O Yes	O No
sore throat	O Yes	O No
nose bleed	O Yes	O No

ENT/RESPIRATORY

cough	O Yes	O No
pain with breathing	O Yes	O No
shortness of breath	O Yes	O No
coughing up blood	O Yes	O No

CARDIOLOGY

chest pain	O Yes	O No
palpitations	O Yes	O No
shortness of breath	O Yes	O No
leg cramps	O Yes	O No
pain in legs while walking	O Yes	O No
irregular heartbeat	O Yes	O No

DERMATOLOGY

rash	O Yes	O No
lumps	O Yes	O No
hives	O Yes	O No
skin cancer	O Yes	O No
laceration	O Yes	O No

GASTROENTEROLOGY

diarrhea	O Yes	O No
vomiting	O Yes	O No
constipation	O Yes	O No
nausea	O Yes	O No
difficulty swallowing	O Yes	O No
abdominal pain	O Yes	O No
heartburn	O Yes	O No
hemorrhoids	O Yes	O No
indigestion	O Yes	O No
frequent bloating	O Yes	O No
vomiting blood	O Yes	O No
rectal bleeding	O Yes	O No

MUSCULOSKELETAL

joint pain	O Yes	O No
joint swelling	O Yes	O No
osteoporosis treatment	O Yes	O No
back pain	O Yes	O No
muscle pain or weakness	O Yes	O No
tingling/numbness	O Yes	O No

UROLOGY

difficulty urinating	O Yes	O No
blood in urine	O Yes	O No
frequent urination	O Yes	O No
urinary incontinence	O Yes	O No
pain with urination	O Yes	O No

PSYCHOLOGY

depression	O Yes	O No
sleep disturbances	O Yes	O No
angry	O Yes	O No
sad	O Yes	O No
happy	O Yes	O No
other	O Yes	O No

ENDOCRINOLOGY

cold intolerance O Yes O No
heat intolerance O Yes O No
diabetes O Yes O No
excessive thirst O Yes O No
hot flashes O Yes O No
urinating frequently O Yes O No

HEMATOLOGY/LYMPH

swollen glands O Yes O No
varicose veins O Yes O No
easy bleeding O Yes O No
anemia O Yes O No
past transfusion O Yes O No

NEUROLOGY

headache O Yes O No
tingling/numbness O Yes O No
seizures O Yes O No
memory loss O Yes O No
dizziness O Yes O No
loss of strength in specific body area O Yes O No
loss of sensation ins specific body area O Yes O No
Migraines O Yes O No
burning pain in feet O Yes O No
trouble with balance O Yes O No
trouble with coordination O Yes O No
loss of consciousness O Yes O No
confusion O Yes O No

PAST MEDICAL HISTORY

hypertension O Yes O No
diabetes O Yes O No
hypercholesterolemia O Yes O No
atrial fibrillation O Yes O No
coronary artery disease O Yes O No
valve replacement O Yes O No
hepatitis C O Yes O No
hepatitis B O Yes O No
treated cancer (not current) O Yes O No
Blood Clot in extremities or lungs O Yes O No

SURGICAL HISTORY

Appendectomy O Yes O No
Hysterectomy O Yes O No
Coronary Bypass O Yes O No
Carotid endarterctomy O Yes O No

SOCIAL HISTORY

Occup. exposure: O yes O no O asbestos O chemicals
O second hand smoke
Drug Abuse: O Yes O No

FAMILY HISTORY:

Do you have any first degree family member (mother, father, brother, etc) with?

