



FLORIDA INTEGRATIVE MEDICAL CENTER

2415 University Pkwy, Ste. 218, Sarasota, FL 34243 | (941) 955-6220

Notice of Privacy Practices

Effective Date: 08.01.2006

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway Ste 218, Sarasota, FL 34243, Tel: 941-955-6220, Fax: (941) 955-1410.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

- 1. Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice including, but not limited to, our doctors and nurses may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
- 2. Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
- 3. Health care operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
- 4. Optional: Appointment reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
- 5. Optional: Treatment options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
- 6. Optional: Health-related benefits and services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
- 7. Optional: Release of information to family/friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

- 8. Disclosures required by law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

- 1. Public health risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,



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- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Optional: Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Optional: Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Optional: Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to



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request a type of confidential communication, you must make a written request to Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway Suite 218 Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway Suite 218, Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. John Monhollon, Florida Integrative Medical Center, 2415 University Parkway, Suite 218 Sarasota, FL 34243, Tel: 941-955-6220, Fax: 941-955-1410. In order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr. John Monhollon, Florida Integrative Medical Center, 2415 University Parkway Suite 218 Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to contact Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway, Suite 218 Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway, Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway, Suite 218 Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: We are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway Suite 218 Sarasota, FL 34243, Tel: 941-955-6220 Fax: 7941-955-1410. Large Print Copies of this Notice are available on request.

I have received and understand the Notice of Privacy Practices.

Signature

Date



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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Florida Integrative Medical Center's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Do we have your permission to:

Leave a detailed message on your home answering machine? Yes No

Leave a detailed message on your cell phone voicemail? Yes No

Leave a message at your place of employment? Yes No

Discuss your medical care with a designated representative? Yes No

Name: _____ Relationship: _____

Phone number: _____

Name: _____ Relationship: _____

Phone number: _____

Print Name

Signature

Date



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Credit Card Authorization

Patient Name: _____ Today's Date: _____

In accordance with the Patient Financial Responsibility Policy, I understand that all payments are due at the time of service. Any charges not paid in full at the time of service, as well as any other fees charges in accordance with the Patient Financial Responsibility Policy, will be automatically charged to my credit card.

Name on card: _____

Billing address: _____

City: _____ State: _____ Zip code: _____

Card Number: _____ Exp: _____ CVV: _____

Type of card: Visa Mastercard American Express Discover

I hereby authorize Florida Integrative Medical Center (FLIMC) to maintain my credit card information on file and to charge my credit card for any services rendered if payment is not otherwise made at the time of my appointment, or if other payment methods or arrangements are not approved by FLIMC. I also authorize FLIMC to charge my credit card for any fees incurred in accordance with the Patient Financial Responsibility Policy, including, but not limited to, late, cancellation, or no-show fees and returned check fees. I understand that any charges to my credit card will appear on my credit card statement as being billed by Florida Integrative Medical Center. By signing below, I acknowledge and agree to a non-refundable 3% card processing fee for any transactions paid by card.

Signature

Date



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Permissions Consent

Do we have your permission to:

Keep your credit card on file? Yes No
(If your card is not kept on file, we cannot schedule any phone consultations to review labs, medications, or patient questions)

Charge the card on file for phone consults, labs, or any extra services? Yes No
(If your card is not kept on file, we cannot schedule any phone consultations to review labs, medications, or patient questions)

Email/mail lab results? Yes No

Send text/email reminders of upcoming appointments? Yes No

Signature

Date



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Medical Appointment Cancellation Policy

In order to effectively and efficiently provide you, your family, and all Florida Integrative Medical Center (FLIMC) patients with excellent medical care, we have developed an appointment system that sets aside ample time for each patient's appointment.

"No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. To reduce the number of such occurrences, we have implemented a Medical Appointment Cancellation Policy as follows:

1. We request that you give our office a **48-hour notice** in the event you need to cancel or reschedule your appointment.
2. If you miss an appointment and do not contact us at least 48 hours prior, we will consider this a missed appointment, and a no-show fee will be assessed to you. The "no-show" fee for Dr. John Monhollon, MD is \$100.
3. Our office makes reminder calls for appointments, however, it is ultimately the patient's responsibility to remember their scheduled appointments.
4. Any "no-show" fees will be billed to you directly, the balance of which must be paid prior to your next appointment. If you do not have a scheduled appointment, the balance is expected in a timely fashion and will be subject to collections if not paid timely.

