MANATEE CARDIOVASCULAR WELLNESS INSTITUTE

NEW PATIENT REGISTRATION

(Please complete and return prior to your visit)

Individual Information			
Name *(First, Middle, Last)*			Birth Date *(MM/DD/YYYY)*
Social Security Number	Marital Status: □ Single □ Married □ Other		Sex: ☐M □ F
Mailing Address of Patient – Street		City	
State	Zip code	Home Phone	Cell Phone
Secondary Mailing Address of Patient – Street		City	
State	Zip code	Home Phone	Cell Phone
Race: □ Caucasian □ African American □ Hispanic □ Asian □ Other □ Declined			
Preferred language: □ English □ Spanish □ Other (specify):			
Email		Would you like to receive our email newsletter? ☐ Yes ☐ No	

Referral and Contact Information		
Primary Care Physician	Referring Physician	
Previous Cardiologist	Address	Phone
Pharmacy	Address	Phone
Next of Kin and/or Healthcare Proxy	Relationship	Phone
Would you choose your next of kin or healthcare proxy to act on your behalf? □ No □ Yes □ Other (specify)		
How did you find us: □ Friend □ Relative □ Doctor □ Internet (specify) □ Advertisement □ Insurance directory □ Hospital visit □ Website (specify)		
May we leave general messages on your home/cell phone about appointments, test results? ☐Yes ☐ No		
Would you permit us to get your medication list from your Pharmacy if you can't remember? ☐Yes ☐ No		
Do you have any specific restrictions abut handling your Protected Health Information? □ No □ Yes (specify)		

Primary Insurance Information			
Primary Insurance Company		Employer	
Policy Number		Group Number	
Policyholder □ Self (if self, go to next section)		□ Other (fill next rows):	
Policyholder name	Relation to patient	Birth Date *(Month/DD/YYYY)*	Social Security No.
Address (if different from patient)		Phone	Employer
Secondary Insurance Information			
Secondary Insurance Company		Employer:	
Policyholder □ Self (if self, go to next section)		□ Other (fill next rows):	
Policyholder name	Relation to patient	Birth Date *(Month/DD/YYYY)*	Social Security Name
Address (if different from patient)		Phone	Employer

Renewal of patient registration

□ By checking this box, I attest that there is no material change in my individual patient information, referral/contact information and insurance information from my prior registration _____ (initials)

Insurance Benefits: Financial Arrangement

I assign, transfer and send over to Manatee Cardiovascular Wellness Institute all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. I understand that I am financially responsible for any charges not covered by my insurance company such as co-payments, co-insurances or deductibles. I also understand that if providers of Manatee Cardiovascular Wellness Institute do not have a contract with my insurance, charges will be submitted to my insurer on an unassigned basis for these services. In the event of any default, I understand that I could be referred to collection agency, and be subject to pay interests, collection costs and/or reasonable attorney fees. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above. This authorization shall remain valid until written notice is given by me revoking said authorization.

ATTN: MEDICARE PATIENTS – LIFETIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished by the providers of Manatee Cardiovascular Wellness Institute, I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agent any information needed to determine these benefits for related services.

_____ _____

Signature *(Required)* Date *(Required) (Month/DD/YYYY)*

MANATEE CARDIOVASCULAR WELLNESS INSTITUTE

PATIENT MEDICAL AND FAMILY HISTORY

PATIENT NAME (LAST, FIRST, MI) _____ DATE _____

REASON FOR THIS EVALUATION (What specific questions do you want answered?) _____

_____

DO YOU HAVE ALLERGIES? □ YES □ NO IF YES, please list: _____

ALLERGY or IODINE or SHELLFISH? □ YES □ NO ALLERGY to IVP DYE? □ YES □ NO

PLEASE LIST **ALL** PREVIOUS SURGICAL PROCEDURES: Continue on BACK if needed

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Have you **EVER** had any of the following Cardiac Procedures?

