Integrity Medical Group, LLC

AUTO

Confidential Patient Case History

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time and answer each question as completely as possible. ***Please sign each page.***

Patient Information

TODAY'S DATE: _____/_____/_____

LAST NAME: _____ FIRST NAME: _____

PREVIOUS NAME: _____ PREFERRED NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE#: (_____) _____ CELL#: (_____) _____

EMAIL: _____@_____.COM

DOB: ___/____/____ AGE: _____ Gender: MALE / FEMALE SOC.SEC#_____/_____/_____

EMERGENCY CONTACT: _____ PHONE #: (___) _____ RELATION: _____

FAMILY PHYSICIAN: _____ PHONE#: (___) _____

PRIMARY LANGUAGE: ENGLISH / SPANISH / OTHER: _____ TRANSLATOR NEEDED? ☐

Auto Insurance Information

NAME OF YOUR INSURANCE COMPANY: _____

DATE OF ACCIDENT: _____ Name on the Policy: _____

POLICY #: _____ CLAIM #: _____

ADJUSTER'S NAME: _____ PHONE #: (_____) _____

IF YOU DO NOT HAVE YOUR OWN INSURANCE, DO YOU LIVE WITH SOMEONE WHO DOES? **YES / NO**

NAME OF THE POLICY HOLDER: _____ RELATIONSHIP: _____

POLICY #: _____ CLAIM #: _____

ARE YOU BEING REPRESENTED BY AN ATTORNEY? Y / N

ATTORNEY'S NAME: _____ PHONE #: (_____) _____

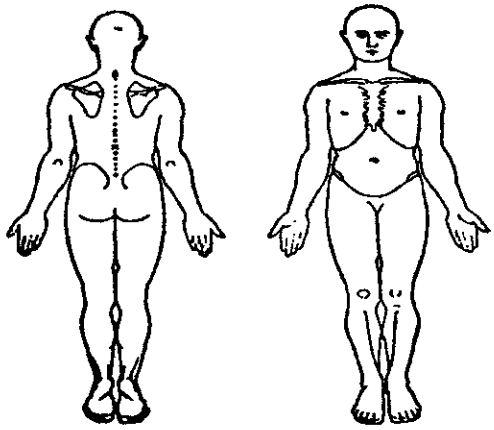
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SIGNATURE: _____ **DATE:** _____

Integrity Medical Group, LLC

CURRENT CONDITION

USING THE FOLLOWING DRAWINGS, PLEASE INDICATE AREAS OF CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT.



For how long have you had this condition? _____ Have you had this condition in the past? YES / NO

PROGRESS: WORSE [____] SAME [_____] CONSTANT [____] COMES AND GOES [_____]

Is this condition interfering with your daily routine? WORK [ ] SLEEP [ ] DAILY ROUTINE [ ] OTHER: _____

List treatments you have had for this problem and all health professionals that you are currently seeing:

PHYSICIANS	SPECIALTY	TREATMENT DURATION

BREIFLY DESCRIBE THE ACCIDENT:

_____

_____

Destination after the accident/ injury:

When did you go to the hospital? _____/_____/_____ Hospital Name: _____

Who drove you to the hospital? _____Were you admitted? _____

Date discharged: _____/_____/_____ Were X-rays taken? YES / NO Describe: _____

Has a doctor or dentist ever diagnosed a TMJ disorder prior to the accident? _____

SIGNATURE: _____ DATE: _____

Integrity Medical Group, LLC

MEDICAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING CONDITIONS APPLY TO YOU OR YOUR FAMILY MEDICAL HISTORY

YOU	FAM.	Condition	YOU	FAM.	Condition
		Allergies			Artificial Implants
		Arthritis			Blood Disorders
		Endocrine disorders: diabetes, osteoporosis, thyroid, etc.			Heart/Circulatory Disorders
		Eyes/Vision Disorders			HIV Disorders
		Liver Disease			Kidney/Urinary Disorder
		Lung/Respiratory Disorders			Muscle Disorders
		Nervous Disorders: multiple sclerosis, Alzheimer's, epilepsy, etc.			Stomach/Intestinal Disorders

