ANASTASIA MEDICAL GROUP

PATIENT INFORMATION FORM

LAST NAME: ___________________________ **FIRST NAME**: _____________________________ **MI**: ____________

ADDRESS: ____
(Street) (City) (State) (Zip)

TELEPHONE: Home ____________________ Cell: ___________________ Work _________________ Ext.: _____

PERMISSION TO LEAVE A VOICE MESSAGE: ☐ YES ☐ NO **CONSENT TO TEXT**: ☐YES ☐ NO

EMAIL: ____
(Required if you would like secure online access to your health records)

PREFERRED METHOD OF COMMUNICATION: ☐ Home ☐ Work ☐ Cell ☐ Text ☐ Email

DATE OF BIRTH: _____/_____/______ **SOCIAL SECURITY #:** ___________________________

SEX: ☐ Male ☐ Female ☐Transgender

MARITAL STATUS: ☐ Single ☐ Widowed ☐ Married ☐ Divorced

RACE: ☐ White ☐ Black/ African American ☐ Native American/ Alaska Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Hispanic/ Latino ☐Other: _______

ETHINICITY: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other _____________ ☐ Decline to report

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other: _____________________

PREFERRED PHARMACY: ____

PRIMARY PHYSICIAN: ____ PHONE #: ______________________

REFERRING PHYSICIAN: ____ PHONE #: _______________________

EMERGENCY CONTACT:

NAME: ____ RELATION: _________________________________

TELEPHONE: Home: _____________________ Work: _____________________ Cell: ____________________

Do we have your consent to discuss your care with above person? **Yes / No**

If NO, please provide name(S) and relationship:

NAME: ____ RELATION: ________________________________

PHONE: ____

Updated 08/2019

INSURANCE INFORMATION

Primary insurance: ___________________________	Secondary Insurance: ___________________________
Primary Insurance ID #:_______________________	Secondary Insurance ID #: ______________________
Policy Holder's Name: ________________________	Policy Holder's Name: __________________________
DOB of Policy Holder: ________________________	DOB of Policy Holder: __________________________
Relationship to Patient: ______________________	Relationship to Patient: ________________________

Authorizations

Authorization for Treatment:

I consent to the rendering of medical care by Physician and/or mid-level providers (Nurse Practitioners, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designee as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for condition which has brought me to seek care at this practice. I understand that no guarantee or assurance has been made as to the results that may be obtained.

Authorization for Assignment of Benefits and Authorization to Release or Receive Medical Information:

- I hereby authorize Anastasia Medical Group, LLC and/or its Providers to release or receive medical or other information necessary for processing of insurance claims.
- I hereby authorize and assign Anastasia Medical Group, LLC and/or its providers all payments and/ or insurance Benefits for services rendered. I agree to complete any additional forms which may be required by my Insurance Plan for assignment of benefits. I understand that I am financially responsible for all amounts not covered by my insurance plan.
- In the event I receive payment from my Insurance Carrier, I agree to endorse any payment I receive to Anastasia Medical Group, LLC for which these fees are payable.
- I authorize, until further notice, that any of my medical records may be released to any physician that I am referred to and I authorize that any of my medical records be released, on a continuing basis, to my chiropractor, dentist, optometrist, audiologist, psychologist, that I am seeing, unless specified otherwise.
- I authorize disclosure of protected Health Information without prior consent in case of an emergency.
- I understand I have the right to revoke the authorizations on this form at any time by notifying Anastasia Medical Group, LLC in writing, except to the extent that Anastasia Medical Group has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing.

A Photocopy of these authorizations and agreement shall be valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY): ____

NAME: _______________________________ DATE: ___________________________

ANASTASIA MEDICAL GROUP
PATIENT HISTORY

Name: ___________________________________ Date: _______________________

Medical concern which brings you to our office: ____

Personal History:

	Alive Y/N	Medical Problems
Father		
Mother		
Brother		
Sister		
Other Family Member		

Habits:
Smoking: no / yes / ready to quit; if yes _____ packs per day ______ years
Caffeine (coffee/ tea/ cola): no / yes; if yes ___________drinks/day
Alcohol: no / yes; if yes ______ drinks/day
Other substance usage: no / yes; if yes, details_______________

Allergies/Intolerances to medicines, foods, or environmental factors:

Name:	Type of reaction	Name:	Type of reaction
1.________________	_____________________	4.______________________	____________________
2.________________	_____________________	5.______________________	____________________
3.________________	_____________________	6.______________________	____________________

