UCF PEGASUS HEALTH
College *of* Medicine
PHYSICIAN PRACTICE

Welcome to UCF Pegasus Health!

As a patient, you'll receive individualized care from the same physicians who are training the next generation of doctors at the UCF College of Medicine.

We appreciate the time and effort it takes to fully complete this new patient packet, which will become part of your permanent medical record. In fact, you should know that all physicians at UFC Pegasus health utilize electronic medical records for the following reasons:

1. **Fewer Errors** – Electronic medical records take the guesswork out of reading handwritten prescriptions at the pharmacy. It also alerts your doctor when there are possible drug interactions, which can be dangerous and even life threatening.
2. **Saves Time** – Prescriptions are sent to your pharmacy electronically from our office so they're ready for pickup when you arrive. Be sure to call first to ensure your medications are in stock and your order has been processed.
3. **Easily Accessible** – Your doctor can easily access your medical records from his/her computer, even after office hours. And if you ever need a copy for yourself or another doctor's office, it's very easy to obtain since it's in a digital format.
4. **Coordinated Care** – If you become ill or have a medical emergency while traveling, authorized physicians can access your medical records so they can make informed treatment decisions based on your medical history. This also is useful for students who attend school out of town and snowbirds who travel to Florida for part of the year.
5. **Higher Security –** Since your medical records are electronic, even if there is a computer outage or natural disaster like a hurricane or fire, your records will remain safe and are still accessible.

Thank you for choosing UCF Pegasus Health for your healthcare needs. We will work hard to keep you healthy and earn your trust during each and every visit.

Sincerely,

Maria Cannarozzi, M.D.
Medical Director, UCF Pegasus Health
Associate Professor, UCF College of Medicine

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Patient Name: ______________________

Date of Birth: ______________________

Medical Record #: ____________

Primary Care Physician: ______________________

Emergency Phone #: ____________ Contact Person/Relationship: ______________________

Reason for the Visit: ______________________

Any Special Concerns: ______________________

Chronic Medical Problem List	Date	Past Surgical History	Date
		Hospitalizations(Reason/Duration)	**Date**

Family History

Y	N	Condition	Family Member
☐	☐	Alzheimer's	________
☐	☐	Anemia	________
☐	☐	Breast Cancer	________
☐	☐	Stroke	________
☐	☐	Cervical Cancer	________
☐	☐	Colon Cancer	________
☐	☐	Heart Disease	________
☐	☐	Depression	________
☐	☐	Diabetes	________
☐	☐	Glaucoma	________
☐	☐	Elevated Cholesterol	________
☐	☐	High Blood Pressure	________
☐	☐	Ovarian Cancer	________
☐	☐	Prostate Cancer	________
☐	☐	Skin Cancer	________
☐	☐	Thyroid Disease	________
☐		Other: ________________	

Vaccines

Vaccine	Date
☐ Pneumonia	________
☐ Tetanus	________
☐ Varicella Zoster	________
☐ Hepatitis B series	________
☐ Measles, Mumps, Rubella	________
☐ Flu shot	________
☐ Other	________

Social History

☐ Married ☐ Single
☐ Divorced ☐ Widow(er)
☐ Lives Alone ☐ Separated
☐ Do you a have a caregiver?

Preferred Language: ____________

Occupation: ____________

Religious Preference: ____________

Education:
☐ High School ☐ College
☐ Other ____________

Patient Name: ________________________________ **Date of Birth:** ________________________________

REVIEW OF SYSTEMS

(*Please place a checkmark for any of the following symptoms you are experiencing.*)

GENERAL:
☐Fever ☐ Chills ☐ Night Sweats ☐ Weakness ☐ Fatigue ☐ Weight Loss ☐Weight Gain

EYE:
☐ Recent visual changes ☐ Yellowness ☐Eye Discharge ☐ Blurring ☐ Double vision ☐ Dry Eyes
☐ Redness ☐ Eye pain

EAR, NOSE, THROAT:
☐ Decreased hearing/Use of hearing aids? ☐ Ear Pain ☐ Nasal Congestion
☐ Sore throat ☐ Dry mouth ☐ Difficulty chewing/swallowing ☐ Snoring ☐ Teeth or gum problems
☐ Mouth sores ☐Nose bleeds

LUNGS:
☐ Shortness of breath ☐ Cough ☐ Sputum ☐ Coughing up blood ☐ Wheezing ☐ Home oxygen use

CHEST:
☐ Chest discomfort ☐ Palpitations ☐ Lightheadedness ☐ Loss of consciousness
☐ Shortness of breath at rest or exertion

ABDOMEN:
☐Nausea ☐Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Abdominal Pain
☐ Black and/or Bloody stools

GENITOURINARY:
☐ Pain or Burning while urinating ☐ Blood in the urine ☐ Change in urine stream ☐ Urinary incontinence

MALES: ☐ History of prostate problems? ☐ Concerns about sexual function?

