Patient Registration Form

David Greene, MD, LLC
1112 Goodlette Rd. North, #203
Naples FL, 34102

Patient Information

Patient Information:

First Name:	**Last Name:**	M.I.:	Previous Name (if applicable)
Sex: ☐ Male ☐ Female ☐ Other	Date of Birth:		Social Security #:
Cell Phone:	**Email**:		**Home Phone:**
Home Address:	Apt #		Work Phone:
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐**Text** ☐**Email** ☐**Voice**			If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work
Primary Care Provider:	Phone:		Fax:
Home Address- (out of town):	Phone (up North/out of town):		Marital Status: ☐Divorced ☐ Married ☐ Single ☐ Other_____
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Preferred Pharmacy Name & Location:

Pharmacy name:	**Pharmacy Address:**	**Pharmacy Phone #:**

Demographics

Preferred Language (please select one): ☐ English ☐ Spanish ☐ Sign Language ☐ Other_____

Ethnicity/Race (please select one or more): ☐ Hispanic or Latino ☐ White ☐ Hispanic ~☐ Other
☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Decline

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to DAVID GREENE MD, LLC's (DGMDLLC) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to DGMDLLC all money to which I am entitled for medical expenses related to the services performed from time to time by DGMDLLC, but not to exceed my indebtedness to DGMDLLC. I authorize DGMDLLC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from DGMDLLC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on the DGMDLLC Public Website. I certify I have read & received the Notice of Privacy Practices.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to DGMDLLC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party:X _____ **Date**:

Printed Name of Responsible Party:X _____ **Date:**

Rev.
5/2020
mrb

ENT NEW PATIENT MEDICAL HISTORY FORM

David Greene, MD, FACS, FARS

Board Certified, Otolaryngology
Nasal, Sinus & Facial Plastic Surgery

Name _____

Date _____

DOB _____

Referring Provider _____

CHIEF COMPLAINT / REASON FOR VISIT

_____

_____

_____

_____

_____

_____

_____

ALLERGIES TO MEDICATION ***YES*** ***NO*** *(please list allergy and the reaction to that medication. eg. Rash, hives, swelling, anaphylaxis.)*

_____

_____

_____

MEDICATIONS *(please list all medications you are currently taking including vitamins, supplements & over the counter meds.)*

_____

_____

_____

_____

REVIEW OF SYSTEMS *Do you currently or frequently have any of these symptoms? (Circle answers)*

Constitutional				
Fatigue	No	Yes		
Fever	No	Yes		
Weight loss	No	Yes		
Weight gain	No	Yes		
Ears				
Hearing Loss	No	Yes	R	L
Ear Pain	No	Yes	R	L
Ear drainage	No	Yes	R	L
Ringing in Ears	No	Yes	R	L
Dizziness	No	Yes		
Nose				
Nasal Congestion	No	Yes		
Post Nasal Drainage	No	Yes		
Sinus Infections	No	Yes		
Runny nose	No	Yes		
Nose Bleeding	No	Yes	R	L
Congestion	No	Yes		
Decreased smell	No	Yes		
Sinus pain	No	Yes		
Throat/Mouth				
Change in Voice	No	Yes		
Trouble Swallowing	No	Yes		
Sore Throat	No	Yes		
Snoring	No	Yes		
Phlegm	No	Yes		
Excess throat mucus	No	Yes		
Oral sores/growths	No	Yes		
Neck / Lymphatic / Endocrine				
Neck lump/mass	No	Yes		
Swollen glands	No	Yes		
Thyroid problems	No	Yes		
Lungs				
Short of Breath	No	Yes		
Wheezing	No	Yes		
Cough	No	Yes		
Heart				
Chest pain	No	Yes		
Gastrointestinal				
Heartburn	No	Yes		
Indigestion	No	Yes		
Neurological / Psych				
Headaches	No	Yes		
History of falls	No	Yes		
Depression	No	Yes		
Anxiety	No	Yes		
Skin				
Rash	No	Yes		
Skin cancer	No	Yes		
Musculoskeletal				
Arthritis	No	Yes		

Blood

Bleeding/Bruising	No	Yes
Blood thinners	No	Yes
Aspirin	No	Yes
Ibuprofen etc.	No	Yes