HEIGHT: _____ WEIGHT: _____ CHILDREN: _____

SMOKER: YES / NO ALCOHOL CONSUMPTION: YES / NO RECREATIONAL DRUGS: YES / NO

Allergies to any medications: _____

Surgical History: _____

Occupation: _____

MARITAL STATUS: Married/Single/Divorced/Widow

Have you had to reduce work related activities due to injuries sustained from this accident? YES / NO

LIST ALL OVER THE COUNTER AND PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

Prior to this occurrence, have you been in an auto accident? YES / NO WHEN? _____

DESCRIBE: _____

Have you had any other personal injury or incident? YES / NO WHEN? _____

DESCRIBE: _____

Is there any possibility that you may be pregnant? YES / NO / MAYBE

*How far along?*_____*Due date:* _____/_____/_____

PATIENT SIGNATURE: _____ Date: _____

WINTER PARK, 1801 Lee Road, Suite 304, Winter Park, FL 32789
KISSIMMEE, 206 w. Oak Street, Suite B, Kissimmee, FL 34741
LAKE MARY, 978 International Parkway, Suite 1440, Lake Mary, FL 32746
THE VILLAGES, 17820 SE 109th Avenue. Ste. 104 Summerfield, FL 34491

Revised 07/02/2019

Integrity Medical Group, LLC

HEALTH INSURANCE DETAIL

TODAYS DATE: _____

DO YOU HAVE HEALTH INSURANCE: YES_____ NO_____

If you answered YES, please fill out below.

LAST NAME: _____

FIRST NAME_____

DOB_____

HEALTH INSURANCE
COMPANY_____

ID#_____GROUP#_____

ADDRESS_____

PHONE#_____

NAME OF PRIMARY HOLDER_____

Integrity Medical Group, LLC

Consent to Obtain Prescription History

This consent form authorizes Integrity Medical Group, LLC to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form you agree that Integrity Medical Group, LLC can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Integrity Medical Group, LLC to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (Printed): _____

Patient Signature: _____

Patient Date of Birth: _____

Date of Signing Consent Form: _____

Primary Pharmacy Information:

Pharmacy Name: _____

City: _____ State: _____ Zip Code: _____

Nearest Cross Street: _____

Pharmacy Phone Number: _____

Integrity Medical Group, LLC

RELEASE OF PATIENT RECORDS AUTHORIZATION

_____ I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of insurance coverage.

_____I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that **Integrity Medical Group, LLC** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **Integrity Medical Group, LLC** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

_____ I hereby authorize **Integrity Medical Group, LLC** to release a copy of my patient records or x-rays containing protected health information to **my insurance company and/or attorney representing me in this case**. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

_____ _____

Patient's or Patient's Legal Representative's Signature **Patient's Date of Birth**

_____ Date Signed

Specific description of information to be disclosed: _____

_____

PATIENT SIGNATURE: _____ **DATE:** _____

Integrity Medical Group, LLC

POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made constituted and appointed, and by these presents does hereby make, constitute and appoint the ***Integrity Medical Group, LLC*** any and all of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or is the undersigned and the said ***Integrity Medical Group, LLC*** which checks, drafts, or money orders are to pay for the services of the like which have been made by _____(Ins. Co.) at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does give and grant unto the said ***Integrity Medical Group, LLC*** as attorney the full power and authority to do and perform all and every act and thing what so ever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present in so far as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which they said attorney shall do or cause to be done by virtue of these presents.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, thus

_____ Day of _____, _____.
(Day) (Month) (Year)

PATIENT/PARENT GUARDIAN SIGNATURE:

_____

WINTER PARK
1801 Lee Road, Suite 304, Winter Park, FL 32789
Phone: 321.765.4373 Fax: 407.542.0666

