Atlas Injury to Health

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: _____/_____/_____ Gender: MALE / FEMALE AGE: _____

LAST NAME: _____ FIRST NAME: _____

DOB: ___/____/____ SOC.SEC#_____/_____/_____ MARITAL STATUS: Married/Single/Divorced/Widow

HOME ADDRESS: _____

CITY: _____ STATE: _____ZIP:_____

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

EMAIL: _____@_____.COM

EMPLOYER: _____ OCCUPATION: _____ PHONE #: (___) _____

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

FAMILY PHYSICIAN: _____PHONE#: (___) _____

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: _____

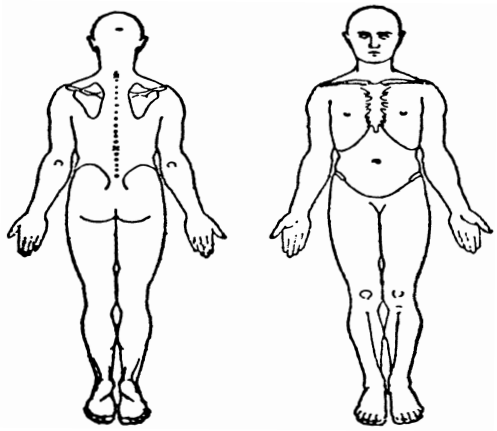
SIGNATURE: _____DATE: _____

Winter Garden
424 N. Dillard St. Winter Garden, FL 34787
Phone: 404-656-0390 Fax: 407-656-3395

Atlas Injury to Health

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:** _____

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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: _____ MARITAL STATUS: _____ CHILDREN: _____

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

Allergies to any medications: _____

Surgical History: _____

Occupation: _____

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:** _____

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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 **Atlas Injury to Health** 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 **Atlas Injury to Health** 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 **Atlas Injury to Health** 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: _____

_____

SWORN AFFIDAVITT

_____ I have been a lawful resident of the State of Florida since _____. I do not own a motor vehicle for which "no-fault / personal injury protection" security is required by the Florida Automobile Reparations Act (F.S. 637.730, 621.741). Nor am I a resident member of a household, or of a relative, who owned a motor vehicle requiring such security, and had no other relative, who owned a motor vehicle requiring such security, and had no other available "no-fault" coverage or insurance affording benefits under the Florida Automobile Reparations Act.

_____ I further state that at the time of the accident occurring on _____I was **not injured in the scope of my employment** and said injury for which I am claiming "no-fault" benefits was **not covered under any Worker' Compensation Act.**

_____ I further state that I am lawfully entitled to "no-fault" benefits being sought under the policy# _____ issued by _____.

_____ I am also aware that under the Florida Fraud Statute that "any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony of the third degree."

PATIENT SIGNATURE: _____ **DATE:** _____

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ATTORNEY'S INFORMATION:

_____ Patient Name: _____

_____ SSN: _____

_____ DOB: _____

I hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or result of the injuries for which I have been treated for injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that which I may eventually recover said fee.

Patient Signature: _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment, or verdict as may be necessary adequately to protect the said doctor named above.

Date: _____ Attorney Signature: _____

To Attorney:

Please date, sign and return one copy to doctor's office at once.
Keep one copy for record.

Michael St. Louis, D.C.

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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 **Atlas Injury to Health**

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.

SIGNATURE: _____ **DATE:** _____

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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.

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

Patient's Signature: _____
(Signature of parent/guardian for minors)

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Patient's Name: _____ DOB: _____

Social Security #: _____ D/A: _____

I request and authorize: _____

To release healthcare information of the patient named above to: **Atlas Injury to Health**
424 N. Dillard St., Winter Garden, FL 34787 ♦ Ph: (407) 656-0390 Fax: (407) 656-3395

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 **Atlas Injury to Health** 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 **Atlas Injury to Health t**o 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

Atlas Injury to Health

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
Atlas Injury to Health 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.

Atlas Injury to Health 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
Atlas Injury to Health 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.

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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.

Atlas Injury to Health

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.

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 TH AT YOU HAV E BEEN A VICTIM OF ABUSE, NEGLECT OR DOM ESTIC V IOLENCE TO THE GOVER NMENTAL ENTITY OR AGENCY A UTH O R I Z E D 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 A ND DRUG ADMINISTR ATION FOR THE PURPOSE OF QU ALITY, SAFETY, OR EFFECTIVENESS OF FDA- REGULATED PRODUCTS OR ACTIVITIES INCLUDING, TO REPORT ADVERSE EVENTS, PRODUCT DEFECTS OR PROBLEM, BIOLOGIC PRODUCT DEVIATIONS, TO TRACK PRODUCTS; TO ENABLE PRODUCT RECALLS; TO M AKE REPAIRS OR REPLACEMENTS, OR TO CONDUCT POST MARKETING SURV EILLANCE , 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 A ND 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.

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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 A ND 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 A NS AFFAIRS OF YOUR ELIGIBILITY FOR BENEFITS, OR (3) TO FOREIGN MILITAR Y AUTHORITY IF YOU ARE A MEM BER 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 WITH WORKERS ' COMPENSATION LAWS AND OTHER SIMILAR LEGALLY-ESTABLISHED P ROG R A MS .

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.

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Atlas Injury to Health

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 INI'ORMATION 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.

Atlas Injury to Health

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 (407) 656.0390 for further information about the complaint process.

This notice was published and becomes effective on 02-22-2018.

Winter Garden
424 N. Dillard St. Winter Garden, FL 34787
Phone: 404-656-0390 Fax: 407-656-3395

Atlas Injury to Health

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.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

Winter Garden
424 N. Dillard St. Winter Garden, FL 34787
Phone: 404-656-0390 Fax: 407-656-3395

Atlas Injury to Health

REQUEST FOR SPECIAL CONFIDENTIAL COMMUNICATIONS PROCEDURES

*****PLEASE CHECK ALL THAT APPLY AND FILL-IN-THE BLANK WITH PROPER INFORMATION**.***

_____I hereby request that **Atlas Injury to Health** request that all written communications to be mailed only to the following address:
_____.

_____I hereby request that **Atlas Injury to Health** request that all telephone calls placed to me only be placed to: _____.

_____I hereby request that **Atlas Injury to Health** request that no voice mail messages be left on the above listed or any other telephone listings relating to me.

_____ _____

Patient's Signature Patient's Date of Birth

For Use by Privacy Officer Only

Practice: ____ Accepts _____ Denies

Signature of Privacy Officer: _____

Date: _____

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