STRESS TEST OF ANY KIND	□ YES □ NO	Month/Year: _____
ECHOCARDIOGRAM	□ YES □ NO	Month/Year: _____
ULTRASOUND OF THE LEGS	□ YES □ NO	Month/Year: _____
CAROTID ULTRASOUND	□ YES □ NO	Month/Year: _____
RENAL ULTRASOUND	□ YES □ NO	Month/Year: _____
CARDIAC CATH	□ YES □ NO	Month/Year: _____
PTCA (ANGIOPLASTY)	□ YES □ NO	Month/Year: _____
STENTS	□ YES □ NO	Month/Year: _____
CORONARY ARTERY BYPASS	□ YES □ NO	Month/Year: _____
PACEMAKER IMPLANT	□ YES □ NO	Month/Year: _____
DEFIBRILLATOR IMPLANT	□ YES □ NO	Month/Year: _____
ABLATION	□ YES □ NO	Month/Year: _____
VALVE REPAIR	□ YES □ NO	Month/Year: _____
VALVE REPLACEMENT	□ YES □ NO	Month/Year: _____
If Yes, □ Mechanical □ Pig Valve	□ YES □ NO	Month/Year: _____

Have you **EVER** had any of the following?

DIABETES	□ YES □ NO	GOUT	□ YES □ NO
ANEMIA	□ YES □ NO	ARTHRITIS	□ YES □ NO
STROKE	□ YES □ NO	HIATAL HERNIA	□ YES □ NO
CHEST PAIN	□ YES □ NO	ULCER	□ YES □ NO

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PALPITATIONS	☐ YES	☐ NO	GALLBLADDER DISEASE	☐ YES	☐ NO
HEART MURMUR	☐ YES	☐ NO	THYROID DISEASE	☐ YES	☐ NO
ABNORMAL EKG	☐ YES	☐ NO	KIDNEY DISEASE	☐ YES	☐ NO
RHEUMATIC DISEASE	☐ YES	☐ NO	LIVER DISEASE	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO	BOWEL DISEASE	☐ YES	☐ NO
BREATHING DIFFICULTY	☐ YES	☐ NO	CANCER	☐ YES	☐ NO
LIGHTHEADED/DIZZY	☐ YES	☐ NO	SKIN LESIONS	☐ YES	☐ NO
HEART ATTACK	☐ YES	☐ NO	PSYCHIATRIC DISEASE	☐ YES	☐ NO
HIGH CHOLESTEROL	☐ YES	☐ NO	UNEXPLAINED WEIGHT	☐ YES	☐ NO

Do you currently use or have you previously used TOBACCO? ☐ YES ☐ NO

If YES, what type? (Please circle one) Cigarette Pipe Cigar Dip/Chew

If CURRENT User: How many years? _____ How many packs/amount per day? _____

If FORMER User: Age Started: _____/Age Stopped: _____ How many packs/amount per day? _____

Do you drink ALCOHOL? ☐ YES ☐ NO

If YES, how often? (Please circle one) Everyday Occasional Never

Do you drink CAFFEINE? ☐ YES ☐ NO

If YES, how often? (Please circle one) Everyday Occasional Never

FAMILY HISTORY

Father Living? ☐ YES ☐ NO Age or Age @ Death: _____ Cause of Death? _____
Any Illnesses? _____

Mother Living? ☐ YES ☐ NO Age or Age @ Death: _____ Cause of Death? _____
Any Illnesses? _____

How many Brothers are living? _____ How many Brothers are deceased? _____
Any Illnesses? _____ Age/Cause of Death? _____

How many Sisters are living? _____ How many Sisters are deceased? _____
Any Illnesses? _____ Age/Cause of Death? _____

How many Daughters are living? _____ How many Daughters are deceased? _____
Any Illnesses? _____ Age/Cause of Death? _____

ACTIVITY HISTORY

What kind of exercise do you do? _____
_____
_____

What is your main hindrance (if any) to exercising? _____
_____
_____

MEDICATION LIST

PATIENT NAME (LAST, FIRST, MI) _____ DATE OF BIRTH _____

Please include all prescriptions and over-the-counter medications, including herbal products and vitamins. Please update the form before every physician visit.

	Medication	Dose	How Often
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

PATIENT CONSENT & CONTACT INFORMATION

PATIENT NAME (LAST, FIRST, MI) _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

I understand that as a part of my healthcare, Manatee Cardiovascular Wellness Institute originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

A basis for planning my care and treatment.
A means of communication among the healthcare professionals who contribute to my care.
A source of information for applying my diagnosis and surgical information to my bill.
A means by which a third-party payer can verify that services billed were actually provided.
A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right.

To object to the use of my health information for directory purposes.
To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have been given a copy of the Name of Privacy Practices.