THE VILLAGES
17820 SE 109th Ave, Ste 104, Summerfield, Fl,34491
Phone:352-320-3200 Fax:352-320-3210

KISSIMMEE
206 w. Oak St. SteB Kissimmee, FL 34741
Phone: 407-930-0838 Fax: 407-930-0841

INTEGRITY MEDICAL GROUP, LLC

Patient Acknowledgement and Waiver

To the extent that, I _____, have health insurance benefits for which my medical service provider may have a provider agreement("Provider Agreement") in effect with such health insurance provider, I acknowledge that:

Despite any requirements in the "Provider Agreement" for provider to submit claims for services and treatments (collectively Services) to my health insurance plan within a particular timeframe, and despite any statement in the provider agreement notifying the medical services provider that failure to submit claims for services within a specific timeframe will preclude payment to the provider and prohibit the medical services provider from charging me(or anyone else related to me) for said services, medical service provider will not be submitting claims to my health insurance plan for any services he/she has rendered to me: and

I have certain third-party beneficiary rights under the provider agreement and I hereby relinquish those rights voluntarily, knowledgeably, and intentionally.

I, _____further acknowledge that:

I will be responsible for the payment for all services rendered to me by the medical services provider;

In lieu of the medical services provider billing me or my health insurance plan for my services, health insurance provider, health insurance provider will enter into a medical lien with myself whereby medical services provider will be compensated for all services he/she provides to me, as a direct or indirect result of my personal injury case, from the proceeds of my settlement of said personal injury case; and

The compensation that medical services provider will receive under the medical lien will likely exceed the compensation that medical services provider would have received if the medical services provider would have submitted claims to my health insurance plan for my services, and I believe that such additional compensation is equitable in light of the nature of the services that medical services provider will be furnishing to me.

I have read and I understand all of the statements above. I acknowledge and understand that I have a right to consult with legal counsel before signing this Patient Acknowledgement and Waiver. I hereby execute this Patient Acknowledgement and Waiver voluntarily, knowledgeably and intentionally

Patient:_____

Signature:_____

Date:_____

WINTER PARK: 1801 Lee Road. #304. Winter Park, FL. 32789
KISSIMMEE • 206 W. Oak St. Ste B Kissimmee, FL. 34741.
LAKE MARY: 978 International pkwy, Suite 1440. Lake Mary, FL 32746
THE VILLAGES: 17820 SE 109thAvenue. STE 104. Summerfield, FL. 34491

INTEGRITY MEDICAL GROUP, LLC

NOTICE OF PHYSICIAN'S FINANCIAL INTEREST

A physician must notify a patient that the owner of the medical practice has a direct financial interest in a separate diagnostic facility where the patient has been referred for services. (Florida statutes 456.052). We will support these laws in order to help patients make informed and reasoned decisions concerning their medical care

In compliance with the requirements of these laws, Donald L Behrman M.D. PhD. The owner of Integrity Medical Group, has ownership interest in Orlando Surgery Center located at 3435 Pinehurst Ave., Orlando, FL. 32804.

In compliance with the requirements of these laws, Paul Shuler M.D. and employee of Integrity Medical Group has ownership interest in Sand Lake Surgical Center located at 7477 Sand Lake Commons Blvd., Orlando, FL. 32819

The surgical services recommended by your treating physician are available elsewhere on a competitive basis by Millennia Surgery Center located at 4901 Vineland Rd. Orlando Florida. 32811 and Park Place Surgery Center located at 2450 Maitland Center Pkwy., Unit 100, Maitland, Florida. 32751

The law requires your acknowledgment that you have read and understood this disclosure by signing and dating this form in the space provided below. We will keep the signed original and your patient file and you may receive a copy upon request.

ACKNOWLEDGEMENT: I have read this"Notice of Physician's Financial Interest "form, and I understand by signing this form that the treating physician at Integrity Medical Group has recommended services at a facility where the owner of Integrity Medical Group has a direct financial interest.