O hypertension O diabetes O hypercholesterolemia O blood clot in extremities or lungs O cancer

Please let us know the reason(s) for your visit today? If you are in pain, please describe location, severity and the onset of the pain:

Is your visit due to an injury? O Yes O No

If yes: O Work O Auto O Other

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

X _____ _____
Signature Date

For MA Use only
VITAL SIGNS: STANDING BP: L _____/_____ OR R _____/_____ HT _____ WT _____ BMI _____
SITTING BP: L _____/_____ AND R _____/_____ TEMP _____ PULSE _____ TAKEN BY: _____

Miscellaneous Medical Notes: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Autorizacion Para Prporcionar Informacion

I HEREBY GIVE MY PERMISSION TO:_____
Yo por este medio doy mi permiso a:
TO RELEASE A COPY OF (LIST SPECIFIC INFORMATION/DOCUMENTS): ***All Medical Records, labs and Diagnostic***
A que proporcione una copia de (liste informacion/documentos especificos): ***test.***

_____

_____

TO: _____ PCP: **BIRJIS K. ALAM, M.D.,P.A.**

Address: **12781 Miramar Parkway, Suite 101, Miramar. FL 33027**
Phone: (954) 437-2020, Fax: (954) 436-9614

FOR THE PURPOSE(S) OF (ALCOHOL & DRUG ABUSE CLIENTS ONLY):_____
Con el proposito de (Clientes de Abuso de Alcohol & Drogas solamente):

_____

THIS IS_____A SINGLE DISCLOSURE OR _____ A CONTINUING DISCLOSURE FOR 90 DAYS. (Check one)
Este es_____una sola autorizacion o_____ una autorizacion continua por 90 Dias. (Marque una)
PRIMARY LANGUAGE (ES PANOL):_____
DATE ON WHICH CONSENT IS GIVEN: _____
Fecha en que se dio consentimiento:
RELEASE EXPIRATION DATE:_____
Fecha de expiracion del consentimiento:

CONSENT IS SUBJECT TO REVOCATION AT ANY TIME.
CONSENTIMIENTO ESTA SUJETO A SER REVOCADO EN CUALQUIER MOMENTO.

I HEREBY RELEASE THE FACILITY FROM ANY LIABILITY WHICH MAY ARIES AS A RESULT OF THE USE OF THE INFORMATION CONTAINED IN THE RECORDS RELEASED.

Yo por este medio relevo a esta empresa de cualquier responsabilidad que pueda surgir como resultado del uso de la informacion contenida en los documentos remitidos.

NAME OF THE PATIENT:_____ BIRTHDATE:_____
Nombre del paciente: (PRINT) Fecha de nacimiento:

SIGNATURE OF PATIENT:_____ DATE:_____
Firma del paciente: Fecha:

SIGNATURE OF GUARDIAN:_____ DATE:_____
Firma del custodio: (IF NEEDED/Si es necesario) Fecha:

SIGNATURE OF WITNESS:_____ DATE:_____
Firma del testigo: Fecha:

TO RECEIVING AGENY: PROHIBITION OF REDICLOSURE
A LA AGENCIA QUE RECIBA LA INFORMACION: PROHIBICION DE REVELAR

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED. ANY FURTHER REDISCLOSURE IS STRICTLY PROHIBITED UNLESS THE PATIENT PROVIDES SPECIFIC WRITTEN CONSENT FOR THE SUBSEQUENT DISCLOSURE OF THIS INFORMATION.

Esta informacion ha sido proporcionada a usted de documentos cuya confidencialidad es protegida. Cualquier declaracion adicional es estrictamente prohibida a menos que el pacient de su consentimiento especificamente por escrito permitiendolo.

THE INDIVIDUAL AUTHORIZING THE RELEASE OF SUCH INDIVIDUAL'S INFORMATION, OR THE PERSON AUTHORIZED TO ACT ON BEHALF OF THE INDIVIDUAL, OR THE INDIVIDUAL'S AUTHORIZED REPRESENTATIVE IS ENTITLED TO RECEIVE A COPY OF THIS AUTHORIZATION FORM, UPON PRESENTING DOCUMENTATION SETTING OUT THE AUTHORIZATION TO ACT ON BEHALF OF SUCH INDIVIDUAL.

La persona que autoriza el suministro de informaci on correspondiente a si misma, o la persona autorizada para actuar en representacion de dicha persona, o la persona autorizada como su representante tiene derecho a recibir una copia de este formulario de autorizacion al presentar la documentacion necesaria que compruebe que ha sido autorizada para actuar en representacion de dicha persona.

BIRJIS K. ALAM, M.D., P.A.