Allergic / Immune

Seasonal Allergies	No	Yes
Food Allergies	No	Yes
Latex Allergy	No	Yes
Frequent Infections	No	Yes

SOCIAL HISTORY

Tobacco

Smoking-ever	No	Yes
Smoking-current	No	Yes
1 pack/day (less than 20)	No	Yes
2 packs/day (up to 40)	No	Yes
Chewing tobacco	No	Yes

Alcohol

Alcohol-ever	No	Yes
Alcohol-current	No	Yes
Over 3 drinks daily	No	Yes

Other

Caffeine	No	Yes _____/day
Vaping	No	Yes
Recreational drugs	No	Yes _____type

VACCINATIONS

Pneumonia Shot	No	Yes ____/____/_____
Influenza Shot	No	Yes ____/____/_____

CURRENT HEIGHT/WT

Height:_____ft _____in Weight:_____lbs

PAST MEDICAL HISTORY (circle all that apply - please add any additional medical history)

Anesthesia Complications	No	Yes	GERD/Reflux	No	Yes
High Blood Pressure	No	Yes	Sleep Apnea	No	Yes
Diabetes	No	Yes	Thyroid Disease	No	Yes
Autoimmune Disorder	No	Yes	Heart Disease	No	Yes
Stroke / TIA	No	Yes	Lung Disease	No	Yes
COPD/Emphysema	No	Yes	MRSA* skin infection	No	Yes
Bleeding Disorder	No	Yes	Hepatitis	No	Yes
Skin Cancer	No	Yes	Head or Neck Cancer	No	Yes
Cancer	No	Yes	Other Chronic Illnesses	No	Yes
AIDS or HIV	No	Yes			

*OTHER:*_____

PAST SURGICAL HISTORY *(circle all that apply - please add any additional surgical history)*

Septoplasty Nasal fracture repair Rhinoplasty Sinus surgery Turbinate surgery Dental implants

Tonsillectomy Adenoidectomy Ear Tubes Ear surgery (other than tubes) Esophagus surgery

Vocal cord surgery O*THER:*_____

HOSPITALIZATIONS No Yes Describe_____

ACCIDENTS No Yes Describe_____

FAMILY HISTORY

High blood pressure Diabetes Hearing loss Sleep Apnea Heart Attack Stroke

Diseases in Father: _____

Diseases in Mother: _____

**Any problems with excessive bleeding or anesthesia related problems in your family members?*

No Yes Describe_____

*Other information not listed above*_____

_____

_____

_____

The above information is true and complete to the best of my knowledge.

Name (printed)_____ ***Signature*** _____ ***Date***_____

PATIENT FINANCIAL & ADMINISTRATIVE AGREEMENT

DAVID GREENE MD LLC is committed to providing you with the best possible care. Your clear understanding of our financial and administrative is important to our professional relationship. Please ask if you have any questions about your responsibilities as a patient when receiving care in our offices.

Patients must fill out patient information forms prior to seeing the doctor. A current insurance card and valid picture ID is required at each visit. You must inform us of any insurance changes prior to making an appointment or being seen.

Definitions
For purposes of this Agreement, the terms "we", "our" the "practice" and "DAVID GREENE, MD, LLC " shall mean DAVID GREENE, MD, LLC (DGMDLLC) and the terms "I", "my", "you" and "your" refer to the patient or responsible party for such patient executing this Agreement.

Referrals & Pre-authorizations
If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, you will be personally responsible for that day's services, and we will file with your insurance on your behalf.

Co-Payments
We are REQUIRED to collect your carrier designated co-pay, co-insurance, and deductibles by the terms of our contract with your insurance company or per CMS rules. This payment is required at the time of service. Please be prepared to pay these required payments at each visit. Should you not pay at the time of service, an administrative fee of $20 may be added to your account.

Commercial Insurance Carriers
We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, copayments and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated. If your insurance company requires preauthorization for services it is your responsibility to obtain preauthorization before treatment begins.