Dated this_____ date of_____,20_____

_____

Signature of Patient or Guardian

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INTEGRITY MEDICAL GROUP, LLC

LIEN LETTER

Date:

RE:

I do hereby authorize you, my attorney, to pay directly to Integrity Medical Group, LLC, such sums as may be due and owing it for medical services rendered me by reason of the accident on _____ and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Integrity Medical Group, LLC.

I understand that Integrity Medical Group, LLC, will not be filing a claim to my health insurance company, if one exists, for services rendered as a result of this accident. In the event that I am a third-party beneficiary under a contract between Integrity Medical Group, LLC and my health insurance carrier, I hereby voluntarily and intentionally waive and relinquish my rights privileges and advantages as a third-party beneficiary under that contract.

I understand that the provider has the right to assign the collection rights for medical expenses related to the medical care I received to an"assignee" or "third party". Lastly, I understand that I will not be liable for any amount of other than the actual amount listed in the"Services Bill" from the medical provider

I agree never to rescind this document and that rescission will not be honored by my attorney. I also agree and understand this document to be valid upon my signature. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the cases as if it were executed by him.

I fully understand that I am directly and fully responsible to Integrity Medical Group, LLC for all medical bills and services rendered to me and that this agreement is made solely for the additional protection of Integrity Medical Group, LLC and in consideration of the Integrity Medical Group's awaiting payment. I further understand that as the recipient of the medical services, I remain personally responsible for the payment of these services even if unsuccessful in my liability claim and that payment for these medical services is not contingent on any settlement, judgment or verdict I may receive. I hereby further state and agree that a photocopy of this document is deemed as valid and binding on all parties involved as the original. I further understand that this provider lien is assignable and transferable.

Dated:_____ Patient's Signature:_____

Attorney/Law Firm Name:_____

This facility holds an assignment/lien on this case for medical services rendered. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this facility for payment.

INTEGRITY MEDICAL GROUP, LLC

SURGERY CANCELLATION POLICY

Integrity Medical Group requires at least 48 business hours cancellation notice for surgical procedures. Please be aware that time is immediately blocked upon scheduling your procedure. If adequate notice is not given, we are unable to utilize this time for another patient.

If you fail to notify our office of your cancellation at least 48 business hours prior to the procedure you will be charged a $5000 cancellation fee. This fee will not be paid by your insurance company. This will be a fee that you must pay personally or through your medical Lien if one is on file.

We do understand that there may be extenuating circumstances such as cancellations secondary to medical problems or abnormal labs. In these cases a fee will not be charged to your count.

By signing below you indicate that you understand the above policy and agree to said charges if adequate notice is not given.

_____

Patient Signature

_____

Patient Name

_____

Date

WINTER PARK: 1801 Lee Road. #304. Winter Park, FL. 32789
KISSIMMEE • 206 W. Oak St. Ste B Kissimmee, FL. 34741.
LAKE MARY: 978 International pkwy, Suite 1440. Lake Mary, FL 32746
THE VILLAGES: 17820 SE 109thAvenue. STE 104. Summerfield, FL. 34491

Integrity Medical Group, LLC

Donald Behrmann, M.D.
Thomas Cooper, M.D.
Pedro Ramirez, M.D.
Paul Shuler, M.D.
Debra Eriksen, D.O.
Thomas Koehne, P.A.-C
Jacob Phillips, P.A.-C
Rafael Romero, P.A.-C
Patricia McFadden, P.A.-C
Kurt Wood, P.A.-C
Shahed Hmeidan PA-C

INITIATION OF TREATMENT

To Whom It May Concern:

This is to inform you that I was injured in a motor vehicle accident. This letter is to confirm that I intend to initiate treatment therapy as outlined by the doctors at **Integrity Medical Group, LLC**

CONSENT FOR TREATMENT

I hereby authorize your practice and whomever the doctor may designate as assistant to perform examination, physiotherapy, physical therapy and perform non-invasive diagnostic tests and, if any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those contemplated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as to the result that may be obtained. I have the right to refuse additional treatment aside from a consultation.