Current Medications (include over the counter medications and natural remedies):

Name	Dose & frequency	Date started	Name	Dose & frequency	Date started
1. _____________________	_________	___________	6._____________________	________	___________
2. _____________________	_________	___________	7._____________________	________	___________
3. _____________________	_________	___________	8._____________________	________	___________
4. _____________________	_________	___________	9._____________________	________	___________
5. _____________________	_________	___________	10._____________________	________	___________

Past Surgery History: No / Yes; if yes please provide details:

What	When (year)	Where	Surgeon
1. _____________________	_______________________	________________________	___________________________
2. _____________________	_______________________	________________________	___________________________
3. _____________________	_______________________	________________________	___________________________
4. _____________________	_______________________	________________________	___________________________
5. _____________________	_______________________	________________________	___________________________

Additional past outpatient medical history including hospitalization history: Negative / Positive; if positive, please provide details:

What	When (year)	Where	Attending Physician's Name
1. _____________________	_______________________	_____________________	_________________________
2. _____________________	_______________________	_____________________	_________________________
3. _____________________	_______________________	_____________________	_________________________
4. _____________________	_______________________	_____________________	_________________________
5. _____________________	_______________________	_____________________	_________________________

Immunization History: Please provide your last date of immunization
Flu Vaccine: _________________________
Pneumonia Vaccine (Pneumovax and Prevnar): __________________
Tetanus vaccine: _______________________
Shingles Vaccine: ______________________

Other Examination: (Please provide name of Doctor and date **if applicable**)
Last Colonoscopy date: ___________________________ Doctor's name: ___________________________________
Last Mammogram date: ___________________________ Doctor's name: ___________________________________
Last Eye Exam date: ______________________________ Doctor's name: ___________________________________

***NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL **NOT** BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.

SIGNATURE: ________________________________ ____
(Signature and Date)

Updated 08/2019

ANASTASIA MEDICAL GROUP

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-prescribe program. These include:

- **Formulary and benefit transactions-** Gives the prescriber information about which drugs are covered by the drug benefit plan**.**
- **Medication history-** Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification-**Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Anastasia Medical Group, LLC can request and use your prescription medication history from other healthcare providers and/or third parties pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Anastasia Medical Group, LLC to enroll me in the E-prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

____	_________________________________
Signature of Patient or Guardian	**Patient DOB**
____	______________________________
Print Name	**Date**
____	
Relationship to Patient	

FIRST COAST CARE CONNECT HEALTH ALLIANCE PRIVATE HEALTH INFORMATION EXCHANGES

Notice of E-Health Information Use and Patient Rights

This provider participates in either the Baptist Connect® Private Health Information Exchange (the "Baptist Connect® PHIE"), First Coast Health Alliance Private Health Information Exchange (the "FCHA PHIE") or the CareQuality eHealth Exchange. The Baptist Connect PHIE, FCHA PHIE, and CareQuality are referred to collectively as the "PHIEs". The PHIEs form a shared health record that permits the sharing of electronic medical information between participating providers with whom a patient has a healthcare relationship. **Utilizing the PHIEs to permit timely access to your electronic medical information may make it easier for participating providers to provide you with safe and effective care, may reduce duplication of efforts and services in connection with your care and ultimately make your health care experience simpler and easier.** This type of sharing of electronic medical information is often referred to as Health Information Exchange or "E-Health", and is seen by many in the health care industry and State and federal government as an important step in promoting patient safety and patient satisfaction.

In order for you to benefit from the PHIEs, we will obtain, exchange and provide access to your electronic medical information through the PHIEs for Treatment and related Healthcare Operations purposes (as those terms are defined in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA")). While we believe that participating in the PHIEs is in your best interest, as it allows us and your other participating providers to see a more complete picture of your health, your ability to obtain treatment from us does not depend in any way on your participation in the PHIEs. Accordingly, if you do not consent to participate in the PHIEs, you may "opt out" of participation in both of the PHIEs by calling 904.819.4410 Monday-Friday during the hours of 9:00am-5:00pm. You will be deemed to have consented to participation in the PHIEs until you "opt out". If you do "opt out", you will be excluded completely from both PHIEs with respect to all participating providers, and you assume the risk that your denial may prevent *your physicians* and other participating providers from having a complete and timely picture of your health. *Note that "Opting out" does not limit any sharing of your medical information otherwise permitted without your consent by HIPAA or applicable State law, including in an emergency situation, and will not affect any previous exchange of your medical information. Also, i*f you "opt out" of participation, it may take up to 48 hours for your request to be processed.

