The Health Associates of Tampa
508 S. Habana Ave Suite #300
Tampa, FL 33609
Phone:(813) 877-6770
Fax: (813) 877-6771

New Patient Information

Patient Name: _____

Home Address: _____

City: _____ State: _____ Zip_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

SSN: _____ Date of Birth: ____/____/_____ Sex: Male / Female

Ethnicity: _____ Marital Status: _____

No. Of Children: _____

Emergency Contact:

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Occupation

Occupation: _____

Employer Name: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Physician Information

Referring Physician Name: _____

Address _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Pharmacy

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Insurance Information

Name of the Carrier:_____

Name of the Policy Holder:_____

Member ID: _____Group #_____

Address of the carrier: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

How did you hear about us or whom we need to thank for this visit?

Friend/Family _____
Employer: _____
Internet: _____ *Direct Mail:* _____
Community event: _____ *Residing community:* _____

PLEASE PROVIDE YOUR DRIVERS LICENSE AND INSURANCE CARD TO THE FRONT DESK

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Name:_____Date of first visit: _____

Reason for visit: _____

Past Medical History

☐ High Blood Pressure	☐ High Cholesterol	☐ Diabetes
☐ Heart Disease	☐ Blood Clots	☐ Stroke
☐ Mini Stroke (TIA)	☐ Emphysema/COPD	☐ Asthma
☐ Pneumonia	☐ Positive PPD	☐ TB
☐ Acid reflux	☐ Stomach Ulcers	☐ Gall stones
☐ Diverticulitis	☐ Colon polyps	☐ Hemorrhoids
☐ Liver Disease	☐ Kidney disease	☐ Kidney stones
☐ Osteoarthritis	☐ Lupus	☐ Rheumatoid
☐ Gout	☐ Psoriasis	☐ Osteoporosis
☐ Thyroid disease	☐ Anemia	☐ Bleeding
☐ Blood Transfusion	☐ Headaches	☐ Migraines
☐ Back pain	☐ Glaucoma	☐ Enlarged
☐ Seizures	☐ Depression	☐ Anxiety
☐ Irregular periods	☐ Macular degeneration	☐ Hearing loss
☐ Other		

Current Medications:

Allergies:

_____

Surgical History

☐ Appendectomy ☐ Cholecystectomy ☐ Thyroid surgery

☐ Hysterectomy ☐ _____ ☐ _____

Social History

Tobacco abuse: Packs per day_____ X years smoked_____.

Alcohol Consumption: _____ Drugs: _____

Diet: _____

Exercise: _____

Family History Mother Father Brother/s Sister/s Other

_____

_____

_____

_____

_____

Vaccination History

Please check if you had any of these	Vaccinations	Date of the most recent
☐	Influenza (Flu shot)	
☐	Pneumonia	
☐	Hepatitis A	
☐	Hepatitis B	
☐	Shingles	
☐	Tetanus	
☐	Other:	

Screening

Please check if you had any of these	Test	Date of the most recent	Any prior dates
☐	Colonoscopy		
☐	Mammogram		
☐	Bone density scan		
☐	PSA		
☐	PAP smear		
☐	Eye exam		
☐	Stool cards		

Review of systems

General: Please check if you had any in the last three months

☐ Any unexplained weight loss ☐ Any fatigue/malaise/lethargy, ☐ Any fever
☐ Any night sweats ☐ Any loss of appetite,

Nutrition:

☐ Special diet or tube feeding
☐ Lost more than 5-10 lbs unintentionally in the last month
☐ Difficulty swallowing food and/or bevarage
☐ BMI less than 19

HEENT:

☐ Any headaches ☐ Ringing in the ears ☐ Sinus pain
☐ Any vision changes ☐ Ear pain ☐ Sore throat
☐ Any double vision ☐ Nose bleeds ☐ Hoarse voice
☐ Dry eyes ☐ Excessive sneezing
☐ Hearing loss ☐ Runny nose

Cardiovascular

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Exercise intolerance
- ☐ PND
- ☐ Orthopnea
- ☐ Edema
- ☐ Palpitations
- ☐ Fainting spell

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Sputum production
- ☐ Blood in sputum

Gastrointestinal

- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Abdominal pain
- ☐ Acid reflux
- ☐ Nausea/ Vomiting
- ☐ Vomiting blood
- ☐ Constipation/ Diarrhea
- ☐ Black stools
- ☐ Blood in stool

Genitourinary

- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Painful urination
- ☐ Dribbling
- ☐ Blood in urine

