FLORIDA CANCER AFFILIATES

Andrew Weber, M.D./ Christopher Haberman, M.D./
Kelly Carver, D.O./Steven Finkelstein/ Steven Stokes
☐ 2100 State, Ave, Panama City, FL 32405
Phone (850) 763-0036 * Fax (850) 763-0259

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES

Date: _____

Patient Name: _____
Last First M.I.

Home Phone: (____) _____ Cell: (____) _____

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

DOB: _____ Age: _____ ☐M ☐F SSN: _____ ☐Married ☐Single ☐Divorced ☐Widowed ☐Other

Email: _____ Race*: _____

Ethnicity* Hispanic/Latino: ☐Yes ☐No Preferred Language: _____

Preferred Contact Method: ☐Cell Phone ☐Home Phone ☐Email ☐Home Address

Veterans Status: ☐Yes ☐No

Employer: _____ (____) _____
Name Telephone

_____ _____
Address Occupation

Responsible Party: _____ _____ (____) _____
Name Relationship Telephone

Emergency Contact: _____ _____ (____) _____
Name Relationship Telephone

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ (____) _____
Telephone

Insured Name: _____ DOB: _____ Group #: _____ Policy #: _____

Secondary Ins: _____ (____) _____
Telephone

Insured Name: _____ DOB: _____ Group #: _____ Policy #: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of interest, collection, and legal action (If required).
2. I authorize my insurance carrier to release information regarding my coverage to Florida Cancer Affiliates.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Florida Cancer Affiliates. This assignment covers any and all benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Florida Cancer Affiliates.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Florida Cancer Affiliates.

- Not Required

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

_____ _____ AM/PM
Patient Signature Date/Time

_____ _____ AM/PM
Responsible Party Signature Relationship Date/Time

FLORIDA CANCER AFFILIATES

HIPAA Release

Patient's Name:_____ DOB:_____

We may release your health information, including information about your condition, to a family member or friend who may be involved in your medical care or who helps pay for your care. As described in our Notice of Privacy Practices, you have the right to request that we do not release your health information to certain individuals.

Please use the form below to indicate with whom we may release your health information to notify or assist in the notification of a family member or friend who may be involved in your care.

Release of Information:

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information.

The information may be released to: (Please be specific with names.)

☐ Spouse: _____

☐ Child(ren): _____

☐ Other: _____

☐ Information is NOT to be released to anyone.

This HIPAA Release will remain in effect until terminated by me in writing.

When leaving messages:

Please call: ☐my home ☐my work ☐ my cell Phone: (_____) _____

If you are unable to reach me:

☐ You may leave a detailed message.

☐ Leave a message requesting me to return your call.

☐ Other: _____

The best time to reach me is _____ (Day of the week), between _____ (Time) and _____ (Time).

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

FLORIDA CANCER AFFILIATES

Acknowledgement of Receipt of Notice of Privacy Practices

Florida Cancer Affiliates is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our organization and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I received a copy of the Notice of Privacy Practices of Florida Cancer Affiliates.

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

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Agreement for Controlled Substances/ Prescriptions

Patient's Name:_____ DOB:_____

Controlled substance medications (i.e. pain, anti-anxiety, and stimulant medications) are very useful, but have a high potential for misuse and are therefore closely controlled by the federal, state, and local government. They are intended to relieve pain or to improve function and/or ability to work and not simply to feel good. Because my physician is prescribing such a medication for me to help manage my symptoms, I agree to the following conditions.
Please initial each number when read.

1. _____ **I am responsible for my controlled substance medication.**
   a) If the prescription of medication is lost, misplaced, stolen, of if I use it other than prescribed and run out before I should, then I understand it cannot be replaced.
   b) I will use my medicine at a rate no greater than the prescribed rate and understand that use of my medicine at a greater rate will result in my being without medication for a period of time.
   c) If rate of medicine prescribed is not relieving pain, I will contact physician's office to let the doctor/nurse know so the dosage can be adjusted and noted in record.
   d) I will not share, sell, or trade my medication with anyone.
   e) As required by law my fill history will be monitored using one of the state approved websites.

2. _____ **I will not request or accept controlled substance medications from any other physician** while I am receiving controlled medication from my physician, as this may endanger my health. The only exception is when it is prescribed when I am admitted to the hospital.

3. _____ **Refills** of controlled substance medication:
   a) Will be made only during regular business hours between the hours of 8am and 5pm, Monday-Thursday and between 8am and 12pm on Friday once each month or during a scheduled office visit. **Refills will not be made after business hours (i.e., at night, on holidays, or weekends).**
   b) Will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
   c) Will not be made as an "emergency", such as a Friday afternoon, because I "suddenly realized I will run out tomorrow". I will notify the clinic staff **at least 3-5 days in advance** if I need assistance with/a refill of a controlled substance medication prescription.