Coverage Changes
If your insurance changes, please notify us before your next visit so we can make the appropriate changes to obtain insurance coverage. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Out Of Network
It is your responsibility to determine whether our practice is "in network" for your insurance plan or not. If our practice is considered "out of network" with your insurance , then you will be responsible for your out of network copayment and deductibles which are usually higher than your in network responsibilities. If your insurance plan does not have "out of network benefits," then you will be directly responsible for the cost of your services from this practice.

Medicare
Our office is a Medicare participating provider and we will bill Medicare for you. We will also bill your secondary insurance for you. Any balance not paid by Medicare and your secondary insurance will be your responsibility.
DAVID GREENE, MD, LLC is a Medicare Part B provider. We will accept assignment on all Medicare Part B claims. By accepting assignment, we agree to adjust your charges to reflect the Medicare approved amount. However, Medicare only pays 80% of the approved amount, and the remaining 20% is your responsibility. If you have supplemental insurance, we will bill your supplement insurance for the 20% balance. If there is any remaining balance after Medicare and the supplement insurance payment, it is the patient's responsibility.

Self-Pay Patients

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Patients without health insurance will be expected to pay in-full at the time of service. A minimum of $200 will be charged for the visit at the time of check in. An estimate will be provided of the cost of the visit prior to checking in.

Worker's Compensation

If your visit is work- related we will need the case number and carrier name prior to your visit in order to correctly bill your workers compensation insurance carrier. This practice DOES NOT PARTICIPATE in Worker Comp insurance, but does care for Worker's Comp patients on a special basis requiring the carrier to contract with us for each case individually. Your CASE MANAGER or ADJUSTER will need to make the appointment.

Automobile Accidents

If your visit is auto-accident related we will need the case number and carrier name prior to your visit in order to bill the car insurance company. If at any time during your visits you exceed your limit set by the car insurance carrier you will be responsible for the remaining balance. At this time, we can bill your primary health insurance if you would like, but if they do not pay, the balance will be the patient's responsibility. Our office does not accept Letters of Protection for any services that are rendered once your PIP benefits have been exhausted, these services must be paid at time of visit.

Methods of Payment

Our office accepts the following payment methods: Cash, Money Orders, Credit Cards and Care Credit as a credit. WE DO NOT ACCEPT PERSONAL CHECKS. For returned checks, we assess a $30.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office. If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, the patient agrees to pay all additional fees assessed in the collection of debt. These fees include collection agency fees and attorney fees. Unsubstantiated credit card disputes will incur a $35 administrative fee. The patient is ultimately responsible for all fees for services.

Usual, Reasonable and Customary

Some insurance carriers have established "usual" and "reasonable and customary" maximum amounts that they will pay for specific procedures. These amounts may vary with each insurance plan. Any amount considered in excess of the "usual" and "reasonable and customary" amount that is not paid by the insurance company, becomes the patient's responsibility.

Non-Covered Services

Not all services are covered by all insurance health plans. Some services may not be covered by your specific or individual policy. Services not covered or considered not payable by the insurance company become the patient's responsibility.

Insurance Claims

Your insurance is a contract between you and your insurance company. It is your responsibility to understand your insurance plan benefits. We will bill your primary insurance company if we are contracted providers. In order to properly bill your insurance company, we require that you disclose ALL insurance information including primary and secondary insurance, as well as any change of insurance information PRIOR to receiving services. Failure to provide complete and accurate insurance information may result in the entire bill being your responsibility.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Once the claim is processed, if there is any additional liability you will be billed accordingly.

Services unexpectedly denied by your insurance plan due to retroactive terminations, Coordination of Benefits (other health insurance that may be primary) denials, payment offset due to retroactive termination, failure to respond to your insurance plans

with requested information or failure to provide our office with any NEW health insurance changes are all reasons patients may be responsible for payment of services received in our office. All of these circumstances are beyond our control. It is the patient's responsibility to resolve any issues that arise with their eligibility and benefits.

Minor Children

The parent who consents to the treatment of a minor child is responsible for payment of services rendered to DAVID GREENE, MD, LLC for any services furnished. We do not promise nor are we obligated to send bills, patient records or related communications to the other parent/legal guardian pertaining to issues of payment or communications.

Payment in Full

Payment in full is required at the time of service. Copays, deductibles, and co-insurance are collected at check-in. All outstanding patient balances from prior visits and services must be paid in full prior to scheduling additional appointments, or receiving further services with our practice. This policy exists to help people avoid running up large bills.