Musculoskeletal:

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle aches
- ☐ Morning stiffness
- ☐Fractures

Neurological:

- ☐ Seizures
- ☐ Tingling
- ☐ Muscle weakness
- ☐ Numbness
- ☐ Slurred speech
- ☐ Dizziness
- ☐ Lack of coordination

Skin:

- ☐ Rash
- ☐ Itch
- ☐ Wounds
- ☐ Nodules
- ☐ Cellulitis
- ☐ Incision

Endocrine:

- ☐ Tremor
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Polyuria
- ☐ Polydipsia
- ☐ Diarrhea
- ☐ Difficult to treat HTN
- ☐ Polyphagia
- ☐ Increased sweating

Hematologic:

- ☐ Anemia
- ☐ Easy bruising
- ☐ Blood thinners
- ☐ Prolonged bleeding
- ☐ Anti-platelet drugs
- ☐ Blood transfusion

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty with sleep
- ☐ Panic attacks
- ☐ Erectile dysfunction

Social:

Y	N		Y	N	
☐	☐	Would you REFUSE blood and/or blood products?	☐	☐	Do you have a history of abuse/violence?
☐	☐	Are you homeless or have housing problems?	☐	☐	Have you recently lost a loved one?
☐	☐	Are you in a drug or alcohol treatment program?	☐	☐	Do you currently live alone?
☐	☐	History of sexual abuse/forced sexual contact?	☐	☐	Have you fallen in the past year/last visit?
☐	☐	Thoughts of hurting or killing or killing self?	☐	☐	Are you currently experiencing domestic violence?
☐	☐	Do you require assistance with walking?	☐	☐	Do you fee like life is not worth living or you're better of dead?
☐	☐	Do you have transportation problems?			

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Office and Financial Policies

We would like to thank you for choosing The Health Associates of Tampa as your primary care provider. We are committed to provide our patients with high quality medical care in a cost effective manner. To accomplish this, we depend on receiving prompt payment for our services. To keep you informed of our current office and financial policies, we ask that you read and sign our financial acknowledgement prior to any treatment. Please keep this document for future reference.

Cancelled Appointments: If you are unable to keep your scheduled appointment, please call our office within 24 hours to reschedule. This will enable us time to use your slot for another patient. We reserve the right to charge a fee of $25 for appointments cancelled or broken without 24 hours notice.

Payment: The Health Associates of Tampa provides a variety of payment methods. We accept cash, checks, Visa and MasterCard. For patients with no medical insurance: Payment will be due at the time of service. If you are unable to pay your balance in full you will need to make prior arrangements with our Billing Office. Patients with Medical Insurance: Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, a processing fee will be added to your account to cover additional billing expenses that will be incurred

You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of that statement. Any balance over 60 days will be assessed a late fee. A payment plan can be arranged with our Billing Department upon request.

Patients are responsible for knowing the benefits covered by their insurance policies. Our services are documented to comply with federal law and will be billed accordingly. Verification that our providers are “in network” with an insurance plan is the patient’s responsibility. Patients are responsible for verification that all referrals or prior authorizations are attained before services are provided, as imposed by their benefit plan.

Auto Accident Injury: If your injury is due to an automobile accident, we require that you provide us with any information that will assist us in getting your medical claims paid. You must contact the office and a form with the information required will be made available for you to complete.

Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

Liability Injury: If your injury is a result from another party's negligence, we request that you provide us with any information that will assist us in obtaining reimbursement for the services rendered to you. You must contact the office and a form with the information required will be made available for you to complete. Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

Worker's Compensation: If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims. Please have your employer contact our Billing Department at 813-890-8004. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

Returned Checks: A $31.00 charge will be added to your account for any check returned by your bank for any reason. This is subject to change based on bank charges.

Medical and Other Forms: There will be a charge of $15.00-$35.00 for the completion of forms such as school physical, school sports, employment, adoption, fitness center, etc. (charge is based upon number of pages and complexity of information requested). Payment is due when you pick up the forms. Please allow 7-10 days for the completion of these forms. If you would like the forms mailed, payment will be due prior to mailing and will include postage costs. (There is no charge for Disability Forms)

Medical Records: We will provide you with a copy of your medical records upon request. You will need to sign a letter of release at the time of pick-up. Please allow 7-10 days for us to copy your records. There is a minimal fee for records based on the number of copies. If you wish for your records to be mailed there will also be an additional fee for postage. Rates charged are within Florida State limits.