Does Manatee Cardiovascular Wellness Institute have permission to:

Send test results to your home? □ Yes □ No
Leave the following information on your preferred answering machine/voicemail:
Appointment information □ Yes □ No
Billing Information □ Yes □ No
Medical Information □ Yes □ No
Leave the following information on your secondary answering machine/voicemail:
Appointment information □ Yes □ No
Billing Information □ Yes □ No
Medical Information □ Yes □ No

I agree that my Protected Health Information may be shared with the following people:

_____ Relationship: _____
Full Name

_____ Relationship: _____
Full Name

I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Manatee Cardiovascular Wellness Institute.

Signature: _____ Date: _____

MANATEE CARDIOVASCULAR WELLNESS INSTITUTE

For Clinic Use Only:
Method of Retrieval (Check One):
□ Picked Up □ Mailed □ Faxed
Date Received: _____
Date Processed: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Telephone: _____ Gender: ☐ Male ☐ Female

Social Security No.: _____ Email Address: _____

RELEASE INFORMATION FROM:

☐ Manatee Cardiovascular Wellness Institute
☐ Other (Specify facility/individual & address below, including phone/fax number is known)
_____
_____
_____
Ph: _____ Fax: _____

RELEASE INFORMATION TO:

☐ Manatee Cardiovascular Wellness Institute
☐ Other (Specify facility/individual & address below, including phone/fax number is known)
_____
_____
_____
Ph: _____ Fax: _____

Purpose of release/disclosure to other person/organization:
☐ Continuation of Care/Transfer of Care ☐ Attorney/Legal ☐ Insurance Company
☐ Workman's Compensation ☐ Other (specify):_____
_____

Information to be Released: Services Dates (Optional) From: _____ To: _____
☐ History & Physical ☐ Office Visits ☐ Lab Reports ☐ X-Ray Reports
☐ Diagnostic Reports ☐ Billing Information ☐ Other: _____

I understand that this authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This authorization shall remain valid until written notice is given by me revoking said authorization.

_____ _____/____/_____
Signature of Patient or Legally Authorized Representative **DATE** (mm/dd/yyyy)

_____
Printed Name of Legally Authorized Representative
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Next-of-Kin ☐ Legal Guardian

MANATEE CARDIOVASCULAR WELLNESS INSTITUTE

For Clinic Use Only:
Method of Retrieval (Check One):
□ Picked Up □ Mailed □ Faxed
Date Received: _____
Date Processed: _____

ADDITIONAL INFORMATION REGARDING YOUR REQUEST

Requesting medical records on behalf of another person
If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavit of Heir at law, etc. Please contact our office to determine the documentation that will be required to process your request.

Submitting requests & receiving record copies – Requests for medical records may be:

- Mailed to Manatee Cardiovascular Wellness Institute, Attn: Medical Records, 2816 Manatee Avenue West, Bradenton, FL 34205.
- Faxed to Manatee Cardiovascular Wellness Institute, Attn: Medical Records at (941) 744-1500
- Submitted in person Monday – Friday 8:00 AM – 5:00 PM to the located noted above.

Our average turnaround time for processing requests is seven business days plus shipping time. Unless otherwise requested, records will be sent through US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Please include your phone number on your request, in case we need to contact you for additional information. **For questions regarding requests for medical record copies, please call: (941) 744-1200.**

Fees are authorized annually by the State of Florida Rule 64B8-10.003, Florida Administrative Code. Some records requested for legal, insurance, or personal use may require a prepayment. If your request requires pre-payment, a fee notice will be sent to you upon processing of your request. Records fees will be billed as follows (plus actual postage):

Patient (paper copy):

- Pages 1-25 $1.00
- Pages 25+ $0.25 for each additional page

MANATEE CARDIOVASCULAR WELLNESS INSTITUTE

For Office Use Only:

Patient Number: _____

OFFICE AND FINANCIAL POLICY & AGREEMENT

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Scheduling and registration: We require you to provide your medical insurance card(s), photo identification, address, date of birth, social security number and phone number. If you receive health benefits through a spouse we require you to provide their address, date of birth, and phone number.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and may ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment, and notify the office of any changes.

