

McDougle Medical, LLC

Patient Name:	Date of Birth
---------------	---------------

Instructions: The following section to be completed by office. Last section to be completed by Patient or Guardian.

Release Information From <input type="checkbox"/> McDougle Medical, LLC 5047 Central Ave. St. Petersburg, FL 33710 Phone: 727-339-5496 Fax: 727-361-6247 <input type="checkbox"/> Other (<i>Specify facility/individual & address below, including phone/fax if known</i>) _____ _____ _____	Release Information To <input type="checkbox"/> McDougle Medical, LLC 5047 Central Ave. St. Petersburg, FL 33710 Phone: 727-339-5496 Fax: 727-361-6247 <input type="checkbox"/> Other (<i>Specify facility/individual & address below, including phone/fax if known</i>) _____ _____ _____
Purpose of Release <input type="checkbox"/> Treatment/Continued care <input type="checkbox"/> Legal purposes <input type="checkbox"/> Other <input type="checkbox"/> Application for insurance <input type="checkbox"/> Payment of _____ <input type="checkbox"/> Personal Insurance <input type="checkbox"/> Disability determination Claims _____	
Information To Be Released (Required: Check all that apply) <input type="checkbox"/> Clinic notes <input type="checkbox"/> Pathology reports <input type="checkbox"/> History and physical <input type="checkbox"/> Radiology reports <input type="checkbox"/> Hospital notes <input type="checkbox"/> Radiology images <input type="checkbox"/> Hospital discharge summary <input type="checkbox"/> Billing information <input type="checkbox"/> EKG's <input type="checkbox"/> Other (<i>specify information to be released below</i>) <input type="checkbox"/> Immunization records _____ <input type="checkbox"/> Laboratory reports _____ <input type="checkbox"/> Operative reports _____	
Service dates (optional) From _____ To _____ Information needed by (optional) _____	

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal law.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.			
<ul style="list-style-type: none"> • If the patient is 18 years of age or older, the patient must sign and date the form. • If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship: <ul style="list-style-type: none"> <input type="checkbox"/> Legal Guardian or Conservator <input type="checkbox"/> Health Care Agent (Health Care Power of Attorney) • If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: <ul style="list-style-type: none"> <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian 			
Signature (<i>Required</i>)		Date Signed (<i>Required</i>) (Month, DD, YYYY)	
Printed Name of Person Signing (if not patient)			
Mailing Address of Patient - Street			
City	State	Zip Code	Phone

NOTICE OF PRIVACY PRACTICES

Patient: _____ **DOB:** _____

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations. We may also create and distribute de-identified health information by removing all references to individually identifiable information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Medical Records Requests

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the Notice of Privacy Practices.

Patient (Print): _____

Date: _____

Patient Signature: _____

Patient: _____

DOB: _____

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

McDougle Medical, LLC reserves the right to communicate PHI with family or friends when it is deemed to be in the best interest of the patient as described in the Notice of Privacy.

In order to have your PHI shared in other circumstances with members of your family or friends, please list those individuals who McDougle Medical, LLC is authorized to release information to.

Signature of Patient

Date

ALTERNATIVE COMMUNICATION RELEASE FORM

I authorize McDougle Medical, LLC, in regards to my protected health information (PHI): (→ *all that apply*)

- To call me at work
- To call me at home
- To call my cell phone
- To send me a message via text messaging
- To contact me via video telephone interface (telemedicine)
- To speak with anyone listed on the Right To Share Information list
- To only speak with me
- To fax information to me at this secured number _____
- Hint, Spruce, and Elation
- Other

**Authorization to Release Protected Information
Notification of Controlled Substances**

While McDougle Medical, LLC is able to prescribe necessary scheduled medications, it is important to disclose our philosophy regarding some of the stronger—and potentially harmful— pain relief medication. McDougle Medical, LLC is aware of the potential side effects of this class of medication (particularly benzodiazepines and opiates), and will do our best to curb their use or find less potentially harmful pharmacological options. Please do not join McDougle Medical, LLC with the assumption that McDougle Medical will fill controlled substances on the initial visit. If certain chronic pain narcotics are necessary, McDougle Medical, LLC will refer out to a local pain management specialist. Candidly, if you are expecting McDougle Medical, LLC to prescribe high dose narcotics such as opiates, McDougle Medical, LLC may not be the right practice for you.

Sincerely,

Eric McDougle, PA-C

Patient Signature

Date

Patient: _____

DOB: _____

Patient No-Show Policy and Procedure

McDougle Medical, LLC provides standards for scheduling patient appointments that help enhance patient care. Please understand that our appointment times are scheduled to allow us to take care of each patient's individual needs during the patients visit. To promote efficient access to our office, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance.

[In an event an appointment is missed or cancelled with less than 24 hours' notice or no notice, McDougle Medical, LLC follows the process below.

- **1st missed appointment:** We will call you and reschedule the appointment
- **2nd missed appointment:** We will call and offer to reschedule. You will receive an email explaining our policy, and you may be charged a missed appointment fee of up to \$35.
- **3rd missed appointment:** This could result in discharge from our practice. You may be asked to find another physician outside of McDougle Medical, LLC.]

Our main concern is to manage your health care with the highest quality skill and efficiency we can offer. If you have question, our staff will be happy to answer them.

Signature of Patient

Date

Communication Guidelines with McDougle Medical, LLC

Dear Member,

Thank you for joining McDougle Medical, LLC! I am honored to have you as a Member and I look forward to our partnership, helping you achieve your optimal health. As a McDougle Medical, LLC Member, we will begin to form a therapeutic partnership that goes beyond that of a traditional primary care practice.

My staff and I want you to feel very comfortable communicating with us when it comes to your overall care and well-being, but because of your likely unfamiliarity with our business model, we'd like to take this time to orient you.

How to Reach Me

Office: Our **preferred means of contact is during office hours** (Monday through Thursday, 9:00 AM–5:00 PM and Friday, 9:00 AM-2:00PM). Please call our office directly at our main office number: (727) 339-5496. We will do our best to get back to you in a timely manner.

For after-hours issues that cannot wait until normal business hours, we have several options for our Members. However, please understand that I am also attending to the needs of my family and other commitments. I appreciate your respect of my personal time. Either way, I will do my best to return your call as promptly as I can and am happy to help you as needed.

Texting: During after-hours or weekends, for a quicker response to pointed questions (such as a script refill that cannot wait until office hours), it is best to reach me via secured messaging. You may message me through our secured messaging app, Spruce (<https://www.sprucehealth.com/www.sprucehealth.com>).

Cell Phone: Calling my office phone on weekends and after-hours will forward you directly to my cell phone. These are for pressing non-emergency needs (such as a laceration). Please know that while McDougle Medical, LLC cannot guarantee 24/7 service, we will do our best to answer your questions in a timely manner.

Life threatening emergencies: Please call 9-1-1 directly for assistance or go to your nearest emergency room.

Email: If any non-pressing medical questions arise, please feel free to e-mail me at stpetedirectprimarycare@gmail.com. For administration questions like Membership, billing, etc., please e-mail us at stpetedirectprimarycare@gmail.com.

McDougle Medical, LLC

Thank you again for joining McDougle Medical, LLC. You have made an important first step to improving your health, and I am honored to be your provider of choice!

Sincerely,

Eric McDougle, PA-C

Thank you for taking the time to complete these forms!