SIGNATURE: _____ **DATE:** _____

Integrity Medical Group, LLC

SIGNATURE: _____ **DATE:** _____

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes overdue interest payments and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.
This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider and to request any statements or examinations under oath the patient provided to any insurer.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer; obtain copies of all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else are received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name (PRINT): _____ **Date** _____

Patient's Signature : _____

WINTER PARK, 1801 Lee Road, Suite 304, Winter Park, FL 32789
KISSIMMEE, 206 w. Oak Street, Suite B, Kissimmee, FL 34741
LAKE MARY, 978 International Parkway, Suite 1440, Lake Mary, FL 32746
THE VILLAGES, 17820 SE 109th Avenue. Ste. 104 Summerfield, FL 34491

Revised 07/02/2019

Integrity Medical Group, LLC

Patient's Name: _____ DOB: _____

Social Security #: _____ D/A: _____

_____ _____

I request and authorize: _____

To release healthcare information of the patient named above to: **Integrity Medical Group, LLC**

☐ 1801 Lee Road, Ste. 304, Winter Park, FL 32789 ◆ Ph: (321) 765-4373 / Fax: (407) 542-0666
☐ 206 W. Oak St.; Ste. B Kissimmee, FL 34741 ◆ Ph: (407) 930-0838 / Fax: (407) 930-0841
☐ 978 International Pkwy, Ste. 1440, Lake Mary, FL 32746 ◆ Ph: (321) 765-4373 / Fax: (407) 542-0666
☐ 17820 SE 109th Ave., Suite 104, Summerfield, FL 34491 ◆ Ph: (352) 320-3200 / Fax: (352) 320-3210

This request and authorization applies to:

- ☐ Full medical records held by this office
- ☐ A specific portion/section of the record as follows: _____
- ☐ Radiology reports
- ☐ Medical record for the period _____ through _____
- ☐ Other diagnostic studies: _____

Purpose of the requested disclosure: _____ At patient's request. _____ Continuing Care

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the privacy officer. I am aware that my revocation is not effective to the extent that the person I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that **Integrity Medical Group, LLC** may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the release information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as the original release.
If I authorize **Integrity Medical Group, LLC** to fax information, I realize there are inherent risks in faxing Protected Health Information; I understand a fee will be charged to cover the cost of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

Patient's or Representative's Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 365 DAYS FROM THE DATE IT IS SIGNED

Integrity Medical Group, LLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Integrity Medical Group, LLC

COMMUNICATION PREFERENCE FORM

Patient Name (please print): _____

Date of Birth: _____

Please indicate which of the following numbers you would like for us to use:

☐ Home Phone: (____) _____-_____ ☐ Work Phone: (____) _____-_____

☐ Cell Phone: (____) _____-_____

E-mail: _____

Please note, if you supply a cell phone number and/or an email address, you will receive appointment reminders through these methods. You may later opt-out of them if you wish.

What is your preferred communication method? ☐ Email ☐ Phone ☐ Text

In an effort to guard your privacy, please answer the following questions on how best to contact you regarding communication from Integrity Medical Group, LLC. In regards to messages left on voicemail or an answering machine, you authorize your doctor or staff (*please choose one*):

☐ To leave messages regarding your medical condition(s), as well as appointment reminders, billing/ financial questions, and requests to call the office.

☐ To leave only messages regarding appointment reminders and requests to call the office. Do not reference your medical condition(s) in the message.

If you wish to allow IMG staff to discuss your protected health information (PHI) with a person(s) you appoint, please fill out the sections below.

☐ IMG may share medical, billing, and appointment information with the following individuals:

☐ Spouse or significant other: _____

☐ Son(s) or daughter(s): _____

☐ Any relative: _____

☐ Other (nursing home, friend, caregiver, etc.): _____

Authorization

I understand I may notify the doctor's office at any time of changes to this request, which would require a new form and authorization to be completed.

