Arthritis & Osteoporosis
treatment center

*Meera R. Oza, M.D., FACR*
*Adam W Bagley, MD.. FACR*
*Diplomate of American Board of Rheumatology*
*Diplomate of American Board of Internal Medicine*
*Pinki Patel, PAC  Carol Hill, ARNP  Maryann Leslie, ARNP*
*2100 Kingsley Ave., Orange Park, FL 32073, Phone: (904) 276-0001, Fax: (904) 276 –5333*

*Dear patient,*

*Welcome to our practice!*

*At our office we are committed to our patients. Our mission is to meet or exceed your expectations from your provider, our clinical staff will ensure your quality of care and, our billing staff will give you peace of mind in making sure that all your claims are billed correctly.*

*Attached are the forms that you need to fill out before coming to our office.*

*Please give us a call two days prior to your appointment to verify insurance information.*

*Remember to call your insurance company and double check if we do participate with your insurance. Also do not forget to bring your referral if required by your insurance. Patient will be responsible for any charges not covered by your insurance. All copays, co-insurance and deductibles will be collected up front.*

*Please make sure you bring the following:*

1. *All enclosed pages, please fill in all requested information.*
2. *All insurance cards.*
3. *A list of all current medications you are taking, with the prescribing doctor's name(s).*
4. *A copy of all blood work you have had done recently (within the last year). If you prefer you may have your doctor fax results to our office at (904) 276-5333.*
5. *All x-rays within the last year.*
6. *Reports of all other diagnostic tests you have had done within the last year, which is pertinent to your visit with us. (MRI, Bone Scan, Bone Density Test, etc.)*

*Failure to bring this may result in having to reschedule your appointment.*

***Please note**: Dr. Oza suffers from severe allergies. Please do not wear any scented perfume, cologne, aftershave, body spray, lotion, etc. Thank you for your consideration.*

*If you have any questions or need directions to our facility, please call us at (904) 276-0001.*

*Thank you.*

*Arthritis & Osteoporosis Treatment Center*

**PATIENT REGISTRATION**

Patient's Last Name: _____ First Name: _____ M.I.:_____

Date of Birth: _____/_____/_____ Email Address: _____

Address: _____ City: _____ State/Zip: _____

TELEPHONE NUMBER
Home # (_____) _____ Cell # (_____) _____ Other # (_____) _____

SS # _____-_____-_____ Race: _____ Ethnicity: _____ Language: _____

Birth Sex: M / F Gender Identity (optional): _____ Marital Status: M S D W

Occupation: _____ Employer/School: _____

INSURANCE
Primary Insurance: _____ ID # _____ Policy Holder: _____

Secondary Insurance: _____ ID# _____ Policy Holder: _____

Policy Holder's Last Name: _____ First Name: _____ M.I.: _____

SS # _____-_____-_____ D.O.B.: _____/_____/_____ Relationship to Patient: _____

Primary Care Physician: _____

Phone # (_____) _____ Fax # (_____) _____

Referring Physician: _____ Phone # (_____) _____

Emergency Contact: _____ Phone # (_____) _____

Relationship to Patient: _____

How did you hear about us? ____Website ____ Friend ____ Magazine ____ Radio ____ Yellow Pages
____ PCP ____ Referring Physician ____ Other

I consent to treatment necessary for the care of the above-named patient. I allow fax transmittal of my medical records if necessary.
I authorize the release of all medical records to the referring and primary care physician and to my insurance company, if applicable.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
**I agree to pay all reasonable attorney fees and collection of costs in the event of default payment of my charges. I further authorize and request that insurance payments be made directly to Arthritis & Osteoporosis Treatment Center should they elect to receive such payment.**
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Patient Signature: _____ Date: _____

**Note:** Medicare Part B may require a separate signature authorizing release of information to the Health Care Financing Administration and Social Security Administration.