HEME/LYMPH:
☐ Bruising tendency ☐ Bleeding tendency ☐ Swollen lymph nodes
☐ History of blood clots in the legs or lungs

ENDOCRINE:
☐ Excessive thirst ☐ Excessive urination ☐ Cold Intolerance ☐ Heat intolerance ☐ Excessive hunger

MUSCULOSKELETAL:
☐ Back pain ☐ Neck pain ☐ Joint pain ☐ Muscle Pain ☐ Joint swelling or redness ☐ Stiffness

SKIN:
☐Rash ☐ Dry skin ☐ Hair loss ☐ Sensitivity to sun

NEUROLOGY:
☐ Abnormal balance ☐ Numbness ☐ Tingling ☐ Headache ☐ Tremors ☐ History of seizures
☐ Memory problems

PSYCHOLOGICAL: ☐ Anxiety ☐ Depression ☐ Difficulty sleeping

OTHERS: ☐ Leg swelling ☐ Leg pain while walking

FEMALES: ☐ Vaginal bleeding ☐ Vaginal discharge ☐ Vaginal dryness
☐ Concerns about sexual function?
☐ Date of last menstrual period: ________________________

FALL RISK ASSESSMENT: ☐ Any falls in the last 12 months?
☐ History of broken bones?
☐ Personal of history osteoporosis

☐ **NONE OF THE ABOVE**

Patient Name: ___________________________________ **Date of Birth:** ___________________________________

Drug Allergies – Please list the medications and reactions they cause.

____

____

Preferred Pharmacy - Name:____

Address:___________________________ Zip Code:__________________

Please list your medications and respective dosages in the chart below and provide the reason why you take it. Please list all vitamins, over the counter medications, herbal medicine and etc.

Medication	Dose(units or mg)	Reason/Prescribed Date

Health Habits				
Tobacco(cigarettes or chewing):	☐ Current	☐ Past	☐ Never	
For Current or Past use please provide Amount/Day:________	Number of years used:________			
Alcohol:	☐ Yes: __Beer __Wine __Hard Liquor	Amount/Day:_____________		☐ No
Sunscreen:	☐ Yes: (If yes, which potency) ________________________			☐ No
Exercise:	☐ Yes: (If yes, which type, frequency per week and duration) _________________________			☐ No

Do you have an Advance Directive? ☐ Yes ☐ No If Yes, date: ___________________

If No, would you like to receive information? ☐ Yes ☐ No

I certify that my *Health History Questionnaire* is accurate. I further certify that I have read and agree to the *Patient Policies and Procedures & Notice of Privacy Practices* (rev. 122009.01) located at **UCF Pegasus Health Website (www.ucfpegasushealth.org)** including: 1) *Payment and Billing Policy & Procedures*; 2) *Missed Appointment Policy*; 3) *Disclosure of Information for Reimbursement & Assignment of Benefits*; 4) *Notice of Privacy Practices (HIPAA)*

I understand it is my responsibility to notify UCF *Pegasus Health* of any changes to the above instructions.

____ ____________________________

Patient Signature *(or caregiver/ parent/guardian if minor)* Date

PATIENT REGISTRATION FORM

Today's Date: ________________________ Are you a current UCF COM student? ☐Yes ☐No

Patient's Last Name: _______________________ First Name: ______________________ Middle Name:_____________

Birth Date: ______/______/_______ Gender: ☐ Male ☐Female

Address: ____City: __________________________

State:_______ ZIP Code: _______________

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Partner

Spouse/Partner's Name: ____

☐Visually Impaired ☐Hearing Impaired

Primary Language ______________________ Race ________________________ Ethnicity_____________________

Parent / Guardian Name if Patient is a minor:

Last Name:____________________________ First Name:___________________________ Middle Name:_________________

Address if different: ___________________________________City: __________________________

State:_______ ZIP Code: _______________

Preferred Method(s) of Contact:

Home Phone: ___________________ Mobile Phone: ______________________ Work Phone: ___________________

The following information will assist us in communicating with you about your care while protecting your confidentiality. When we return calls and an answering machine picks up, we do not leave a message if the name of the telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

May we speak with someone other than you when confirming your appointment?