_____ _____

Signature **Date**

Integrity Medical Group, LLC

NOTICE *of* PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO TIDS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICER.

This Notice of Privacy Practices describes how
Integrity Medical Group, LLC may use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Integrity Medical Group, LLC and all clinic personnel are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that
Integrity Medical Group, LLC is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to the primary care physician that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to who you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider *(e.g.,* a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

PAYMENT: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a diagnostic test, such as an MRI, may

require that your relevant protected health information be disclosed to the health plan to obtain approval for the MRI to be performed.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, licensing, and conducting or arranging for other business activities.

We will share your protected health information with third party "**business associates**" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

REQUIRED BY LAW: WE MAY USE OR DISCLOSE YOU R PROTECTED HEA LTH INFORMATION TO THE EXTENT THAT THE USE OR DISCLOSURE IS REQUIRED BY LAW. THE USE OR DISCLOSURE WILL BE MADE IN COMPLIA NCE W ITH THE LAW AN D WILL BE LIMITED TO THE RELEVANT REQUIREMENTS OF THE LAW. YOU WILL BE NOTIFIED, IF REQUIRED BY LAW ' OF ANY SUCH USES OR DISCLOSURES.

PUBLIC H E A L T H : WE MAY DISCLOSE YOUR PROTECTED H EALTH INFORM ATION FQR PU BLIC HEALTH ACTIV ITIES AND PURPOSES TO A PU BLIC HEALTH AUTHORITY THAT JS PERMITTED BY LAW TO COLLECT OR R ECEIV E THE INFORMATION. FOR EXAMPLE, A DISCLOSURE MA Y BE MADE FOR THE PURPOSE OF PREVENTING OR CONTROLLING DISEASE, INJURY OR DISABILITY.

COMMUNICABLE DISEASES: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION, IF AUTHORIZED B Y LAW, TO A PERSON WHO MA Y HAVE BEEN EXPOSED TO A COM M UNICABLE DISEASE OR M AY OTHER WISE BE AT RISK OF CONTR ACTING OR SPREADI NG TH E DISEASE OR CONDITION.

HEALTH OVERSIGHT: WE MAY DISCLOSE PROTECTED HEALTH INFORMATION TO A HEALTH OV ERSIGHT AGENCY FOR ACTI V ITIES AUTHORIZED BY LAW, SUCH AS AUDITS, INVESTIGATIONS, AND INSPECTIONS. OVERSIGHT AGENCIES SEEKING THIS INFORM ATION INCLUDE GOV ER NMENT AGENCIES THAT OVERSEE THE HEALTH CARE SYSTEM, GOVERNMENT BENEFIT PR OGRAMS, OTHER GOVER NMENT REGULATORY PROGRAMS AND CIV IL RIG HTS LAWS.

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ABUSE OR NEGLECT: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO A PUBLIC HEALTH AUTHORITY THAT JS AUTHORIZED BY LAW TO RECEIVE REPORTS OF CHILD ABUSE OR NEGLECT. IN ADDITION, WE MA Y DISCLOSE YOUR PROTECTED HEALTH INFORMATION IF WE BELIEVE THAT YOU HAV E BEEN A VICTIM OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE TO THE GOVER NMENTAL ENTITY OR AGENCY AUTHORIZED TO RECEIVE SUCH INFORMATION. IN THIS CASE, THE DISCLOSURE WILL BE M ADE CONSISTENT WITH THE REQU IREMENTS OF APPLICABLE FEDERAL AND STATE LAWS.

FOOD AND DRUG ADMINISTRATION: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO A PERSON OR COMPAN Y REQUIRED B Y THE FOOD AND DRUG ADMINISTR ATION FOR THE PURPOSE OF QUALITY, SAFETY, OR EFFECTIVENESS OF FDA- REGULATED PRODUCTS OR ACTIVITIES INCLUDING, TO REPORT ADVERSE EVENTS, PRODUCT DEFECTS OR PROBLEMS, BIOLOGIC PRODUCT DEVIATIONS, TO TRACK PRODUCTS; TO ENABLE PRODUCT RECALLS; TO M AKE REPAIRS OR REPLACEMENTS, OR TO CONDUCT POST MARKETING SURVEILLANCE, AS REQUIRED.