Participating providers in the PHIEs will only re-disclose your electronic medical information to the extent permitted by applicable laws and regulations. You should be aware that if your electronic medical information contains information related to mental health, substance abuse and sexually transmissible diseases, such electronic medical information may be shared with participating providers, as well. You also have the right to receive a copy of this Notice of E-Health Information Use and Patient Rights.

Patient Name:			**Birth Date:**	
Street Address:			**Telephone No.:**	
City:	**State:**	**Zip Code:**	**Last 4 SSN:**	**Gender:**

I acknowledge that I have received a copy of this Notice of E-Health Information Use and Patient Rights and have been informed of my right to "opt out" from participation in the PHIEs in the manner described above:

____ ______________________________

SIGNATURE OF PATIENT **DATE**

If the patient is (i) a minor, the patient's parent or guardian should consent by signing below, or (ii) an adult but mentally or physically unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:

____ ______________________________

Signature of Representative *Telephone*

____ ______________________________

Name of Representative *Relationship to Patient*

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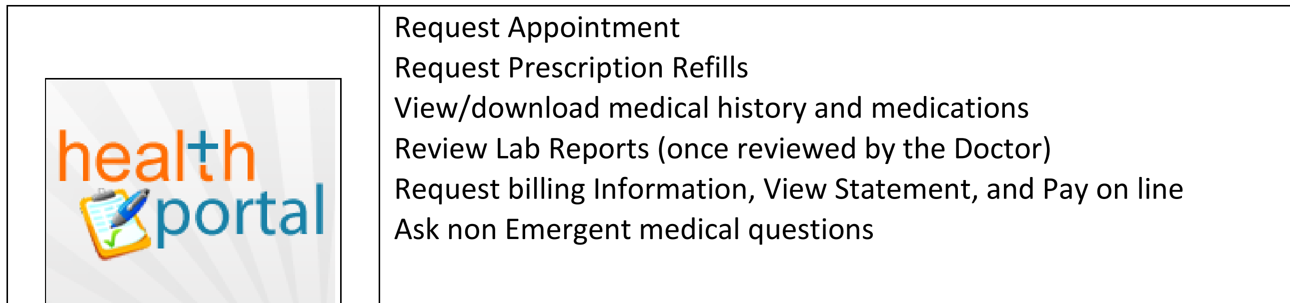
ANASTASIA MEDICAL GROUP

<u>PATIENT PORTAL ACCESS</u>

Please provide your e-mail address so you can have access to:



Request Appointment
Request Prescription Refills
View/download medical history and medications
Review Lab Reports (once reviewed by the Doctor)
Request billing Information, View Statement, and Pay on line
Ask non Emergent medical questions

E-mail Address (*Please print clearly*): ____

You can also access your health records through Healow App on your Mobile device anywhere, anytime.

You can easily link Healow App with our Practice

1.	**2.**	**3.**
Download the free app	**Enter Practice Code**	**Enter Portal username and password**

Our Practice Code: FHGCAA

Updated 08/2019

ANASTASIA MEDICAL GROUP

FINANCIAL POLICY

Welcome to Anastasia Medical Group, LLC! The office of Dr. Neerukonda, and Dr. Pereira,
Our goal is to provide you with quality state- of -the art care in a cost effective manner. In order to maintain that goal we have established the following policies to improve communication regarding appointments, medical records and your financial responsibility at the time of service or prior any scheduled surgery. If you have any questions please feel free to ask a staff member.

Your Insurance Policy: It is the policy of Anastasia Medical Group to collect any applicable co-payment, co-insurance and/or deductible at the time of service or prior to surgery. Please be aware that your insurance may require a higher co-payment for a specialist office visit.

At this time our office is a participating provider for most insurance plans and most major insurance networks. If we are not a participating provider for your insurance plan we will still file your insurance claim as a courtesy. However, you will ultimately be responsible for any fees.

If you are enrolled in a managed care insurance plan (HMO) you must obtain a referral from your Primary Care Physician (PCP) before your office visit. We will assist you in this process if applicable. Please be aware that without a referral from your PCP your visit may have to be rescheduled.