Arthritis & Osteoporosis
**treatment center**

# Patient History Form

Date of first appointment: ____/____/____ (MONTH / DAY / YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST / FIRST / MIDDLE INITIAL / MAIDEN) Birthdate: ____/____/____ (MONTH / DAY / YEAR)

Address: _____ (STREET / APT#) Age: _____ Sex: ❑ F ❑ M

_____ (CITY / STATE / ZIP) Telephone: Home (____) _____
Work (____) _____

**MARITAL STATUS:** ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age ____ ❑ Deceased/Age ____ Major Illnesses _____

**EDUCATION** (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, Name: _____

Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____

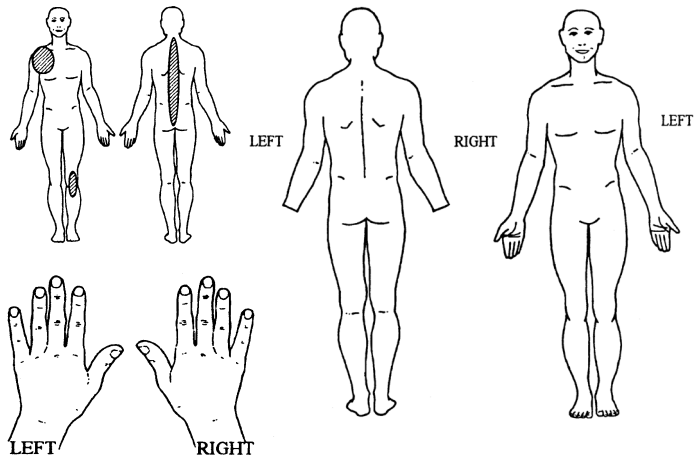
Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

Please list the names of other practitioners you have seen for this problem:

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:




Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

**RHEUMATOLOGIC (ARTHRITIS) HISTORY**

At any time have you or a blood relative had any of the following? (check if "yes")

| Yourself | | Relative Name/Relationship | Yourself | | Relative Name/Relationship |
|---|---|---|---|---|---|
| | Arthritis (unknown type) | | | Lupus or "SLE" | |
| | Osteoarthritis | | | Rheumatoid Arthritis | |
| | Gout | | | Ankylosing Spondylitis | |
| | Childhood arthritis | | | Osteoporosis | |
| Other arthritis conditions: | | | | | |

Patient's Name _____ Date _____ Physician Initials _____

**SYSTEMS REVIEW**

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x–ray ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

**Constitutional**

- ❑ Recent weight gain
  amount _____
- ❑ Recent weight loss
  amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

**Eyes**

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

**Ears–Nose–Mouth–Throat**

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

**Cardiovascular**

- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

**Respiratory**

- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

**Gastrointestinal**

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

**Genitourinary**

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, “smoky” urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

*For Women Only:*

Age when periods began:_____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? ____/____/____/

Date of last pap?_____/____/____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

**Musculoskeletal**

- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

**Integumentary (skin and/or breast)**

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

**Neurological System**

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

**Psychiatric**

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

**Endocrine**

- ❑ Excessive thirst

**Hematologic/Lymphatic**

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

**Allergic/Immunologic**

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient’s Name _____ Date _____ Physician Initials _____

**SOCIAL HISTORY**

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago?_____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No
If yes, please list: _____

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week_____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

**PAST MEDICAL HISTORY**

Do you now or have you ever had: *(check if "yes")*

| | | |
|---|---|---|
| ❑ Cancer | ❑ Heart problems | ❑ Asthma |
| ❑ Goiter | ❑ Leukemia | ❑ Stroke |
| ❑ Cataracts | ❑ Diabetes | ❑ Epilepsy |
| ❑ Nervous breakdown | ❑ Stomach ulcers | ❑ Rheumatic fever |
| ❑ Bad headaches | ❑ Jaundice | ❑ Colitis |
| ❑ Kidney disease | ❑ Pneumonia | ❑ Psoriasis |
| ❑ Anemia | ❑ HIV/AIDS | ❑ High Blood Pressure |
| ❑ Emphysema | ❑ Glaucoma | ❑ Tuberculosis |

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

**Previous Operations**

| ***Type*** | ***Year*** | ***Reason*** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |

Any previous fractures? ❑ No ❑ Yes Describe:_____

Any other serious injuries? ❑ No ❑ Yes Describe:_____

**FAMILY HISTORY:**

| | **IF LIVING** | | **IF DECEASED** | |
|---|---|---|---|---|
| | Age | Health | Age at Death | Cause |
| Father | | | | |
| Mother | | | | |

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

_____

Do you know of any blood relative who has or had: (check and give relationship)

| | | | |
|---|---|---|---|
| ❑ Cancer _____ | ❑ Heart disease _____ | ❑ Rheumatic fever_____ | ❑ Tuberculosis _____ |
| ❑ Leukemia _____ | ❑ High blood pressure _____ | ❑ Epilepsy_____ | ❑ Diabetes _____ |
| ❑ Stroke _____ | ❑ Bleeding tendency _____ | ❑ Asthma _____ | ❑ Goiter _____ |
| ❑ Colitis _____ | ❑ Alcoholism_____ | ❑ Psoriasis _____ | |

Patient's Name _____ Date _____ Physician Initials _____

## MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Type of reaction: _____

**PRESENT MEDICATIONS** (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

| Name of Drug | Dose (include strength & number of pills per day) | How long have you taken this medication | Please check: Helped? A Lot | Some | Not At All |
|---|---|---|---|---|---|
| 1. | | | ❑ | ❑ | ❑ |
| 2. | | | ❑ | ❑ | ❑ |
| 3. | | | ❑ | ❑ | ❑ |
| 4. | | | ❑ | ❑ | ❑ |
| 5. | | | ❑ | ❑ | ❑ |
| 6. | | | ❑ | ❑ | ❑ |
| 7. | | | ❑ | ❑ | ❑ |
| 8. | | | ❑ | ❑ | ❑ |
| 9. | | | ❑ | ❑ | ❑ |
| 10. | | | ❑ | ❑ | ❑ |

**PAST MEDICATIONS** Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

| Drug names/Dosage | Length of time | Please check: Helped? A Lot | Some | Not At All | Reactions |
|---|---|---|---|---|---|
| **Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)** | | ❑ | ❑ | ❑ | |
| **Circle any you have taken in the past**<br>Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac)<br>Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac)<br>Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen)<br>Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac) | | | | | |
| **Pain Relievers** | | | | | |
| Acetaminophen (Tylenol) | | ❑ | ❑ | ❑ | |
| Codeine (Vicodin, Tylenol 3) | | ❑ | ❑ | ❑ | |
| Propoxyphene (Darvon/Darvocet) | | ❑ | ❑ | ❑ | |
| Other: | | ❑ | ❑ | ❑ | |
| Other: | | ❑ | ❑ | ❑ | |
| **Disease Modifying Antirheumatic Drugs (DMARDS)** | | | | | |
| Auranofin, gold pills (Ridaura) | | ❑ | ❑ | ❑ | |
| Gold shots (Myochrysine or Solganol) | | ❑ | ❑ | ❑ | |
| Hydroxychloroquine (Plaquenil) | | ❑ | ❑ | ❑ | |
| Penicillamine (Cuprimine or Depen) | | ❑ | ❑ | ❑ | |
| Methotrexate (Rheumatrex) | | ❑ | ❑ | ❑ | |
| Azathioprine (Imuran) | | ❑ | ❑ | ❑ | |
| Sulfasalazine (Azulfidine) | | ❑ | ❑ | ❑ | |
| Quinacrine (Atabrine) | | ❑ | ❑ | ❑ | |
| Cyclophosphamide (Cytoxan) | | ❑ | ❑ | ❑ | |
| Cyclosporine A (Sandimmune or Neoral) | | ❑ | ❑ | ❑ | |
| Etanercept (Enbrel) | | ❑ | ❑ | ❑ | |
| Infliximab (Remicade) | | ❑ | ❑ | ❑ | |
| Prosorba Column | | ❑ | ❑ | ❑ | |
| Other: | | ❑ | ❑ | ❑ | |
| Other: | | ❑ | ❑ | ❑ | |