☐ Do not leave me a message or release information to anyone. Please speak to me directly.

☐ Yes – Please list below

Name: ____ Relationship to Patient: _______________________

WHO IS FINANCIALLY RESPONSIBLE FOR THE PATIENT (GUARANTOR)

Patient: ☐ Yes ☐No **if no, please provide details below.**

Last Name:____________________________First Name:____________________________ Middle Name:_________________

Address: _____________________________________City: _________________________State:_______ ZIP Code: __________

Birth Date: _____/_____/______ Gender: ☐Male ☐Female

Home Phone: ____Mobile Phone: ____

Work Phone: _________________________________ Ext: _____ E-mail Address: _______________________

Guarantor's Employer: ____

Patient's Relationship to Guarantor: ____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name: ____

Insurance ID # ____ Group # ____________________________________

Customer Service or Benefits Phone:____

Authorization or Certification Phone: ____

Is the Patient the primary policy holder: ☐ Yes ☐No

Is the Guarantor the primary policy holder: ☐Yes ☐No

If both answers are no, please complete the information below regarding the primary policy holder.

Last Name:____________________________________ First Name:___________________________ Middle Name:__________

Birth Date: _____/_______/_______ Patient's Relationship to Insured: ________________________

Address: ____City: __________________________

State:_______ ZIP Code: _______________

Home Phone: _________________________ Mobile Phone: _______________________

Employer: ____

Work Phone: _________________________________ Ext: __________

SECONDARY INSURANCE INFORMATION

Do you have secondary insurance? ☐Yes ☐No

If yes, please complete the information below regarding the primary policy holder on the secondary insurance.

Secondary Insurance Company Name: ______________________________

Insurance ID #: ______________________ Group #: ______________________

Customer Service or Benefits Phone: ______________________

Authorization or Certification Phone: ______________________

Is the Patient the primary policy holder: ☐Yes ☐No

Is the Guarantor the primary policy holder: ☐Yes ☐No

If both answers are no, please complete the information below regarding the primary policy holder.

Last Name: ______________ First Name: ____________ Middle Name: ____________

Birth Date: ____/____/____ Patient's Relationship to Insured: ______________

Address: ______________________City: ______________

State:_______ ZIP Code: ______________

Home Phone: ______________ Mobile Phone: ______________

Employer: ______________________________

Work Phone: ______________ Ext: ________

EMERGENCY CONTACT INFORMATION

Name:______________ Relationship: ____________ Phone: ____________

Name:______________ Relationship: ____________ Phone: ____________

Name:______________ Relationship: ____________ Phone: ____________

I certify that the above information is my personal information and has not been fraudulently derived. I understand that it is my responsibility to notify UCF Pegasus Health of any changes to the above instructions.

______________________________ ______________________

Signature of Patient or Patient's Authorized Representative Date

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

______________________________ ______________________

Name Relationship to Patient

How Did You Hear About Us?

1. How did you hear about us? Please check all that apply.

   ___ **Friend or Family Member**

   ___ **Physician Referral** – Which one? ______________________________

   ___ **Insurance Company** – Which one? ______________________________

   ___ **UCF Student Health**

   ___ **Information by Mail** *(Postcard, letter, etc.)* – Please explain __________________________

   ___ **Television or Radio** *(News story, ad, etc.)* – Please explain ___________________________

   ___ **Print Publication** *(Newspaper, magazine, etc.)* – Please explain _________________________

   ___ **Email** *(Email newsletter, etc.)* – Please explain _____________________________________

   ___ **Internet** *(Our website, Healthgrades, etc.)* – Please explain _____________________________

   ___ **Social Media** *(Facebook, Twitter, etc.)* – Please explain _______________________________

   ___ **Event** *(Health fair, community event, etc.)* – Please explain ____________________________

   ___ **Visited UCF Pegasus Health** *(Seminar, special event, etc.)* – Please explain ________________

   ___ **Health Tips** *(Sent via email or online)*

   ___ **Driving By**

   ___ **Other** – Please explain _____________________________

2. What is your zip code? _____________________________

3. If you would like to receive periodic health information, please give us your name and email. You can easily opt out at any time.

