

**BIRJIS K. ALAM, MD PA**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ DATE: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # (H): \_\_\_\_\_ (W): \_\_\_\_\_ (Cell): \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_ Email Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

Whom may we thank for referring you to us: \_\_\_\_\_ Home: \_\_\_\_\_

Allergies/Adverse Reactions?  Yes  No If yes, please list: \_\_\_\_\_

**Please review the following questions and darken/check in the circles of the symptoms that apply to you only:**

<p><b>CONSTITUTIONAL</b> weight gain <input type="radio"/> Yes <input type="radio"/> No loss of appetite <input type="radio"/> Yes <input type="radio"/> No fever <input type="radio"/> Yes <input type="radio"/> No weakness <input type="radio"/> Yes <input type="radio"/> No weight loss <input type="radio"/> Yes <input type="radio"/> No fatigue <input type="radio"/> Yes <input type="radio"/> No night sweats <input type="radio"/> Yes <input type="radio"/> No</p> <p><b>HEENT</b> Change in vision <input type="radio"/> Yes <input type="radio"/> No hearing loss <input type="radio"/> Yes <input type="radio"/> No diminished vision <input type="radio"/> Yes <input type="radio"/> No pain in eyes or ears <input type="radio"/> Yes <input type="radio"/> No discharge from ears <input type="radio"/> Yes <input type="radio"/> No eye irritation or redness <input type="radio"/> Yes <input type="radio"/> No sore throat <input type="radio"/> Yes <input type="radio"/> No nose bleed <input type="radio"/> Yes <input type="radio"/> No</p> <p><b>ENT/RESPIRATORY</b> cough <input type="radio"/> Yes <input type="radio"/> No pain with breathing <input type="radio"/> Yes <input type="radio"/> No shortness of breath <input type="radio"/> Yes <input type="radio"/> No coughing up blood <input type="radio"/> Yes <input type="radio"/> No</p> <p><b>CARDIOLOGY</b> chest pain <input type="radio"/> Yes <input type="radio"/> No palpitations <input type="radio"/> Yes <input type="radio"/> No shortness of breath <input type="radio"/> Yes <input type="radio"/> No leg cramps <input type="radio"/> Yes <input type="radio"/> No pain in legs while walking <input type="radio"/> Yes <input type="radio"/> No irregular heartbeat <input type="radio"/> Yes <input type="radio"/> No</p> <p><b>DERMATOLOGY</b> rash <input type="radio"/> Yes <input type="radio"/> No lumps <input type="radio"/> Yes <input type="radio"/> No hives <input type="radio"/> Yes <input type="radio"/> No skin cancer <input type="radio"/> Yes <input type="radio"/> No laceration <input type="radio"/> Yes <input type="radio"/> No</p>	<p><b>GASTROENTEROLOGY</b> diarrhea <input type="radio"/> Yes <input type="radio"/> No vomiting <input type="radio"/> Yes <input type="radio"/> No constipation <input type="radio"/> Yes <input type="radio"/> No nausea <input type="radio"/> Yes <input type="radio"/> No difficulty swallowing <input type="radio"/> Yes <input type="radio"/> No abdominal pain <input type="radio"/> Yes <input type="radio"/> No heartburn <input type="radio"/> Yes <input type="radio"/> No hemorrhoids <input type="radio"/> Yes <input type="radio"/> No indigestion <input type="radio"/> Yes <input type="radio"/> No frequent bloating <input type="radio"/> Yes <input type="radio"/> No vomiting blood <input type="radio"/> Yes <input type="radio"/> No rectal bleeding <input type="radio"/> Yes <input type="radio"/> No</p> <p><b>MUSCULOSKELETAL</b> joint pain <input type="radio"/> Yes <input type="radio"/> No joint swelling <input type="radio"/> Yes <input type="radio"/> No osteoporosis treatment <input type="radio"/> Yes <input type="radio"/> No back pain <input type="radio"/> Yes <input type="radio"/> No muscle pain or weakness <input type="radio"/> Yes <input type="radio"/> No tingling/numbness <input type="radio"/> Yes <input type="radio"/> No</p> <p><b>UROLOGY</b> difficulty urinating <input type="radio"/> Yes <input type="radio"/> No blood in urine <input type="radio"/> Yes <input type="radio"/> No frequent urination <input type="radio"/> Yes <input type="radio"/> No urinary incontinence <input type="radio"/> Yes <input type="radio"/> No pain with urination <input type="radio"/> Yes <input type="radio"/> No</p> <p><b>PSYCHOLOGY</b> depression <input type="radio"/> Yes <input type="radio"/> No sleep disturbances <input type="radio"/> Yes <input type="radio"/> No angry <input type="radio"/> Yes <input type="radio"/> No sad <input type="radio"/> Yes <input type="radio"/> No happy <input type="radio"/> Yes <input type="radio"/> No other <input type="radio"/> Yes <input type="radio"/> No</p>
--	---

**ENDOCRINOLOGY**

cold intolerance  Yes  No  
 heat intolerance  Yes  No  
 diabetes  Yes  No  
 excessive thirst  Yes  No  
 hot flashes  Yes  No  
 urinating frequently  Yes  No