Patient's Name _____ Date _____ Physician Initials _____

**PAST MEDICATIONS Continued**

| | | | | | |
|---|---|---|---|---|---|
| **Osteoporosis Medications** | | | | | |
| Estrogen (Premarin, etc.) | | ❑ | ❑ | ❑ | |
| Alendronate (Fosamax) | | ❑ | ❑ | ❑ | |
| Etidronate (Didronel) | | ❑ | ❑ | ❑ | |
| Raloxifene (Evista) | | ❑ | ❑ | ❑ | |
| Fluoride | | ❑ | ❑ | ❑ | |
| Calcitonin injection or nasal (Miacalcin, Calcimar) | | ❑ | ❑ | ❑ | |
| Risedronate (Actonel) | | ❑ | ❑ | ❑ | |
| Other: | | ❑ | ❑ | ❑ | |
| Other: | | ❑ | ❑ | ❑ | |
| **Gout Medications** | | | | | |
| Probenecid (Benemid) | | ❑ | ❑ | ❑ | |
| Colchicine | | ❑ | ❑ | ❑ | |
| Allopurinol (Zyloprim/Lopurin) | | ❑ | ❑ | ❑ | |
| Other: | | ❑ | ❑ | ❑ | |
| Other: | | ❑ | ❑ | ❑ | |
| **Others** | | | | | |
| Tamoxifen (Nolvadex) | | ❑ | ❑ | ❑ | |
| Tiludronate (Skelid) | | ❑ | ❑ | ❑ | |
| Cortisone/Prednisone | | ❑ | ❑ | ❑ | |
| Hyalgan/Synvisc injections | | ❑ | ❑ | ❑ | |
| Herbal or Nutritional Supplements | | ❑ | ❑ | ❑ | |
| Please list supplements: | | | | | |
| | | | | | |
| | | | | | |

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list: _____

## PATIENT'S PREFERRED PHARMACY INFORMATION:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone # _____

Pharmacy Fax # _____

Mail Order/Specialty Pharmacy Name: _____

Mail Order Pharmacy Address: _____

Mail Order Pharmacy Phone # _____

Mail Order Pharmacy Fax # _____

Mail Order Pharmacy Electronic ID # _____

Patient's Name _____ Date _____ Physician Initials _____

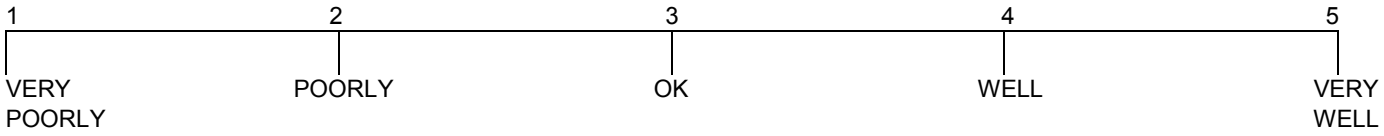
**ACTIVITIES OF DAILY LIVING**

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework?_____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*




Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

| | Usually | Sometimes | No |
|---|---|---|---|
| Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.) | ❑ | ❑ | ❑ |
| Walking? | ❑ | ❑ | ❑ |
| Climbing stairs? | ❑ | ❑ | ❑ |
| Descending stairs? | ❑ | ❑ | ❑ |
| Sitting down? | ❑ | ❑ | ❑ |
| Getting up from chair? | ❑ | ❑ | ❑ |
| Touching your feet while seated? | ❑ | ❑ | ❑ |
| Reaching behind your back? | ❑ | ❑ | ❑ |
| Reaching behind your head? | ❑ | ❑ | ❑ |
| Dressing yourself? | ❑ | ❑ | ❑ |
| Going to sleep? | ❑ | ❑ | ❑ |
| Staying asleep due to pain? | ❑ | ❑ | ❑ |
| Obtaining restful sleep? | ❑ | ❑ | ❑ |
| Bathing? | ❑ | ❑ | ❑ |
| Eating? | ❑ | ❑ | ❑ |
| Working? | ❑ | ❑ | ❑ |
| Getting along with family members? | ❑ | ❑ | ❑ |
| In your sexual relationship? | ❑ | ❑ | ❑ |
| Engaging in leisure time activities? | ❑ | ❑ | ❑ |
| With morning stiffness? | ❑ | ❑ | ❑ |
| Do you use a cane, crutches, as walker or a wheelchair? (circle one) | ❑ | ❑ | ❑ |