   Name: _____________________________ Email: _____________________________

UCF PEGASUS HEALTH
College of Medicine

CONSENT AND AUTHORIZATION

Patient's Name: ______________________________

Date of Birth: ______/______/______ Date of Visit: ______/______/______

Welcome to UCF Pegasus Health. We are a clinical faculty of the University of Central Florida College of Medicine and our goal is to provide high quality medical care that meets your individual needs. Our physicians and staff are all part of the UCF College of Medicine, and on occasion we include medical students in our clinical teams.

We are honored to serve you and welcome your questions and suggestions. Below are some standard consents and authorizations.

I. **Authorization for Routine Diagnostic Procedure and Medical Treatment** - I hereby consent to such diagnostic procedures and medical treatments which in the judgment of my health care provider may be considered necessary or advisable while a patient at UCF Pegasus Health. I recognize that the UCF Pegasus Health physicians and staff are employees of a health care teaching and research institution and that my treatment and care may be observed and in some instances aided by medical students under appropriate supervision. I consent to UCF Pegasus Health taking photographs of me in the course of and related to my treatment and to their use of such photographs and my medical data for educational purposes. I hereby authorize UCF Pegasus Health to retain, preserve and use for scientific, educational or research purpose, or dispose of as they might deem fit, any specimens or tissues taken from my body.

II. **Assignment of Benefits and Responsibilities for Payment** - I hereby assign to UCF Pegasus Health payment from all third party payors with whom I have coverage or from whom benefits are or may become payable to me, for the charges of any health care services I receive for, related to, or connected with this visit or treatment by UCF Pegasus Health (past, present, or future). I agree to be personally responsible for payment of any health care services that are not covered by my third party payors, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurance, and/or co-payments. Third party payors include, but are not limited to, coverage available from: Medicare, Medicaid, Tri-care, or governmental programs; health, accident, automobile, or other insurance; worker's compensation; HMO (commercial, Medicaid, Medicare); self-insured employers; and any sponsors who may contribute payment for services.

III. **Release of Medical Information by UCF Pegasus Health** - By signing below as Patient/Representative, I hereby authorize the UCF Pegasus Health physicians providing services during treatment and care, to release information from and/or copies of my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, and HIV tests), and other information as may be required for my medical care and to secure payment for charges incurred by me or on my behalf, to: any UCF Pegasus Health affiliated facility or provider, the Tumor Registry, my physician, my referring physician, the Guarantor on my accounts, insurance companies for which I have assigned benefits for my treatment and care, or to any sponsors that UCF Pegasus Health may later obtain to contribute payment for my treatment and care. I also authorize release of any information to any and all regulatory and/or accrediting organizations as necessary for UCF Pegasus Health to maintain its licensure and accredited status. In addition, I authorize release of any information to county, state or federal public health agencies, and as required by law. I further authorize the Department of Child and Family Services and/or the Social Security Administration to release any confidential case information to my application for government assistance,

which is requested by UCF Pegasus Health.

IV. **Guarantor Agreement** - By signing below as Patient/Representative or Guarantor, or as Patient's/Representative's Spouse or Guarantor's Spouse, I hereby agree that all charges connected with the treatment, not covered by any insurance, program, sponsorship or other third party coverage I may have, are due and payable by me at the time of the visit or discontinuation of treatment. If the insurance information I have provided is not active at the time of service or if the services provided are not covered by my insurance company, I will be responsible for any balance due at the time of service. The charges I agree to pay are those listed in the current Billing Charge Fee Schedules unless otherwise established by an applicable agreement. I understand that billing statements will be sent to the patient for whom the services have been rendered, but as guarantor, I am responsible for payment. I hereby acknowledge that, unless UCF Pegasus Health and my insurance company or third party carrier have agreed that I will not be billed, if UCF Pegasus Health has agreed to bill my insurance or other third party carrier it has agreed to do so as a courtesy and that UCF Pegasus Health has the right to demand payment in full from me at any time prior to full payment from any insurance carrier. If an overdue account is referred by collections, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a Judgment is entered against me for collection of the charges I have agreed to pay.