4. _____ While I am receiving controlled substance medication, it may be deemed necessary by my doctor for me to see a specialist in interventional pain, psychology, psychiatry, or other specialty with the goal of improving my symptoms. I understand if I do not attend this appointment that my medications may not be continued or refilled past a tapering dose to completion. I understand that if a specialist feels that I am at risk for psychological dependence (addiction) that my medications no longer will be refilled.

Patient's Name:_____ DOB:_____

5. _____ I understand that driving a vehicle may not be allowed at times while taking controlled substance medications and that it is my responsibility to comply with the laws of this state while taking the controlled substance medication prescribed.

6. _____ I understand that **if I violate any of the above conditions,** my controlled substance prescriptions and/or treatment may be tapered immediately. If the violations involve the use of non-prescribed, illicit (illegal) drugs while I am receiving my controlled substance medication or involves obtaining controlled substances from another individual as described in section 2, then I may also be reported to my physician, medical facilities, and other appropriate agencies.

7. _____ I understand that the main treatment goal is to improve my ability to function and/or work and/or reduce pain. In consideration of that goal and the fact that I am given potent medication to help me reach that goal, I agree to help myself by the following better health habits: exercise, weight control, and avoiding the use of tobacco and alcohol. I must comply with the treatment plan as prescribed by my doctor. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

8. _____ I understand that the long-term advantages of chronic opioid use have yet to be scientifically determined and treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substance medications and that my physician will advise me as knowledge and training advances will make appropriate treatment changes.

I have been fully informed regarding psychological dependence (addiction) of a controlled substance medication, which I understand is rare when using medication correctly. I know that some persons may develop a tolerance, which is the need to increase the dose of medication to achieve the desired effect. I also understand that I can become physically dependent on the medication if I am on the medication for several weeks, and that in order to stop the medication I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I have read this agreement and I understand the consequences of violating this agreement. If I have any questions, then I can ask the physician or staff regarding the use of controlled substances at any time.

I agree to use _____ Pharmacy, located at _____, or **in case of an emergency**

I agree to use _____ Pharmacy, located at_____, for filling prescriptions for **all** of my controlled substance prescriptions.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Witness Date

FLORIDA CANCER AFFILIATES

User Electronic Mail Authorization Form (Optional)

Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal"), offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record; we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this user Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand that you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. Please look for an email from My-Care Plus promptly after submitting this form. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

Patient Name (First Name, Middle Name, Last Name)

Email Address of Patient/Authorized User

Patient's Date of Birth

Physician's Name

Authorized User is:

☐ Patient
☐ Patient's Designee

Patient's Designee's Name (Printed)

Patient's Designee's Signature

Patient's Medical Record Number

Patient's Signature

Date

Signature of Practice Staff
(Confirming User's identity and authority)

Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e. the Patient's Designated User) understand and agrees to use the listed email address for this purpose. Make a copy for the patient.

FLORIDA CANCER AFFILIATES

What is Patient Assistance?

"Patient Assistance" is a term used to describe a charitable organization dedicated to providing help to individuals with difficulty affording the high cost of healthcare associated with their specific illness. These foundations offer financial assistance to eligible patients for covering out-of-pocket healthcare costs. For instance, there are specific foundations established to help with coinsurance for certain cancer drugs or blood disorders.

Specific patient guidelines must be met for acceptance into these programs. Some of these guidelines include household income, insurance coverage, diagnosis, specific chemotherapy drugs, and available funding.

How do we help you?

Once our billing specialist has determined that you may be a candidate for assistance, you will be referred to our Patient Benefit Representatives. From here, we try to match your diagnosis and therapy plan with a foundation that may be able to assist with funds. In order to begin the process, you will be asked to provide proof of income and diagnosis. Once all proper documentation has been obtained, we will submit the application on your behalf. From there, the foundation will determine your eligibility.

It is important to note that regardless of your eligibility with patient assistance and regardless of your status in these programs, you are still responsible for paying your co-payment. The assistance that you may or may not receive will help only with specific drugs and not your entire balance. Please remember, you alone are responsible for your balance.

This service is not a guarantee of payment. It is simply to assist in trying to minimize your out-of-pocket expenses with our office. We encourage our patients to seek out other forms of assistance as well for making payments on your balance. If you do take outside assistance, please let someone in our insurance and billing department know of your status in these organizations.

If you have any questions, please do not hesitate to ask to speak to one of our Patient Benefit Representatives.

I understand the above specifications and conditions of the patient assistance program and accept the guidelines listed above.

_____ _____

Patient/Responsible Party Signature Date

FLORIDA CANCER AFFILIATES

Patient Financial Policy

We understand that healthcare can be expensive. We would like to partner with you to make sure you understand your insurance coverage and out of pocket costs for your care. We will assist with establishing a financial plan in advance to avoid any misunderstandings or confusion regarding payment expectations.