Nonpayment

If your account is over 90 days, you may receive a courtesy phone call to remind you that payment is due in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if this courtesy call is unanswered, or the balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed Appointments

We require cancellation at least 24 hours in advance of the appointment time, so as to provide appointments to care for other patients. Therefore, we reserve the right to charge for "no-shows," and missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. No-shows (with no notice) will be charged a fee of $75. Late cancellations (with less than 24 hours' notice) will be charged a fee of $50.00. Multiple "no shows" and late cancellations will result in termination from our practice. Please help us to serve you better by keeping your regularly scheduled appointment and calling at least 24 hours in advance if you need to cancel or reschedule.

Other Non-Covered Services

There will be a professional fee for the completion of Disability, Insurance Forms, and Other Forms as insurance does not cover this service. Alternatively, you may be required to schedule an appointment. Payment is due prior to performance of the service. We transmit copies of our medical records to your other physicians from our office free of charge, to facilitate continuity of care. It is your responsibility to provide exact information to us to facilitate this transfer of records. If you want a hard copy of your medical records, the cost is not covered by insurance, and there is a charge to defray the expense of up to $1.00 per page to produce the chart. A signed release of medical records request form is required, and payment must be received prior to the printing and production of your medical records for release. Please allow up to 30 days for this request to be processed.

Communication

From time to time, we may need to communicate with you electronically. Your signature is your consent to receive calls, text messages and emails from DAVID GREENE, MD, LLC and its Business Associates regarding your account information, which may contain Personal Health Information (PHI), at the listed phone number(s) below, including my wireless number provided. You understand you may be charged for such calls by your wireless carrier and that such calls may be generated by an automated dialing system.

Notice to Patients

We will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary.

Acknowledgement of Insurance Rules Regarding Office Diagnostic & Medically Necessary ENT Procedures

Please be aware that, in order to determine the correct diagnosis so that the most appropriate treatment can be recommended for your medical condition, your ENT doctor may need to perform certain in-office procedures which enable that diagnosis to be made. These procedures are not part of the basic examination, and your insurance may include them in your deductible. Every insurance is different, and your doctor has no control in this matter. If performed, these diagnostic procedures are billed as an additional item charge on your office visit statement. Although these procedures are purely diagnostic in nature, your particular insurance carrier may classify them as "surgical procedures." If so, the charge may be subject to the surgical deductible of your particular insurance plan. As per the rules of your insurance carrier, you may be responsible for covering any deductible payment. Also note that sinus debridement, by insurance and federal rules, is not included as part of the sinus surgery done in the operating room. It is an independent and separately billed procedure per insurance and federal rules. We follow strict federal and state billing and coding guidelines. The most common diagnostic procedures which may fall under your surgical deductible are Nasal Endoscopy, Nasopharyngoscopy, Flexible Laryngoscopy, and Sinus Debridement.

Telemedicine Visits

DAVID GREENE MD LLC offers Telemedicine visits. This means that patients can have visits with Dr. Greene via audiovisual equipment. I hereby consent to Telemedicine Visits terms and conditions. I also understand that: I can decline the Telemedicine Visit service at any time without affecting my right to future care or treatment. Dr. Greene cannot provide all services remotely and I may have to travel to see Dr. Greene in person for these services. The same confidentiality protections that apply to my other medical care also apply to the Telemedicine service. I will have access to all medical information resulting from the Telemedicine service as provided by law. The information from the Telemedicine service is protected the same as all other medical records. I will be informed of all people who will be present at all sites during my Telehealth service. I may exclude anyone from any site during my Telemedicine service. I also understand that my insurance will be billed for this visit, that I may be billed for what my insurance does not cover.

Age of Coronavirus / COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I understand COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that DGMDLLC is closely monitoring this situation and has implemented reasonable preventative measures aimed at reducing the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of being out of my home and around other people. I understand even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. All patients and staff must wear masks to protect each other.