Pre-certification or authorization for a service is not a guarantee of benefits. Benefits are determined when your insurance company receives our claim. If no benefits are due you will be responsible for any balance pertaining to denied services. In certain situations there may be appeal rights for our office. If so we will attempt an appeal even without you requesting us to do so. If no appeal rights are available for our office you will be mailed a statement for the balance due. Please be aware that any appeal rights available to the patient will have to be handled by the patient.

If your insurance policy is new you may be subjected to a pre-existing conditioned waiting period. This does not apply to Medicare coverage. Any services not paid by your insurance company for this reason will be your responsibility.

Any fees we charge are for our services only. Any services provided outside our office will be billed separately by that provider. This would include laboratory, CT Scans, MRI Scans and surgery performed at the hospital or any other facility. Please speak directly with those providers regarding their fees.

Federal Law prohibits our office from writing off any balance due after your insurance company pays. Patients that are experiencing financial difficulties should speak to the office manager prior to their office visit.

Missed Appointments/Late Cancellations:
Missed appointments represent a cost to us, to you and other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to your appointment for an office visit. We reserve the right to charge $40.00 for a missed or late cancellation for an office visit. A fee of $200.00 may be applied to a missed or late cancellation of an office procedure**.** This fee is not covered by your insurance company. Excessive abuse of scheduled appointments may result in a discharge from our practice. Our office understands that emergencies do arise, but please call our office to discuss this matter with a staff member.

REFUNDS: Overpayments will be refunded upon request to the responsible party within 30 days. Please keep this in mind that an overpayment from your insurance company is not a credit to you and cannot be refunded to you.

Medical Records: Upon request we will provide you with copies of your medical records. However, this can be time consuming, so we charge $1.00 per page for first 25 pages and $0.25 per page for additional pages, with a minimum of $5.00. Your insurance company does not cover this fee. Please allow 7 business days for this request.

Your Account: You will be mailed a statement on a monthly basis for any balance due. We request that you pay upon receipt of the statement. Should you have any questions concerning your statement please do not hesitate to call our office. We will make an attempt to collect any prior balance at your office visit as well as any applicable co-payment/co-insurance and/ or deductible. Your account must be current prior to any scheduled appointments. If your account is past due then future services may be postponed. For your convenience our office accepts cash, checks, Visa and MasterCard. **There will be a $35.00 charge for returned checks. Contact Stephanie Feutz with billing questions at 904-461-0821.**

Copay/Co-insurance/Deductible: It is our policy to collect your co-pay, co-insurance and deductible at the time services are rendered**.**

Seriously past due accounts those older than 120 days or those failing to honor agreed-upon terms- will be sent to a collection agency. Our office will forward your account balance plus any fees charged by the collection agency. Once the collection agency receives your information your past due debt will be reported on your credit history. Additionally you will be dismissed from our practice for financial matters and will have to seek healthcare elsewhere.

Patient dismissal: Failure to observe these policies, demonstration of unacceptable behavior, or medical non-compliance can result in dismissal from the practice.

I hereby understand and agree to the financial policy of Anastasia Medical Group.

Patient Name: ____

Signature: ____________________________________ **Date**___________________

Updated 08/2019

ANASTASIA MEDICAL GROUP, LLC
1301 Plantation Island Drive South, Suite 203A, St. Augustine, Florida 32080
Phone #: (904) 461-0821, Fax #: (904) 461-0823

NOTICE OF PRIVACY PRACTICES

Effective Date: November 18, 2013

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

1. **Your Rights**

You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

2. Your Choices

You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

3. Our Uses and Disclosures

We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

4. Our Responsibilities
- **Maintain the privacy and security of your protected health information**

1. Your Rights

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

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this by contacting our Privacy Officer.
- We will provide a copy or a summary of your health information, usually within 30 days of your written request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us in writing to correct health information about you that you think is incorrect or incomplete. Ask us how to do this by contacting our Privacy Officer.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us in writing to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Ask us how to do this by contacting our Privacy Officer.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us in writing not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. Ask us how to do this by contacting our Privacy Officer.
- **If you pay for a service or health care item out-of-pocket in full**, you can ask us in writing **not to share** that information for the purpose of payment or our operations with your **health insurer**. We will say "yes" unless a law requires us to share that information. Ask us how to do this by contacting our Privacy Officer.

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

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Ask us how to do this by contacting our Privacy Officer.