PROVIDING QUALITY MEDICAL CARE TO OUR PATIENTS IS OUR PRIMARY CONCERN. It is our privilege to provide high quality care to you, our patient; however, it is your responsibility to understand your insurance benefits and communicate directly with your insurance company for clarification of questions relating to your coverage. Payment for co-pays, deductibles, and balances not paid by your insurance company is your responsibility.

- ☐ All patients are responsible for ensuring our office has the most current insurance and billing information.
- ☐ All patients are responsible for assisting the practice in obtaining any referrals necessary prior to your appointment if required by your insurance plan.
- ☐ All patients are responsible for co-pays at the time of service. We may also ask for payment of any patient balances not covered by your insurance or agreed upon budget plan payments. A receipt will be provided for all payments made at the practice site; cash, check, money order, charge and debit cards are accepted.
- ☐ You will be assigned a designated Patient Benefit Representative at the office and an Insurance Specialist at the Central Business Office who will assist with any insurance or financial questions you may have.
- ☐ Your Patient Benefit Representative will meet with you on your first visit to the practice, at any time your insurance changes, and if you have specific questions.
- ☐ Your Patient Benefit Representative will meet with you when a treatment plan has been established by your physician; to review your benefits and provide you with the best possible out-of-pocket cost estimate of your financial responsibility.
- ☐ Your Patient Benefit Representative may be able to locate assistance if needed from a wide variety of sources. We encourage you to communicate financial needs you may have, so we can guide you to those resources.
- ☐ A monthly patient statement is sent detailing any patient balance activity. Our Central Business Office accepts check and credit card payments by phone, and you may also pay your bill or set up monthly recurring payments on . our website: http://floridacancer.com/patients/payment/
- ☐ If your physician is not a provider with your insurance company, as a courtesy, we will file your claims for you if you assign benefits to your physician. If your insurance company does not pay within a reasonable time, you will be responsible for payment on your account.
- ☐ RETURNED CHECKS- The charge for a returned check is $30.00 payable by cash or money order. This will be applied to your balance, in addition to any additional insufficient funds we incur. You may be placed on a "Cash Only" basis following any returned check.
- ☐ MEDICAL RECORD COPIES & FMLA PAPERWORK- If you want a copy of your records, then you will be charged a copying fee of $1.00 per page for the first 25 pages and $0.25 for each page in excess of 25 pages. There is a $15.00 fee for completion of FMLA paperwork.

Our goal is to assist you, with your cooperation, in receiving all the benefits offered to you by your insurance plan or patient assistance programs and allowing us to do what we do best — concentrating on delivering high quality medical care.

I understand these policies and have had opportunity to discuss any questions.

_____ _____

Patient/Responsible Party Signature Date

FLORIDA CANCER AFFILIATES
NORTH FLORIDA

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.

About Us

In this Notice, we use terms like "we," "us," "our" or "Practice" to refer to Florida Cancer Affiliates, its physicians, employees, staff and other personnel. All of the sites and locations of Florida Cancer Affiliates follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information without your written authorization:

For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another healthcare provider to be sure they have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment of supplies used in the course of treatment.

We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

Individuals Involved in Your Care or Payment for Your Care and Notification: If you verbally agree to the use or disclosure, and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information

We may use or disclose your information to notify or assist in notifying a family member, personal representative or any other person responsible for your care regarding your physical location within the Practice, general condition or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status and location.

We are also allowed to the extent permitted by applicable law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- Activities related to the quality, safety or effectiveness of FDA-regulated products;
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law, if you are provided notice of such disclosure.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement authorities to identify or apprehend an individual.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation or banking of organs, eyes, or tissues.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:
Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.
- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.
- Sale of Your Health Information: We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information
You have the following rights regarding health information we maintain about you:

Right to Request Restrictions: You have the right to request restriction on how we use and disclose your health information for treatment, payment or health care operations. **In most circumstances, we are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make requests in writing and submit it to the **Practice Administrator of this Facility.** We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to **Practice Administrator of this Facility.** We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used about your care. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the **Practice Administrator of this Facility.** You may request access to your medical information in a certain electronic form and format if readily producible, or if not readily producible, in a mutually agreeable electronic form and format. Further, you may require in writing that we transmit a copy of your health information to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your requests.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect of incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the Practice Administrator of this Facility.

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us which will become part of your medical record.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the Practice Administrator of this Facility. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice at any time, even if you previously agreed to receive the Notice electronically. To obtain a paper copy of this Notice, please contact the Practice Administrator of this Facility. You may also obtain a paper copy of this Notice at our website, www.florida cancer.com.

Changes to this Notice
We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the lobby. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, www.floridacancer.com.

Complaints
If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to the Practice Administrator of this Facility. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing a complaint.

Questions
If you have any questions, please call the Practice Administrator of this Facility at 850-763-0036.