Additionally, I understand that even after the state and federal governments allow elective surgery to proceed, COVID-19 will continue to be a risk with or without surgery but increased by surgery. I understand possible exposure to COVID-19 before/during/after my surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

Authorizations & Assignment of Benefits

I authorize DAVID GREENE, MD, LLC to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to DAVID GREENE, MD, LLC. I understand that I am financially responsible to the Provider for all charges, for any balance or fee not covered in the event that I have no insurance, or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

Private Insurance Authorization for Assignment of Benefits / Information Release – I, the undersigned, authorize payment of medical benefits to DAVID GREENE, MD, LLC for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to DAVID GREENE, MD, LLC for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

I declare that all information presented at the date of service is complete and accurate. In the event that insurance is inaccurate or incomplete the patient will be responsible for all charges incurred.

I have read and fully understand this information and I agree to accept financial responsibility for the unpaid balance of all accounts in the event the following authorization is insufficient to liquidate the account.

I consent to retrieve my prescription history into my medical record in the electronic medical record system of this practice.

I consent to this medical record being allowed to interface with the immunization registry.

I acknowledge this practice may use off-site scribes to type encounter notes and perform data entry into the electronic medical record.

I hereby assign and transfer any insurance benefit due me for the professional services that I have received to DAVID GREENE, MD, LLC. My practice has documented that this Patient has provided their prior express consent to receive automated text and voice messages at the phone number(s) above.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you, including but not limited to home phone, work phone, cell phone, text and email, or any other phone numbers, in compliance with the Telephone Consumer Protection Act (TCPA).

I have read and understand the practice's financial and administrative policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Patient Name (Printed) _____

Patient Signature_____

Date_____

Responsible party name_____ ***Responsible party signature***_____

Relationship_____ ***Date***_____

ACKNOWLEDGEMENT OF MEDICALLY NECESSARY PROCEDURES THAT YOUR INSURANCE MAY APPLY TO YOUR DEDUCTIBLE

Please be aware that, in order to determine the correct diagnosis so that the most appropriate treatment can be recommended for your medical condition, your physician may need to perform certain in-office procedures which enable that diagnosis to be made.

If performed, these diagnostic procedures are billed as an additional item charge on your office visit statement. Although these procedures are purely diagnostic in nature, your particular insurance carrier may classify them as "surgical procedures." If so, the charge may be subject to the surgical deductible of your particular insurance plan. **As per the rules of your insurance carrier*, you will be responsible for covering any deductible payment*.**

DAVID GREENE, MD, LLC and the Florida Sinus Institute follow strict federal and state billing and coding guidelines. The most common diagnostic procedures which may fall under your surgical deductible are Nasal Endoscopy, Nasopharyngoscopy, Flexible Laryngoscopy, Cerumen (Wax) Removal, Ear Microscopy, and Sinus Debridement.

I acknowledge that I have read and understand the above disclosure.

Name_____

Signature_____

Date_____

DAVID GREENE, MD, LLC
1112 Goodlette Road North
Suite 203
Naples, FL 34102
239-263-8444

NOTICE OF PRIVACY PRACTICES

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.

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. A copy of this Notice can be obtained on our website at www.davidgreenemd.com.

Inspect and Copy. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. You must submit a written request to your physician in order to inspect and/or obtain a copy of your health information. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Request an Amendment. You can ask us to correct health information about you that you think is incorrect or incomplete. To request an amendment, complete and submit a *Request for Amendment of Protected Health Information (PHI)*. We may deny, or say "no" to your request for an amendment, but will tell you why in writing within 60 days.

Request Confidential Communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. To make a request for confidential communications, you must complete and submit the *Request for Restriction Confidential Communication.* We will accommodate all reasonable requests.

Request Restrictions. You can ask us 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. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. Unless required by law to share that information, these request are approved or we be approved. To request a restriction on the health information we use or disclose about you, you must submit a written request by completing our *Request for Restrictions on Use and Disclosure* form.

Request an Accounting of Disclosures. You can ask 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. To obtain this list, you must submit in writing your request. 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.

Right to a Copy of This 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.

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 on your behalf before we take any action.

File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer, Astara N. Crews at 560 White Plains Road, Ste. 615; Tarrytown, NY 10591; tel. (914) 333-5896 or reception@davidgreenemd.com. We will not intimidate and/or retaliate against any individual who, in good faith, reports a complaint.