What is the hardest thing for you to do?_____

Are you receiving disability? Yes ❑ No ❑

Are you applying for disability? Yes ❑ No ❑

Do you have a medically related lawsuit pending? Yes ❑ No ❑

Patient's Name _____ Date _____ Physician Initials _____

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# Permission to discuss Medical Case

Date: _____

Patient name: _____
Date of Birth: _____

I hereby give permission to Meera R. Oza M.D. and her staff to discuss my medical case and personal information with the following individuals:

(Please list names and relationship to you.)

1. _____Relationship to patient: _____Phone #: _____
2. _____Relationship to patient: _____Phone #: _____
3. _____Relationship to patient: _____Phone #: _____
4. _____Relationship to patient: _____Phone #: _____

I understand that the above-mentioned individuals may speak to Dr. Oza or her staff about anything concerning my medical condition. The above also has my permission to sign for any prescriptions, x-rays or medical records that may need to be picked up from the office for me in the future.

**I also authorized Arthritis and Osteoporosis Treatment Center to leave a message in my answering machine regarding my treatment, blood work results, appointments and, billing issues.**

I understand that if in the future I wish to revoke my permission, I must notify Dr. Oza's office in writing to that effect.

_____ _____
Patient signature  Date

_____ _____
Witness signature  Date

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# Statement of Policies

The following policies are laid down for mutual convenience and benefit, please read them carefully and sign at the bottom to indicate your agreement with it.

1. We strictly provide **Rheumatological services**; we **do not** provide primary care services. Patients are expected to have or arrange for a primary care physician.

2. We do not do evaluation or paperwork for **disability.**

3. **Deductible** and **co-pay** associated with each visit are payable at the beginning of that visit. Any outstanding balance at the beginning of the visit is also fully payable at the time of your visit. **A $25 billing fee will be added to any unpaid copays, co-insurance, deductibles or balance.** If you are not able to pay, please make special payment arrangements with our business office at the beginning of the visit.

4. **Patient is responsible for referrals required by their insurance, also is responsible to call their insurance company to make sure Dr. Meera Oza is a participating provider for their insurance. Patient will be responsible for any charges not covered by your insurance.**

5. If you are not able to keep your appointment for the medical visit, please call during office hours to cancel your appointment at least **48 hours in advance**. Failure to do so will result in a $50.00 (fifty dollars) **charge for a broken appointment**.

6. **Dr. Oza is allergic to perfumes and other odors.** Please avoid wearing perfumes or anything with a strong smell during your visit.

7. During the first visit, the patients will be seen by any of the **nurse practitioners or the physician assistant** in order to obtain initial information. Then the patient will be seen by **Dr. Oza** who will evaluate the patient and make a treatment plan.

8. During the follow-up visits, the patient **may be seen** by any of the nurse practitioners or the physician assistant who work under the close supervision ofa physician. The physician will see the patient if the nurse practitioners or the physician assistant feel the need to do so.

I acknowledge that I have read and understood the **Statement of Policies** carefully and agree to abide by them.

_____ _____

Patient signature  Date

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## CHANGES TO THIS NOTICE

*We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the practice lobby The notice will contain on the first page, in the bottom left-hand corner, the effective date. In addition, each time you register for treatment or health care services we may offer you a copy of the current notice in effect.*

## COMPLAINTS

*If you believe your privacy rights have been violated you may file a complaint with the practice Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Privacy Official at (904) 276-0001. You will not be penalized for the filing a complaint.*

## OTHER USES OF MEDICAL INFORMATION

*Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.*

*By signing below I acknowledge receipt of the Notice of Privacy Practices.*

_____
Patient Name (Print)

_____
Patient Signature

_____
Date