LEGAL PROCEEDINGS: WE M AY DISCLOSE PROTECTED HEALTH INFORMATION IN THE COURSE OF A NY JUDICIAL OR A DMINISTR ATIVE PROCEEDING, IN RESPONSE TO AN ORDER OF A COURT OR ADMINISTRATIV E TRIBU NAL (TO THE EXTENT SUCH DISCLOSURE IS EXPRESSLY AUTHORIZED), OR IN CERTAIN CONDITIONS IN RESPONSE TO A SUBPOENA, DISCOVER Y REQUEST OR OTHER LAWFUL PROCESS.

LAW ENFORCEMENT: WE M AY ALSO DISCLOSE PROTECTED HEALTH INFORMATION, SO LONG AS APPLICABLE LEGAL R EQUIREMENTS ARE MET, FOR LAW ENFORCEMENT PURPOSES. THESE LAW ENFORCEMENT PURPOSES INCLUDE (1) LEGAL PROCESSES AND OTHERWISE REQUIRED B Y LAW, (2) LIMITED INFORMATION REQUESTS FOR IDENTIFICATION AND LOCATION PURPOSES, (3) PERTAINING TO V ICTIMS OF A CRIME, (4) SUSPICION TH AT DEATH H AS OCCU RRED AS A RESULT OF CRI MINAL CONDUCT, (5) IN THE EVENT THAT A CRIME OCCU RS ON THE PR EMISES OF OUR PRACTICE, AND (6) MEDICAL EMERGENCY (NOT ON O UR PR ACTICE'S PREMISES AND IT JS LIKELY THAT A CRIME HAS OCCURRED.

CORONERS, FUNERAL DIRECTORS AND ORGAN DONATION: WE MAY DISCLOSE PROTECTED HEALTH INFORMATION TO A CORONER OR MEDICAL EXAMINER FOR IDENTIFICATION PURPOSES, DETERMINI NG C AUSE OF DEATH OR FOR THE CORONER OR MEDICAL EXAMINER TO PERFOR M OTHER DUTIES AUTHORIZED BY LAW. WE MAY ALSO DISCLOSE PR OTECTED HEALTH INFORMATION TO A FUNERAL DIRECTOR, AS AUTHORIZED BY LAW, IN ORDER TO PERMIT THE FUNER AL DIRECTOR TO CARRY OUT THEIR DUTIES. WE MAY DISCLOSE SUCH INFORMATION IN R EASONABLE ANTICIPATION OF DEATH. PROTECTED HEALTH INFORM ATION M A Y BE USED AND DISCLOSED FOR CADAVERIC ORGAN, EYE OR TISSUE DONATION PURPOSES.

RESEARCH: WE M AY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO

RESEARCHERS WHEN THEIR RESEARCH HAS BEEN APPROVED B Y AN INSTITUTIONAL REVIEW BOARD THAT HAS REV IEWED THE RESEARCH PR OPOSAL AND ESTABLISHED PROTOCOLS TO ENSURE THE PRIVACY OF YOU R PROTECTED HEALTH INFORMATION.

CRIMINAL ACTIVITY: CONSISTENT WITH APPLICABLE FEDER AL AND STATE LAWS, WE MAY DISCLOSE YOU R PROTECTED HEALTH INFORMATION, IF WE BELIEVE THAT THE USE OR DISCLOSURE JS NECESSARY TO PREVENT OR LESSEN A SERIOUS AND IM MINENT THREAT TO THE HEALTH OR SAFETY OF A PERSON OR THE PUBLIC. WE MAY ALSO DISCLOSE PROTECTED HEALTH INFORMATION IF IT IS NECESSARY FOR LAW ENFORCEME NT AUTHORITIES TO IDENTIFY OR APPREHEND AN INDIVIDUAL.