You can 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

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.

For Treatment. We can use your health information and share it with other healthcare professionals who are treating you. We may use and disclose your protected health information to provide, coordinate, or manage your medical treatment and related services. For example, your physician may ask another physician about your overall health condition.

For Health Care Operations. We can use and share your health information to run our practice, improve your care and contact you when necessary. For example, we may also use your health information about you to manage your treatment and services.

For Payment. We can use and share your health information to bill and get payment from health plans or other entities. For example, we may tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

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.**

Public Health Activities 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

Research. We can use or share your information for health research.

Required By 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.

Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank.

Coroners, Medical Examiners and Funeral Directors. 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

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.

Most disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and disclosures that constitute the sale of your health information require your prior written authorization. We may, however, provide you with marketing materials in a face to face encounter without your authorization or communicate with alternatives or other health related products and services that may be beneficial to you in relation to your treatment.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you. In order to disclose these types of records for purposes of treatment, payment and health care operations, we will have a special written authorization that complies with the law governing HIV or substance abuse records, when required by applicable law.

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, let us know.

Family and Friends. We may disclose to your family members or friends health information about you which is directly relevant to their involvement in your care or payment for your care, if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. Additionally, we may use or disclose your protected health information to notify or assist in the notification of a family member or friend responsible for your care or your location, general condition or death.

OUR RESPONSIBILITY

- 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. You may change your mind at any time. Please let us know in writing when you have changed 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 inform

This notice is effective as of 5/8/2020

David Greene, MD, FACS
Otolaryngology, Nasal & Facial Plastic Surgery
Florida Sinus Institute
1112 Goodlette Road N. #203
Naples, FL 34102

Patient Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Other: _____

I authorize _____ to release healthcare information to:

Facility/Company: **David Greene, MD, FACS**

Address: 1112 Goodlette Road N. #203 City: Naples State: FL Zip: 34102

Phone #: 239-263-8444 Fax: **239-308-0894**

I authorize the release/disclosure of the following healthcare information:

☒ Visit Note(s) ☒ ED Records ☒ Diagnostic Imaging Report(s) ☒ **Laboratory** Report(s)
☒ Pertinent Records ☒ Immunization Record(s) ☐ Diagnostic Imaging Film(s) ☐ Billing Record(s) ☐
☒ Plan of Care ☒ Medication Record(s) Other (describe)_____

Dates of information to be disclosed: from _____ to _____

Purpose of disclosure: ☐ Insurance ☐ Legal ☒ Physician ☐ Self ☐ Research ☐ AFH/ALF ☐ Other _____

Is disclosure to an employer or fi nancial institution? ☐ Yes ☐ No (if yes, authorization expires 1 year after signing)

This authorization may include the release of the following sensitive medical information **unless specifically excluded** (please check if you do **NOT** want this information released): ☐ Sexually Transmitted Disease
☐ AIDS/HIV Diagnoses Report(s) ☐ Alcohol/Drug Abuse or Treatment ☐ Mental Health

DAVID GREENE MD LLC is hereby released from all legal responsibilities or liability for the release of the above-mentioned information.

REDISCLOSURE: Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of Alcohol and Drug Abuse records, which are protected by Federal Confidentiality Rules that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing to DAVID GREENE MD LLC the at the address listed above. **I understand that I do not have to sign this authorization in order to receive Health Care treatment.** I further understand that if I request records for personal use, or for parties not involved in my health care, there may be a charge.
This authorization expires on_____ or when the following event occurs _____
If there is no expiration date given, this authorization will expire one year from the date of signature. If the disclosure is to an employer or financial institution this authorization expires 1 year after signing.

Signature: _____ Date: _____
(If signed by a personal representative of the patient, please complete the following)

Personal Representative's Name: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian* ☐ Holder of a Power of Attorney* ☐ Executor of Estate*
*Please attach Legal Documentation if you are the Legal Guardian, Power of Attorney or Executor of Estate

PLEASE PROVIDE A COPY OF A GOVERNMENT ISSUED PHOTO ID

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION
FORM ID ADM 536
Approved 05/2020

APPLY PATIENT LABEL HERE

MR