I have read and understand the Medical Appointment Cancellation Policy and agree to the terms and conditions of this policy.

Signature

Date



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General Office Policies

At Florida Integrative Medical Center (FLIMC), we are dedicated to providing our clients with quality, comprehensive, and individualized healthcare. To ensure that your health needs are addressed in a timely and efficient manner, the following office policies are implemented.

1. **Payment is due at time of service.** We accept cash, checks, and credit cards. TO expedite your needs in a timely manner, we do require a credit card be kept on file.
2. There is a **\$30 charge** for questions submitted to Dr. John Monhollon, MD that is **outside of a normal office visit or phone consultation.**
3. Phone consultations are available to all patients and are billed at **\$6 per minute** for Dr. John Monhollon.
4. We require a **24 to 48 hour notice** for prescription refills (not including weekends). It is helpful to have your pharmacy fax our office a refill authorization form. There is a **\$30 charge** per prescription/lab requisition **outside of normal office visits or phone consultations.** You may also purchase a **\$100 package** to cover prescription/lab requisitions for one year.
5. Our refund policy is as follows:
 - All packages for IV therapies are **NON-REFUNDABLE** and **NON-TRANSFERRABLE.**
 - Supplements may be returned within **15 days** of purchase if they are **unopened.**
6. Insurance (including Medicare) is **not accepted.** Some, but not all of the services rendered at FLIMC may be covered by your insurance plan. It is **your responsibility** to know which services are and are not covered by your insurance plan and to request reimbursement from your insurance plan. CPT and ICD-10 codes will be made available at your request.
7. While in the IV room, we require that you observe the following:
 - Only one family member (when necessary) is allowed in the IV room with the patient.
 - Place cell phones on vibrate and keep usage to a minimum.
 - Use headsets with all audio devices.
 - Make sure all beverages have a lid to avoid spillage.
 - If sick, please notify the staff so that we may provide you with a mask.
 - Respect other people's privacy. Many patients prefer not to disclose their medical info.
 - Wi-Fi is available for your personal use. Please ask for the password.

I have read and understand Florida Integrative Medical Center's office policies.

Signature

Date



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Summary of the Florida Patient’s Bill of Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider or health care facility’s right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation or his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given, by the health care provider, information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request and prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if they refuse treatment or do not follow the health care provider’s instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

I have read and understand my rights and responsibilities as a patient.

Signature

Date



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Florida Integrative Medical Center Statement of Patient Financial Responsibility

The doctors and staff of Florida Integrative Medical Center (FLIMC) appreciate the confidence you have shown in choosing them to provide for your health care needs. We are committed to providing you with the best possible medical care. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full for our services. You are ultimately responsible for payment of services and care received under the care of FLIMC.

Payments

Payment Policy

Full payment is expected at the time of service. *If for some reason full payment cannot be made at the time of service, please speak with the practice Administrator prior to your office visit or services rendered to determine if a reasonable payment arrangement can be established.*

Returned Check Policy

There is a \$25.00 service charge on all returned checks. After receiving a returned check, FLIMC will only accept cash, money order, or credit card.

If you fail to meet the financial obligations agreed upon in this financial policy or other payment arrangements made with FLIMC, your outstanding balance will be sent to a collection agency and the complete balance will have to be paid before receiving any further treatment. Your future status with this office will be considered at that time and may lead to you being discharged from FLIMC.

If you have any questions, please contact our billing coordinator.

I have read and understand FLIMC’s Statement of Patient Financial Responsibility. I agree to assign insurance benefits to FLIMC where necessary. I authorize FLIMC to release information to a collection agency or attorney. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. FLIMC reserves the right to change or amend this statement at any time and at its discretion.

Signature

Date