MILITARY ACTIVITY AND NATIONAL SECURITY: WHEN THE APPROPRIATE CONDITIONS APPLY, WE MA Y USE OR DISCLOSE PROTECTED HEALTH INFOR MATION OF INDI VIDU ALS WHO A RE ARMED FORCES PERSONNEL (1) FOR ACTIVITIES DEEMED NECESSARY BY APPROPRIATE MILITAR Y COMMAND A UTHORITIES; (2) FOR THE PURPOSE OF A DETERMINATION BY THE DEPARTMENT OF VETER ANS AFFAIRS OF YOUR ELIGIBILITY FOR BENEFITS, OR (3) TO FOREIGN MILITARY AUTHORITY IF YOU ARE A MEMBER OF THAT FOREIGN MILITARY SERVICES. WE MAY ALSO DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO A UTHORIZED FEDER AL OFFICIALS FOR CONDUCTING NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES, INCLUDING FOR THE PROVISION OF PROTECTIVE SERVICES TO THE PRESIDENT OR OTHERS LEGALLY AUTHORIZED.

WORKERS' COMPENSATION: WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION AS A UTHORIZED TO COM PLY W ITH WORKERS ' COMPENSATION LAWS AND OTHER SIMILAR LEGALLY ESTABLISHED PROGRAMS.

INMATES: WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION IF YOU ARE AN INMATE OF A CORRECTIONAL FACILITY AND YOUR PHYSICIAN CREATED OR RECEIVED YOUR PROTECTED HEALTH INFORMATION IN THE COURSE OF PROVIDING CARE TO YOU.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made ONLY with your written authorization, unless otherwise permitted or required by law as described below. *You* may revoke this authorization in writing at any time. If you revoke your authorization, we Will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

OTHERS INVOLVED IN YOUR HEALTH CARE OR PAYMENT FOR YOUR CARE:
UNLESS YOU OBJECT, WE MAY DISCLOSE TO A MEMBER OF YOUR FAMILY, A

RELATIVE, A CLOSE FRIEND OR ANY OTHER PERSON YOU IDENTIFY YOUR PROTECTED HEALTH INFORMATION THAT DIRECTLY RELATES TO THAT PERSON 'S INVOLVEMENT IN YOUR HEA LTH CARE. IF YOU ARE UNABLE TO AGREE OR OBJECT TO SUCH A DISCLOSURE, WE MAY DISCLOSE SUCH INFORMATION AS NECESSARY II' WE DETERMINE THAT IT IS IN YOUR BEST INTEREST BASED ON OUR PROFESSIONAL JUDGMENT. WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION TO NOTIFY OR ASSIST IN NOTIFYING A FAMILY MEMBER, PERSONAL REPRESENTATIV E OR A NY OTHER PERSON THAT IS RESPONSIBLE FOR YOUR CARE OF YOUR LOCATION, GENERAL CONDITION OR DEATH. FINALLY, WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INIFORMATION TO AN A UTHORIZED PUBLIC OR PRIVATE ENTITY TO ASSIST IN DISASTER RELIEF EFFORTS AND TO COORDINATE USES A ND DISCLOSURES TO FAMILY OR OTHER INDIVIDUALS IN VOLVED IN YOUR HEALTH CARE.

2. **YOUR RIGHTS**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of , or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

Integrity Medical Group, LLC

You have the right to request restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by completing the Patient Request for Special Confidential Communication Procedures Form.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information.
This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, at (321) 765.4373 for further information about the complaint process.

This notice was published and becomes effective on 06-02-2015.

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KISSIMMEE, 206 w. Oak Street, Suite B, Kissimmee, FL 34741
LAKE MARY, 978 International Parkway, Suite 1440, Lake Mary, FL 32746
THE VILLAGES, 17820 SE 109th Avenue. Ste. 104 Summerfield, FL 34491

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