Keeping Appointments for Consultation, Follow up or Testing: All appointments are very important to initiate and/or execute my treatment plan. During these appointments, my physician might order tests, review my plan of care, prescribe medication, or even discover and treat a serious health condition. If I don't show up for my appointment, or miss my appointment and fail to reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. (_____) Initial

In addition, I understand that missing or not showing up for my appointment creates a significant hardship for my physician and is not fair for other patients who would like to access cardiology services by my physician's practice. I will make every effort to notify my physician, his or her nurse or the scheduling team a minimal of 48 hours in advance of my appointment cancellation and reschedule missed appointments, as soon as possible. (_____) Initial

If you are unable to make your appointment due to a *bona fide* emergency no cancellation fee will apply provided you supply written documentation or proof of the emergency. In all other instances:

- A **"$25.00 no show cancellation fee"** will be charged, without exception, for un-kept office visit appointments not canceled 48 hours before the scheduled appointment time. (_____) Initial
- A **"$50.00 no show cancellation fee"** will be charged, without exception, for un-kept ultrasound appointments not canceled 48 hours before the scheduled appointment time. (_____) Initial
- A **"$100.00 no show cancellation fee"** will be charged, without exception, for un-kept nuclear stress testing appointments not canceled 48 hours before the scheduled appointment time. This test requires a daily purchase and delivery of pharmaceuticals with a shelf life of only one day. (_____) Initial

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage and to contact your carrier prior to receiving services to verify your coverage and responsibilities.

MANATEE CARDIOVASCULAR WELLNESS INSTITUTE

Authorizations: You are responsible to make sure all necessary referrals, pre-certifications or other required documentation are obtained prior to your appointment. If our team determines that your plan requires an authorization, and you do not provide such referral, authorization or certification, you may be required to sign a waiver in order to receive services or the appointment may be rescheduled.

Copayments: It is **our responsibility**, as detailed by the terms of our contracts with health insurance companies, to collect any copayment amounts at the time of your appointment. It is **your responsibility**, as detailed by the terms of your health insurance coverage, to pay any copayment amounts at the time of your appointment. Please have your payment ready upon check-in. There will be a Service Charge on all returned checks.

Previous balances and/or deductibles: It is our responsibility, as detailed by the terms of our contracts with health insurance companies, to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and notice, your account may be sent to a collection agency.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. Payment arrangements may be made on a case by case basis by contacting us and providing proof of financial hardship.

Medical Records: A fee of $1.00 per page for the first 25 pages and .25 for each additional page will be charged for a copy of your medical records for the purpose of transferring care or personal use. There is no charge for medical records that we are requested to forward by mail or fax to other treating physicians.

Form Completion: A fee of $20 will be charged for the completion of most forms (disability, FMLA, etc.)

Prescription Refills: Please call your pharmacy and ask them to send us an electronic request for a refill of your prescription(s). Upon receipt, please allow us up to 48 hours for the request to be completed.

Patient Acknowledgment

I have read and understand the above agreement and agree to abide by the policies outlines above.

Signature: _____ Date: _____

Respecting Your Privacy

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.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this physician practice is required by federal and state law to protect and maintain the privacy of your health information. We call it "Protected Health Information" (PHI).

The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by the physician practice, our employees and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted to abide by its contents. This physician practice follows the practices contained within this Notice. Other physicians have created their own Notice. Those members of the Medical Staff who opt not to abide by this Notice are required to give you a separate Notice that will explain their privacy practices.

Each participant who joins in this joint Notice of Privacy Practices serves as his or her own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For hospital specific issues or questions, please feel free to contact the hospital directly.

Physician practice members, employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Physician practice contacts for more information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT:

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an X-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT:

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS:

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in the hospital. Other uses of your PHI may include business planning for the hospital or the resolution of a complaint.

SPECIAL USES:

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services
- Ask you to contribute to our charitable activities, unless you tell us not to ask. You have a right to opt out of receiving such communications.

YOUR AUTHORIZATION MAY BE REQUIRED:

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure, which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW:

As a physician practice, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES:

- If you do not verbally object, we may include information identifying you in a visitors' directory of patients while you are an inpatient in the hospital. This information may include your name, general condition and religious affiliation, if any.
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances, which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers' Compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.

- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.
- For surveys, including patient satisfaction surveys.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE:

You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

- The disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- The PHI pertains solely to a health care item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION:

You have the right to receive confidential communications of PHI from the physician practice at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION:

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY:

You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI:

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI:

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH:

You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE:

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

WHAT IF YOU HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at **1-800-852-3449**. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to:
  200 Independence Ave., S.E.
  Washington, DC 20201
  Or call **1-877-696-6775**

CONTACT FOR ADDITIONAL INFORMATION

If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from the hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

MANATEE CARDIOVASCULAR WELLNESS INSTITUTE