PATIENT NAME_____DATE OF BIRTH_____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by The Health Associates of Tampa. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including coinsurance, deductibles and co-pays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to The Health Associates of Tampa for any medical services furnished. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my charges as outlined in office and financial policies guidelines. I acknowledge that I have received a copy of the office policies.

Signed_____ Date_____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby give my consent to The Health Associates of Tampa to use or disclose, for the purpose of carrying out treatment, payment or healthcare operations all protected health information contained in the patient record of *(patient name)* _____.

For a more detailed description of this consent and other uses and disclosures please review our Notice of Privacy Practices. I understand that The Health Associates of Tampa reserves the right to change its privacy practices that are described in the Notice. I also understand that any Revised Notice will be posted on The Health Associates of Tampa's website and will be posted at the office.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied upon it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed _____ Date_____

The Health Associates of Tampa
508 S Habana Ave. Suite 300
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813-877-6770 (Phone)
813-877-6771 (Fax)

Use and Disclosure Authorization

Patient Name: _____

Date of Birth: _____

You may discuss information regarding my treatment and care with the following family members and/or friends:
(Please list name, relationship to patient, and contact number)

_____

_____

1. You may leave the following messages on answering machines:

☐ Referral Information

☐ Prescription refill information

☐ Test results

☐ Appointment Reminder

☐ Other: _____

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

_____ _____

Patient Signature **Date**

THE HEALTH ASSOCIATES OF TAMPA BAY, P.A.
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Revised as of January 5th, 2018

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.

If you have any questions or wish to receive additional information about the matters covered by this Notice of Privacy Practices ("Notice"), please contact the Privacy Officer for THE HEALTH ASSOCIATES OF TAMPA BAY, P.A. ("THAT"), Tej Atluri, M.D. at 608 S. Tampania Ave., Tampa, FL 33609 or call: (813) 877-6770.

This Notice is provided to you in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and associated regulations, as may be amended (collectively referred to as "HIPAA") describing THAT's legal duties and privacy practices with respect to your Protected Health Information ("PHI"). THAT is required to abide by the terms of this Notice currently in effect, and may need to revise the Notice from time to time. Any required revisions of this Notice will be effective for all PHI that THAT maintains. A current copy of the Notice will be posted in each office and you may request a paper, or electronic, copy of it.

PHI consists of all individually identifiable information which is created or received by THAT and which relates to your past, present or future physical or mental health condition, the provision of health care to you, or the past, present or future payment for health care provided to you.

USE AND DISCLOSURE OF PHI FOR WHICH YOUR CONSENT OR AUTHORIZATION IS NOT REQUIRED

HIPAA permits THAT to use or disclose your PHI in certain circumstances, which are described below, without your authorization. However, Florida law may not permit the same disclosures. THAT will comply with whichever law is stricter.

1. **Treatment**: THAT may use and disclose your PHI to provide, coordinate or manage your health care and related services, including consulting with other health care providers about your health care or referring you to another health care provider for treatment. For example, THAT may discuss your health information with a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you. Further, THAT may contact you to remind you of a scheduled appointment.

2. **Payment**: THAT may use and disclose your PHI, as needed, to obtain payment for the health care it provides to you. For example, THAT may disclose to a third-party payer the treatment you are going to receive to ensure that the payer will cover that treatment. Additionally, THAT may disclose to a third party payer or grant funding service, as necessary, the type of services you received to reimbursement for your treatment.

3. **Health Care Operations**: THAT may use or disclose your PHI in order to carry out its administrative functions. These activities include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, conducting training programs in which students provide treatment under the supervision of one of THAT's health care professionals, business planning and development, business management and general administrative activities. For example, THAT may disclose your PHI to accreditation agencies reviewing the types of services provided.

4. **Required by Law**: THAT may use or disclose your PHI to the extent that such use or disclosure is required by law.

5. **Public Health**: THAT may disclose your PHI to a public health authority, employer or appropriate governmental authority authorized to receive such information for the purpose of: (a) preventing or controlling disease, injury or disability; reporting disease or injury; conducting public health surveillance, public health investigations and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency in collaboration with a public health authority; or reporting child abuse or neglect; (b) activities related to the quality, safety or effectiveness or activities or products regulated by the Food and Drug Administration; (c) notifying a person who may have been exposed to a communicable disease or may otherwise be at risk of spreading a disease or condition.