12781 Miramar Parkway, Suite 101
Miramar, FL 33027

PATIENT NAME: _____

CONSENT FOR DIAGNOSTIC, PRESCRIPTION HISTORY AND/OR THERAPEUTIC PROCEDURES

I hereby consent to and authorize the physician and any other health professional as designated to perform a physical examination and routine diagnostic procedure upon me, I also, consent to and authorize the physician and any other health professional to view my prescription history from external sources and to prescribe a therapeutic regime which I shall follow.

Patient signature: _____ Date: _____

REFERRAL POLICY

All referrals requests must comply with the referral policy due to software changes.
If a patient is currently contacted with an insurance company that requires a referral to either a specialist, diagnostic facility, therapy facility or durable medical equipment, the following protocol shall be followed to ensure all referrals are generated in the proper order according to medical need, date seen and/or date referral was requested.

- Only "Dr.-determined" referral of absolute **emergent** necessity -issued same day
- Only "Dr.-determined" referral of **urgent** necessity -24-hour time limit
- **Routine referral request by either physician, specialist or patient - 5-10 business days. If not requested with in the timeframe listed above the appointment must be rescheduled.**

There will be no exceptions to the policy. Please make sure you contact our referral department with ample time for all your referral needs.

Patient signature: _____ Date: _____

NO SHOW POLICY

We understand that there are reasons for having to cancel an appointment, we ask you to show consideration by calling well in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor. Please let this notice serve to notify you that if you fail to give us a 24-hour notice of cancellation, there will be a $35.00 cancellation fee.

Patient signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

BIRJIS K. ALAM, M.D., P.A.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE SEND AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. if we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy for Protected Health information available upon request.

II. How We May Use or Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information.

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment is best for you. Your medical information might also be shared among members of your treatment team, or with pharmacy(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services. For Example, we may release portions of your medical information to Medicare and/or a private insurer to get paid for services that we delivered to you, or to obtain permission for an anticipated plan of treatment.

For health care operations: We may use and/or disclose your medical information in the course of operating our **practice**. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or attorney for audit purposes.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- Unless you object, we may send appointment reminders, information about treatment alternatives and other health-related benefits and services that may be interest to you.
- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.

- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organization relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help the coordination of disaster relief efforts.
- We may share with these people information directly related to your family's, friend's or other person's involvement in your care, or payment of your care. We may also share medical information with these people to notify them about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may contact you for certain fund raising events.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have the following rights relating to your protected health information:

- You have the right to ask that we limit how we use or disclose your medical information. We will consider your request, but are not legally bound to agree to the restriction. You have the right to ask that we send you information at an alternative address or by an alternative means. We will agree to your request as long as it is reasonably easy for us to do so.
- Unless your access is restricted for clear and documented treatment reasons, you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your medical information, a charge of copying may be imposed, but may be waived, depending on your circumstances. you have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- If you believe that there is a mistake or missing information in our record of your medical information, you may request, in writing, that we correct or add to the record. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will change the medical information and so inform you.

- You have the right to an accounting of the disclosures of your medical information other than instances of disclosure for which you gave consent. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.
- You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

IV. How to Complain about our Privacy Protection:

- If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, you may file a complaint with the person listed in Section V. below. You may also file a written complaint with Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington, DC 20201. We will take no retaliatory action against you if you make such complains.

V. Contact Person for Information, or to Submit a Complaint:

- If you have any questions about this Notice or any complaints, about our privacy practices, please contact our Privacy Compliance officer at (954) 437-2020.

VI. Effective Date: This Notice was effective April 14, 2003.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's name: _____ Account # _____
Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

BIRJIS K. ALAM, M.D., P.A.
12781 Miramar Parkway, Suite 101
Miramar, FL 33027

3. The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate).

Demographic information (such as name, address, telephone number, e-mail address, etc.)
Problem list
Medication list
List of allergies
Immunization record
Most recent history and physical
Most recent discharge summary
Laboratory results from (date)_____ to (date)_____
X-Ray and imaging reports from (date)_____ to (date)_____
Consultation reports from (doctor's names) _____
Entire record
Other_____
_____

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

5. This information may be disclosed to and used by the following individual
Names:_____
Organization:_____
Address:_____
_____
For the purpose of:_____
_____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual/organization noted in #2 above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have question about disclosure of my health information, I can contact **Maxine** at (954) 437-2020.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient

_____

Signature of Witness

A. Notifier: BIRJIS K. ALAM, MD PA

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If INSURANCE doesn't pay for **D.** Listed below, you may have to pay. Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Insurance may not pay for the **D. Services** below.