V. **Lien on Third Party Liability Proceeds** - If my admission or treatment is due to an accident or injury, UCF Pegasus Health shall have a lien upon the proceeds of any cause of action, suit, claim, counterclaim, or demand accruing to me or my legal representative as a result of such accident or injury, in order to recover payment for all charges of health care services I receive for, related to, or connected with such accident or injury (past, present, or future), effective as of the date treatment was first provided. The foregoing shall be sufficient notice to me of the existence of a lien, which shall be effective whether or not it is filed in the public records. The foregoing is in addition to any lien to which UCF Pegasus Health may be entitled by law.

VI. **Agreement to Pay for Professional Component and Other Pathology Services** - When a specimen of my blood, urine, stool, or similar material is tested, the testing will be performed under the supervision of the pathologist who directs the laboratory. The pathologist may not perform the test or personally review its results. However, the pathologist is responsible for supervising the laboratory to assure that the results of all of my tests are clinically reliable and are reported to my doctor in a timely manner. I will receive a bill from the pathologist for these supervisory services for each test even if the pathologist did not personally perform the test or review its results. By signing this Agreement, I agree to be responsible for the pathologist's bill to the extent that my insurer or managed care plan does not pay for it.

By signing below, I acknowledge that I have read and understand this Consent and Authorization.

Patient/Representative ____________________________	Patient/Guardian Spouse ____________________________
Insured ____________________________________ (if other than patient)	Insured ____ (if other than patient)
Guarantor __________________________________ (if other than patient)	Guarantor's Spouse _________________________________ (if other than patient)
Witness ____________________________________	Date ____

COPIES OF THIS STATEMENT SHALL BE AS VALID AS THE ORIGINAL.
ORIGINAL SIGNATURES ON FILE WITH UCF PEGASUS HEALTH.

UCF PEGASUS HEALTH
College of Medicine
PHYSICIAN PRACTICE

Introducing the UCF Pegasus Health Patient Portal

We are excited to introduce the Pegasus Health Patient Portal which is making it easier than ever for you to communicate with our medical staff, view prescriptions and schedule appointments—all from the privacy of your own home though a secure online patient portal called IQ Health.

Registering for IQ Health is quick and easy. Simply request portal access information from our office staff, then go online and register. In just minutes, your personalized UCF Pegasus Health patient portal will be ready to use anytime.

Powered by Cerner Health, this leading-edge healthcare technology is HIPAA compliant, so you can log on with confidence that your health and personal information is fully protected. It also improves efficiency of communication regarding your health, eliminating the need for multiple phone calls.

IQ Health users will be able to view test results online and receive reminders for preventative care measures like annual physical exams and cancer screenings.

Understanding Electronic Communication

What should you know about e-mail communication?

The most important thing you should know is we cannot guarantee the confidentiality of unsecured email. While the security of e-mail is comparable to other types of communication (such as phone calls), there are some challenges with e-mail.

- If your e-mail address is through your employer, your employer may own all e-mails sent to that address.
- If your e-mail is a family address, other family members may see your messages.
- If you use an internet service provider, there is a small risk that messages may be intercepted by others.

Due to the reasons above, Pegasus Health has adopted the patient portal as the only source of secure electronic communication. Pegasus Health is not responsible for technical difficulties or network infractions beyond the computer and software systems we operate.

- You should also know that secure messages sent through the patient portal will be read by designated staff in our practice.
- Like phone calls, these messages may be screened by office staff before being routed to the appropriate person for a response. Copies of your secure messages may be placed in your medical record.

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What types of communication are appropriate for secure messaging through the patient portal?

Types of requests or messages are appropriate for secure messaging:

- Prescription refill requests
- Appointment scheduling
- Non-urgent medical follow-up (including some types of test results)
- Non-urgent medical correspondence

Subjects that are **NEVER** appropriate for secure messaging:

- Any urgent medical problem or emergency
- Mental health issues
- Drug and alcohol problems
- HIV and other sexually transmitted diseases
- Work-related injuries and disability
- Any information that infringes the rights of others or violates their privacy or publicity rights, in particular (without limitation), material which is of a bullying, harassing or discriminatory nature.

Please keep in mind that although secure messaging can be a very effective tool, it is not a substitute for a face to face visit with your physician. Please call as soon as possible if you feel the need to be evaluated.

How do I communicate with my physician using secure messaging through patient portal?

- Many patient e-mail addresses do not clearly identify the sender. Please make sure your full name and date of birth is present in the body of the message.