6. **Abuse, Neglect or Domestic Violence**: THAT may disclose your PHI to a government authority authorized to receive reports of abuse, neglect or domestic violence if it reasonably believes that you are a victim of abuse, neglect or domestic violence. Any such disclosure will be made: 1) to the extent it is required by law; 2) to the extent that the disclosure is authorized by statute or regulation and THAT believes the disclosure is necessary to prevent serious harm to you or other potential victims; or 3) if you agree to the disclosure.

7. **Health Oversight Activities**: THAT may disclose your PHI to a health oversight agency for any oversight activities authorized by law, including audits; investigations; inspections; licensure or disciplinary actions; civil, criminal or administrative actions or proceedings; or other activities necessary for the oversight of the health care system, government benefit programs, compliance with government regulatory program standards or applicable laws.

8. **Judicial and Administrative Proceedings**: THAT may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process upon receipt of "satisfactory assurance" that you have received notice of the request.

9. **Law Enforcement Purposes**: THAT may disclose limited PHI about you for law enforcement purposes to a law enforcement official: (a) in compliance with a court order, a court-ordered warrant, a subpoena or summons issued by a judicial officer or an administrative request; (b) in response to a request for information for the purposes of identifying or locating a suspect, fugitive, material witness or missing person; (c) in response to a request about an individual that is suspected to be a victim of a crime, if, under limited circumstances, THAT is not able to obtain your consent; (d) if the information relates to a death THAT believes may have resulted from criminal conduct; (e) if the information constitutes evidence of criminal conduct that occurred on the premises of THAT ; or (f) in certain emergency circumstances, to alert law enforcement of the commission and nature of a crime, the location and victims of the crime and the identity, or description and location of the perpetrator of the crime.

10. **Coroners, Medical Examiners and Funeral Directors**: THAT may disclose your PHI to a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law. THAT may disclose your PHI to a funeral director, consistent with all applicable laws, in order to allow the funeral director to carry out his or her duties.

11. **Research**: THAT may use or disclose your PHI for research purposes, provided than an institutional review board authorized by law or a privacy board waives the authorization requirement and provided that the researcher makes certain representations regarding the use and protection of the PHI.

12. **Serious Threat to Health or Safety**: THAT may disclose your PHI, in a manner which is consistent with applicable laws and ethical standards, if the disclosure is necessary to prevent or lessen a serious threat to health or safety of a person or the public, or the information is necessary to apprehend an individual.

13. **Specialized Government Functions**: THAT may also disclose your PHI, (a) If you are a member of the United States or foreign Armed Forces, for activities that are deemed necessary by appropriate military command authorities to assure the proper execution of a military mission; (b) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by law; (c) to authorized federal officials for the provision of protective services to the President, foreign heads of state, or other people authorized by law and to conduct investigations authorized by law; or (d) to a correctional institution or a law enforcement official having lawful custody of you under certain circumstances.

14. **Workers' Compensation**: THAT may disclose your PHI as authorized by, and in compliance with, laws relating to workers' compensation and other similar programs established by law.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

15. If you do not object to the following uses or disclosures of your PHI, THAT may: 1) disclose to a family member, other relative, a close personal friend, or other person identified by you the information relevant to their involvement in your care or payment related to your care; 2) notify others, or assist in the notification, of your location, general condition, or death; or 3) disclose your PHI to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES OF PHI

16. Any use or disclosure of your PHI that is not listed herein will be made only with your written authorization. You have the right to revoke such authorization at any time, provided that the revocation is in writing, except to the extent that: 1) THAT has taken action in reliance on the prior authorization; or 2) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

YOUR RIGHTS REGARDING YOUR PHI

17. **Restriction of Use and Disclosure**: You have the right to request that THAT restrict the PHI it uses and discloses in carrying out treatment, payment and health care operations. You also have the right to request that THAT restrict the PHI it discloses to a family member, other relative or any other person identified by you, which is relevant to such person's involvement in your treatment or payment for your treatment. By law, THAT is not obligated to agree to any restriction that you request. If THAT agrees to a restriction, however, it may only disclose your PHI in accordance with that restriction, unless the information is needed to provide emergency health care to you. If you wish to request a restriction on the use and disclosure of your PHI, please send a written request to the Privacy Officer which specifically sets forth: 1) that you are requesting a restriction on the use or the disclosure of your PHI; 2) what PHI you wish to restrict; and 3) to whom you wish the restrictions to apply (e.g., your spouse). THAT will not ask why you are requesting the restriction. The Privacy Officer will review your request and notify you whether or not THAT will agree to your requested restriction. You also have the right to request to restrict disclosure of your PHI to a health plan, if the disclosure is for payment or health care operations and the disclosure pertains to a health care item or service for which you have paid out of pocket in full.