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

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

2. Your Choices

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

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

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

In these cases we never share your information unless you give us **written permission**:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you have the right to opt out, and we will honor your request if you tell us that you would not like to receive these communications.

3. Our Uses and Disclosures

How do we typically use or share your health information?
- We typically use or share your health information in the following ways.

Treat you
- We can use your health information and share it with other professionals who are treating you.
- *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Bill for your services
- We can use and share your health information to bill and get payment from health plans or other entities.
- *Example: We give information about you to your health insurance plan so it will pay for your services.*

Run our organization
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- *Example: We use health information about you to manage your treatment and services.*

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

Help with public health and safety issues

We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
- We can use or share your information for health research, so long as we obtain documentation that an alteration to or waiver of the individual authorization has been approved by either an Institutional Review Board (IRB) or privacy board.

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

Respond to organ and tissue donation requests
- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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

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

Respond to lawsuits and legal actions

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

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

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.
http://www.anastasiamedicalgroup.com/

Privacy Officer

If you would like to contact us for information about this notice or to complain about our privacy practices, please contact:
Kalpana Shrestha, Privacy and Security Officer
Anastasia Medical Group, LLC
1301 Plantation Island Drive South
Suite 203A, St. Augustine, Florida 32080
Phone #: (904) 461-0821, Fax #: (904) 461-0823

Other Instructions for Notice

Under Florida law, we will never share treatment records without your written permission for the following areas, unless an exception applies:
Alcohol and substance abuse
Genetic testing
HIV/AIDS
Mental Health

Acknowledgement

You will be asked to sign an acknowledgement of your receipt of this Notice of Privacy Practices. We are required by law to make a good faith effort to provide you with our Notice of Privacy Practices and obtain such acknowledgment from you. However, your receipt of care and treatment from Anastasia Medical Group, LLC is not conditioned upon your providing the written acknowledgement.

Acknowledgement of Receipt

I hereby acknowledge that I have received and reviewed a Copy of Anastasia Medical Group, LLC's Notice of Privacy Practices.

____ Date___________________________

(Signature of patient or patient's representative)

Printed name of patient/patient's representative: ____

Relationship to the patient: ____

Updated 08/2019

ANASTASIA MEDICAL GROUP

1301 PLANTATION ISLAND DRIVE SOUTH, SUITE 203A, ST. AUGUSTINE, FL32080
PHONE #: (904) 461-0821, Fax #: (904) 461-0823

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. PATIENT INFORMATION	NAME:____________________ DATE OF BIRTH: ______________ SSN #: ____________ ADDRESS:____________________ TELEPHONE #: ________________
2. TYPE OF RELEASE AUTHORIZATION **PHYSICIAN INFORMATION**	☐ I AUTHORIZE ANASTASIA MEDICAL GROUP **TO RELEASE** MEDICAL RECORDS INFORMATION **TO:** ☐ I AUTHORIZE ANASTASIA MEDICAL GROUP **TO OBTAIN** MEDICAL RECORDS INFORMATION ON ME **FROM**: NAME OF PHYSICIAN: ____________________ ADDRESS: ____________________ PHONE #: ______________ FAX #: ____________
3. PURPOSE FOR REQUEST	☐ CONTINUITY OF CARE ☐ ATTORNEY ☐ PERSONAL ☐ INSURANCE CLAIM ☐ CHANGE OF INSURANCE ☐ OTHER: ____________________
4. INFORMATION NEEDED (CHECK OFF ALL THAT APPLY)	☐ ALL ☐ LABORATORY RESULTS ☐ X-RAY REPORTS ☐ HISTORY AND PHYSICAL ☐ IMMUNIZATION RECORD ☐ OTHER: ____________________

I specifically consent to release information relating to: (initial selection)

STD ________ HIV/AIDS __________ TB __________ Drug/Alcohol __________ Mental Health __________ WIC Eligibility ___________

EXPIRATION DATE: This authorization will expire on (____). I understand that if I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form. I understand that I may inspect or copy the information to be used or disclosed in 45 C.F.R. 164.524.

REVOCATION: I understand that I have the right to revoke this authorization any time in writing. I understand that the Practice shall not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. 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, Medicaid and Medicare when the law provides my insurer with the right to contest a claim under my policy.

Patient's /Legal Representative Signature: ______________________________________ Date: ___________________________________

If signed by Legal Representative, relationship to patient: ____________________________________

Updated 08/2019