You can expect a response to your message by the next business day. You should not expect to receive a response on weekends or holidays or any other time the office may be closed.

Patient Portal Enrollment

- Complete the following form with:
  - First Name, Middle Name (if applicable), Last Name, Date of Birth, and email.
- A Pegasus Health team member will create your account.
- You will receive an email invitation from www.iqhealth.com at the email address provided.
- Click on the link within the invitation email to begin the registration process.
- Sign in with Cerner Health using your temporary password.
- Complete full registration.
- Please use a password that you will remember. Pegasus Health team members will not have access to this information.

IQ Health Portal Participation Agreement

By signing this form you are granting permission to Pegasus Health to register you as a member of the UCF Pegasus Health Patient Portal.

Patient's First, Middle (if applicable), and Last Name

Date of Birth (Month, Day, Year)

Email

Last Four Digits of SSN (This will be your temporary password for registration)

Signature

Today's Date

Administrative Use:

MRN: ___________________

______ IQ Health Registration Complete   ______ Temporary Password Emailed

Completed By: ___________________________________   Date: ______________

UCF PEGASUS HEALTH
COLLEGE OF MEDICINE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health information; to provide you this detailed Notice of our legal duties and privacy practices relating to your health information; to notify you following a breach of the privacy or security of your unsecured protected health information and to abide by the terms of the Notice that are currently in effect. The effective date of this Notice is September 23, 2013.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The following lists various ways in which we may use or disclose your health information for purposes of treatment, payment and health care operations.

For Treatment. We will use and disclose your health information in providing you with treatment and services and coordinating your care and may disclose information to other providers involved in your care. Your health information may be used by doctors involved in your care and by nurses, medical assistants and technologists and other care givers as well as by physical therapists, pharmacists, suppliers of medical equipment or other persons involved in your care. For example, Pegasus Health physicians and medical assistants will discuss coordination of your care.

For Payment. We may use and disclose your health information for billing and payment purposes. We may disclose your health information to your representative, or to an insurance or managed care company, Medicare, Medicaid or another third party payor. For example, we may contact Medicare or your health plan to confirm your coverage, to request prior approval for services that will be provided to you, and/or for reimbursement of care provided to you.

For Health Care Operations. We may use and disclose your health information as necessary for health care operations, such as accreditation, management, personnel evaluation, education and training and to monitor our quality of care. We may disclose your health information to another healthcare-related entity with which you have or had a relationship if that entity requests your information for certain of its health care operations or health care fraud and abuse detection or compliance activities. For example, health information of many patients may be combined and analyzed for purposes such as evaluating and improving quality of care.

II. SPECIFIC USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following lists various ways in which we may use or disclose your health information.

<u>Individuals Involved in Your Care or Payment for Your Care</u>. Unless you object, we may disclose health information about you to a family member, close personal friend or other person you identify, including clergy, who is involved in your care.

<u>Emergencies</u>. We may use or disclose your health information as necessary in emergency treatment situations.

<u>As Required By Law</u>. We may use or disclose your health information when required by law to do so.

<u>Business Associates</u>. We may disclose your protected health information to a contractor or business associate who needs the information to perform services for UCF Pegasus Health. Our contractors and business associates are committed to preserving the confidentiality of this information.

<u>Public Health Activities</u>. We may disclose your health information for public health activities. These activities may include, for example, reporting to a public health authority for preventing or controlling disease, injury or disability; reporting child abuse or neglect or reporting births and deaths.

<u>Reporting Victims of Abuse, Neglect or Domestic Violence</u>. If we believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your health information to notify a government authority, if authorized by law or if you agree to the report.

<u>Health Oversight Activities</u>. We may disclose your health information to a health oversight agency for oversight activities authorized by law, such as audits, investigations, inspections, licensure, disciplinary actions or for activities involving government oversight of the health care system or facility.

<u>To Avert a Serious Threat to Health or Safety</u>. When necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person, we may use or disclose health information, limiting disclosures to someone able to help lessen or prevent the threatened harm.

<u>Judicial and Administrative Proceedings.</u> We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request or other lawful process so long as the party seeking the information demonstrates reasonable efforts were made by such party to contact you about the request or to obtain a qualified protective order in accordance with 45 CFR section 164.512 (e)(1)(v).

<u>Law Enforcement</u>. We may disclose your health information for certain law enforcement purposes, including, for example, to comply with reporting requirements; to comply with a court order, warrant, or similar legal process; or to answer certain requests for information concerning crimes.