18. **Authorization Required**: Most uses and disclosures of PHI for marketing and the sale of PHI require your authorization. In addition, disclosure of psychotherapy notes is prohibited without your authorization, except as allowed by law.

19. **Fundraising**: THAT may contact you for purposes of fundraising to support its programs. You have the option to opt-out of this type of communication.

20. **Confidential Communications**: You have the right to receive confidential communications of your PHI. You may request that you receive communications of your PHI from THAT in alternative means or at alternative locations. THAT will accommodate all reasonable requests, but certain conditions may be imposed.

To request that THAT make communications of your PHI by alternative means or at alternative locations, please send a written request to the Privacy Officer setting forth the alternative means by which you wish to receive communications or the alternative location at which you with to receive such communications. THAT will not ask why you are making such a request.

21. **Access to PHI**: You have the right to inspect and obtain a copy of your PHI maintained by THAT. Under HIPAA, you do not have the right to inspect or copy information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or information that THAT is otherwise prohibited by law from disclosing.

If you wish to inspect or obtain a copy of your PHI, please send a written request to the Privacy Officer. If you request a copy of your PHI, THAT may charge a fee for the cost of copying and mailing the information. You may also request that a copy of your PHI be transmitted to you electronically.

HIPAA permits THAT to deny your request to inspect or obtain a copy of your PHI for certain limited reasons. If access is denied, you may be entitled to a review of that denial. If you receive an access denial and want a review, please contact the Privacy Officer. The Privacy Officer will designate a licensed health care professional to review your request. This reviewing health care professional will not have participated in the original decision to deny your request. THAT will comply with the decision of the reviewing health care professional.

22. **Amending PHI**: You have the right to request that THAT amend your PHI. To request that an amendment be made to your PHI, please send a written request to the Privacy Officer. Your written request must provide a reason that supports the request amendment. THAT may deny your request if it does not contain a reason that supports the requested amendment. Additionally, THAT may deny your request to have your PHI amended if it determines that: 1) the information was not created by THAT and amendment may be made elsewhere; 2) the information is not part of a medical or billing record; 3) the information is not available for your inspection; or 4) the information is accurate and complete.

23. **Notification of Breach**: THAT will notify you following a breach of your PHI as required by law.

24. **Accounting of Disclosure of Your PHI**: You have the right to request a listing of certain disclosure of your PHI made by THAT during the period of up to six (6) years prior to the date on which you make your request. Any accounting you request will not include: 1) disclosures made to carry out treatment, payment or health care operations; 2) disclosures made to you; 3) disclosures made pursuant to an authorization given by you; 4) disclosures made to other people involved in your care or made for notification purposes; 5) disclosures made for national security or intelligence purposes; 6) disclosure made to correctional institutions or law enforcement officials; or 7) disclosures made prior to April 14, 2003. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations set forth in applicable statutes and regulations.

To request an accounting of the disclosures of your PHI, please send a written request to the Privacy Officer. Your written request must set forth the period for which you wish to receive an accounting. THAT will provide one free accounting during each twelve (12) month period. If you request additional accountings during the same twelve (12) month period, you may be charged for all costs incurred in preparing and providing that accounting. THAT will inform you of the fee for each accounting in advance and will allow you to modify or withdraw your request in order to reduce or avoid the fee.

25. **Obtaining a Copy of this Notice**: You have the right to request and receive a paper or electronic copy of this Notice at any time.

COMPLAINTS

26. If you believe that your privacy rights have been violated, you may file a complaint with THAT or with the Secretary of Health and Human Services. To file a complaint with THAT, please contact the Privacy Officer at the address listed on page 1 of this notice. All complaints must be submitted in writing. THAT WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

THE HEALTH ASSOCIATES OF TAMPA BAY, P.A.
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Revised as of July 31, 2013

By law, we are required to make available to you a copy of our Notice of Privacy Practices ("Notice"). By signing below you acknowledge that you received, or been offered and declined, a copy the Notice.

A current copy of the Notice is also posted in the office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time.

You may decline to sign this acknowledgement.

I have ❒ received or ❒ declined a copy of the Notice of Privacy Practices.

Patient Name (Print): _____

Signature of Patient or Legal Representative: _____

If Legal Representative, list Relationship to Patient: _____

Date: _____

For Office Use Only

We were unable to obtain this written acknowledgement because:

_____

_____

Initials: _____ Date: _____