D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
OFFICE VISIT ***EKG*** ***BLOOD TEST*** ***STOOL TEST*** ***SPIROMETRY/OXYMETRY*** ***PAPSMEAR*** ***IMMUNIZATION***	***NON-COVERED SERVICES*** ***DEDUCTABLES*** ***COINSURANCE***	***OPEN***

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but insurance cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want insurance billed for an official decision on payment, which is sent to me on a Insurance Summary Notice (MSN). I understand that if insurance doesn't pay, I am responsible for payment, but **I can appeal to Insurance** by following the directions on the MSN**.** If Insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Insurance is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if insurance would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare or Insurance decision

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

NOTICE OF PRIVACY PRACTICES

BIRJIS K. ALAM, M.D.,P.A.

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We under stand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practice for Protected Health Information available upon request.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment is best for you. Your medical information might also be shared among members of your treatment team, or with you pharmacist(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services. For example, we may release portions of your medical information to Medicare and/or a private insurer to get paid for services that we delivered to you, or to obtain permission for an anticipated plan of treatment.

For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or attorney for audit purposes.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- Unless you object, we may send appointment reminders, information about treatment alternatives and other health-related benefits and services that may be of interest to you.
- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- We may share with these people information directly related to your family's, friend's or other person's involvement in your care, or payment for your care. We may also share medical information with these people to notify them about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may contact you for certain fund raising events.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have the following rights relating to your protected health information:

- You have the right to ask that we limit how we use or disclose your medical information. We will consider your request, but are not legally bound to agree to the restriction. You have the right to ask that we send you information at an alternative address or by an alternative means. We will agree to your request as long as it is reasonably easy for us to do so.
- Unless your access is restricted for clear and documented treatment reasons, you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your medical information, a charge for copying may be imposed, but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- If you believe that there is a mistake or missing information in our record of your medical information, you may request, in writing, that we correct or add to the record. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will change the medical information and so inform you.

You have the right to an accounting of the disclosures of your medical information, c than instances of disclosure for which you gave consent. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such each year. There may be a charge for more frequent requests.

You have a right to receive a paper copy of this Notice and/or an electronic copy by e upon request.

IV. How to complain about our Privacy Practices:

If you think we may have violated your privacy rights, or you disagree with a decisior we made about access to your medical information, you may file a complaint with the person listed in Section V. below. You may also file a written complaint with Secreta of the U.S. Department of Health and Human Services at 200 Independence Avenue S Washington, DC 20201. We will take no retaliatory action against you if you make si complaints.

V. Contact Person for Information, or to Submit a Complaint:

If you have questions about this Notice or any complaints, about our privacy practices please contact our Privacy Compliance Officer at (954) 437-2020.

VI. Effective Date: This Notice was effective April 14, 2003.

Signature:_____

Name:_____

Date:_____

ADVANCE CARE PLANNING

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse to be artificially prolonged or to not be artificially prolonged.

In the event that I have been determined to be unable to provide and express an informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: _____
Address:_____
City: _____ State: _____ Zip: _____
Phone: _____ Relation:_____

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

_____ **I CHOOSE TO NOT BE PROLONGED**

_____ **I CHOOSE TO BE PROLONGED**

_____ **I CHOOSE TO NOT MAKE THIS DECESION AT THIS TIME**

Patient Name: _____

Patient Signature: _____ Date: _____

Witness: _____
Street Address: _____
City, State & Zip: _____
Phone: _____

Witness: _____
Street Address: _____
City, State & Zip: _____
Phone: _____