<u>Research</u>. We may use or disclose your health information for research purposes if the privacy aspects of the research have been reviewed and approved, if the researcher is collecting information in preparing a research protocol, if the research occurs after your death, or if you authorize the use or disclosure.

<u>Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations</u>. We may release your health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

<u>Disaster Relief</u>. We may disclose health information about you to a disaster relief organization.

<u>Military, Veterans and other Specific Government Functions</u>. If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities. We may

disclose health information for national security purposes or as needed to protect the President of the United States or certain other officials or to conduct certain special investigations.

Workers' Compensation. We may use or disclose your health information to comply with laws relating to workers' compensation or similar programs.

Inmates/Law Enforcement Custody. If you are under the custody of a law enforcement official or a correctional institution, we may disclose your health information to the institution or official for certain purposes including the health and safety of you and others.

Appointment Reminders. We may use or disclose health information to remind you about appointments.

Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

Fundraising. We may, with your permission, contact you for fundraising for the benefit of Pegasus Health and you have a right to opt out of receiving such communications.

III. USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Except as described in this Notice, we will use and disclose your health information only with your written Authorization (such as, for certain types of marketing, sale of your protected health information). For example, we will only use and disclose your health information for the purposes of marketing with your written Authorization. Further, most psychotherapy notes may not be disclosed for any purpose, including treatment, payment or health care operations, without your written Authorization. You may revoke an Authorization in writing at any time. If you revoke an Authorization, we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Listed below are your rights regarding your health information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to the UCF Pegasus Health. At your request, UCF Pegasus Health will supply you with the appropriate form to complete. You have the right to:

Request Restrictions. You have the right to request restrictions on our use or disclosure of your health information for treatment, payment, or health care operations. You also have the right to request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction EXCEPT (i) if you request that we not disclose certain medical information to your health insurer and that medical information relates to a health care product or service for which we otherwise have received payment in full from you or on your behalf (from someone other than your health insurer), then we must agree to the request unless the disclosure is otherwise required by law and (ii) if you are competent you may restrict disclosures to family members or friends. If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment.

Access to Personal Health Information. You have the right to inspect and obtain a copy of your clinical or billing records or other written information that may be used to make decisions about your care, subject to some exceptions. Your request must be made in writing. In most cases we may charge a reasonable fee for our costs in copying and mailing your requested information. You may request an electronic copy of any of your clinical or billing records that are maintained electronically.

We may deny your request to inspect or receive copies in certain circumstances. If you are denied access to health information, in some cases you have a right to request review of the denial. This review would be performed by a licensed health care professional designated by UCF Pegasus Health who did not participate in the decision to deny.

Request Amendment. You have the right to request amendment of your health information maintained by UCF Pegasus Health for as long as the information is kept by or for UCF Pegasus Health. Your request must be made in writing and must state the reason for the requested amendment.

We may deny your request for amendment if the information (a) was not created by UCF Pegasus Health, unless the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by or for UCF Pegasus Health; (c) is not part of the information to which you have a right of access; or (d) is already accurate and complete, as determined by UCF Pegasus Health.

If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial and how you may file such a statement. In addition, you may request that UCF Pegasus Health provide your request for amendment and the denial with any future disclosures of the protected health information that is the subject of the amendment, in lieu of submitting the statement of disagreement.

Request an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your health information. This is a listing of disclosures made by UCF Pegasus Health or by others on behalf of UCF Pegasus Health, but does not include disclosures for treatment, payment and health care operations (except where such disclosures are through an electronic health record). , disclosure made pursuant to your Authorization, and certain other exceptions.

To request an accounting of disclosures, you must submit a request in writing, stating a specific time period. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs.

Request a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. In addition, you may obtain a copy of this Notice at our website, www.ucfpegasushealth.com.

Request Confidential Communications. You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

V. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact the UCF College of Medicine HIPAA Privacy Officer at 407-266-1000.

If you believe that your privacy rights have been violated, you may file a complaint in writing with UCF College of Medicine/Pegasus Health and/or the Office of Civil Rights in the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint.

To file a complaint with UCF Pegasus Health, contact the UCF College of Medicine HIPAA Privacy Officer at 407-266-1000.

VI. CHANGES TO THIS NOTICE

We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all health information already received and maintained by UCF Pegasus Health as well as for all health information we receive in the future. We will provide a copy of the revised Notice upon request or you can access it from the UCF Pegasus Health website at www.ucfpegasushealth.com.

UCF PEGASUS HEALTH
College of Medicine

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Name of Patient: ____

Date of Birth: ________________________

I have received a copy of UCF Pegasus Health's *Notice of Privacy Practices*. I understand that UCF Pegasus Health has the right to change its *Notice of Privacy Practices* from time to time and that I may contact UCF Pegasus Health at any time to obtain a current copy of the *Notice of Privacy Practices*.

I am Consenting to the disclosure of my protected health information to the following individuals.

Name:____________________________________ Relationship:_________________________

Name:____________________________________ Relationship:_________________________

Name:____________________________________ Relationship:_________________________

_________________________________ _____________________________

Signature of Patient or Patient's Authorized Representative   Date

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

________________________________ _____________________________

Name   Relationship to Patient

For Office Use Only – To be completed only if no signature is obtained.

I have made a good faith effort to obtain the patient's signature on this form, but was not able to do for the following reason:

❑ Patient (or Patient's Representative) refused to sign.

❑ Other: ____

Signature of UCF Pegasus Health representative: ________________________________
Date: _______________

UCF PEGASUS HEALTH
College of Medicine

PATIENT'S BILL OF RIGHTS & RESPONSIBILITIES

As a patient at UCF Pegasus Health, you have certain rights and responsibilities.

You have the right to:

- At all times and upon all occasions, be treated with courtesy and respect, with appreciation of your dignity, safety and privacy.
- Retain certain rights to privacy of your clinical records, to the extent consistent with providing adequate medical care and the efficient administration of UCF Pegasus Health's office. This right will be respected without regard to your economic status or source of payment for your care.
- A prompt and reasonable response to your questions and requests.
- Know, upon request, the name, function, and qualification of each person who is providing medical services and who is responsible for your care.
- Know what patient support services are available to you, including an interpreter in your language if you do not speak English, if one is readily available, at no charge to you.
- Participate in decisions involving your health care and be given information concerning your diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to you. In this event, the information will be given to your guardian or the person designated as your representative. You have the right to refuse this information.
- Refuse treatment based on information provided to you by your health care provider. If you refuse any treatment, your refusal will be documented by your health care provider in your care record.
- Know what rules and regulations apply to your conduct.
- Be provided, upon request, full information and necessary counseling on the availability of known financial resources for your care.
- To know, upon request and prior to treatment, whether UCF Pegasus Health accepts the Medicare assignment rate and to receive a Medicare "Notice of Non-Coverage Rights" when necessary.
- Receive, upon request and prior to treatment, a reasonable estimate of charges for your medical care. If you are uninsured you have the right to receive, upon request and prior to the start of a medical service, a reasonable estimate of charges for such services and information regarding UCF Pegasus Health's discount or charity policies for which you may be eligible. The estimate will be based on your current condition and treatment plan.
- Receive, upon request, a copy of a clear and understandable itemized bill and a full explanation of all charges.

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- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Assistance with obtaining emergency medical treatment.
- Access any mode of treatment that is, in your own judgment and the judgment of your health care provider, in your best interest, including complementary or alternative health care treatments, to the extent such mode of treatment is offered by UCF Pegasus Health.
- Know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research. Your refusal of such experimental research will not compromise your access to any other services. Your acceptance or refusal will be documented in your care record.
- Know UCF Pegasus Health's procedure for expressing a grievance regarding any alleged violations of your rights and express your grievances regarding any alleged violation of your rights, through the grievance procedure of your health care provider or UCF Pegasus Health and the appropriate state agency.
- Be provided with written information about advance directives and available health care decision-making options in Florida.
- Access information contained in your clinical records upon request within a reasonable time frame.

<u>It is your responsibility to:</u>

- Provide UCF Pegasus Health, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
- Report unexpected changes in your condition to your health care provider.
- Tell your health provider if you do not understand your care plan and what is expected of you.
- Follow the treatment plan recommended by your health care provider.
- Keep your appointments and, when you're unable to do so for any reason, notify UCF Pegasus Health.
- Be responsible for your actions if you refuse treatment or do not follow your health care provider's instructions.
- Assure the financial obligations of your health care are fulfilled as promptly as possible.
- Follow UCF Pegasus Health's rules and regulations affecting patient care and conduct.

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