**HEMATOLOGY/LYMPH**

swollen glands  Yes  No  
 varicose veins  Yes  No  
 easy bleeding  Yes  No  
 anemia  Yes  No  
 past transfusion  Yes  No

**NEUROLOGY**

headache  Yes  No  
 tingling/numbness  Yes  No  
 seizures  Yes  No  
 memory loss  Yes  No  
 dizziness  Yes  No  
 loss of strength in specific body area  Yes  No  
 loss of sensation ins specific body area  Yes  No  
 Migraines  Yes  No  
 burning pain in feet  Yes  No  
 trouble with balance  Yes  No  
 trouble with coordination  Yes  No  
 loss of consciousness  Yes  No  
 confusion  Yes  No

**PAST MEDICAL HISTORY**

hypertension  Yes  No  
 diabetes  Yes  No  
 hypercholesterolemia  Yes  No  
 atrial fibrillation  Yes  No  
 coronary artery disease  Yes  No  
 valve replacement  Yes  No  
 hepatitis C  Yes  No  
 hepatitis B  Yes  No  
 treated cancer (not current)  Yes  No  
 Blood Clot in extremities or lungs  Yes  No

**SURGICAL HISTORY**

Appendectomy  Yes  No  
 Hysterectomy  Yes  No  
 Coronary Bypass  Yes  No  
 Carotid endarterctomy  Yes  No

**SOCIAL HISTORY**

Occup. exposure:  yes  no  asbestos  chemicals  
 second hand smoke  
 Drug Abuse:  Yes  No

**FAMILY HISTORY:**

Do you have any first degree family member (mother, father, brother, etc) with?

hypertension  diabetes  hypercholesterolemia  blood clot in extremities or lungs  cancer

Please let us know the reason(s) for your visit today? If you are in pain, please describe location, severity and the onset of the pain:

Is your visit due to an injury?  Yes  No

If yes:  Work  Auto  Other

*I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.*

X \_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

**For MA Use only**

VITAL SIGNS: STANDING BP: L \_\_\_\_\_ / \_\_\_\_\_ OR R \_\_\_\_\_ / \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_ BMI \_\_\_\_\_  
 SITTING BP: L \_\_\_\_\_ / \_\_\_\_\_ AND R \_\_\_\_\_ / \_\_\_\_\_ TEMP \_\_\_\_\_ PULSE \_\_\_\_\_ TAKEN BY: \_\_\_\_\_

Miscellaneous Medical Notes: \_\_\_\_\_

# AUTHORIZATION FOR RELEASE OF INFORMATION

Autorizacion Para Prporcionar Informacion

I HEREBY GIVE MY PERMISSION TO: \_\_\_\_\_

Yo por este medio doy mi permiso a:

TO RELEASE A COPY OF (LIST SPECIFIC INFORMATION/DOCUMENTS): **All Medical Records, labs and Diagnostic**

A que proporcione una copia de (liste informacion/documentos especificos): **test.**

TO: \_\_\_\_\_ PCP: **BIRJIS K. ALAM, M.D., P.A.**

Address: **12781 Miramar Parkway, Suite 101, Miramar. FL 33027**  
**Phone: (954) 437-2020, Fax: (954) 436-9614**

FOR THE PURPOSE(S) OF (ALCOHOL & DRUG ABUSE CLIENTS ONLY): \_\_\_\_\_

Con el proposito de (Clientes de Abuso de Alcohol & Drogas solamente): \_\_\_\_\_

THIS IS \_\_\_\_\_ A SINGLE DISCLOSURE OR \_\_\_\_\_ A CONTINUING DISCLOSURE FOR 90 DAYS. (Check one)

Este es \_\_\_\_\_ una sola autorizacion o \_\_\_\_\_ una autorizacion continua por 90 Dias. (Marque una)

PRIMARY LANGUAGE (ES PANOL): \_\_\_\_\_

DATE ON WHICH CONSENT IS GIVEN: \_\_\_\_\_

Fecha en que se dio consentimiento:

RELEASE EXPIRATION DATE: \_\_\_\_\_

Fecha de expiracion del consentimiento:

CONSENT IS SUBJECT TO REVOCATION AT ANY TIME.  
CONSENTIMIENTO ESTA SUJETO A SER REVOCADO EN CUALQUIER MOMENTO.

I HEREBY RELEASE THE FACILITY FROM ANY LIABILITY WHICH MAY ARIES AS A RESULT OF THE USE OF THE INFORMATION CONTAINED IN THE RECORDS RELEASED.

Yo por este medio relevo a esta empresa de cualquier responsabilidad que pueda surgir como resultado del uso de la informacion contenida en los documentos remitidos.

NAME OF THE PATIENT: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

Nombre del paciente: \_\_\_\_\_ (PRINT) Fecha de nacimiento: \_\_\_\_\_

SIGNATURE OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

Firma del paciente: \_\_\_\_\_ Fecha: \_\_\_\_\_

SIGNATURE OF GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

Firma del custodio: \_\_\_\_\_ (IF NEEDED/Si es necesario) Fecha: \_\_\_\_\_

SIGNATURE OF WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_

Firma del testigo: \_\_\_\_\_ Fecha: \_\_\_\_\_

TO RECEIVING AGENCY: PROHIBITION OF REDICLOSURE  
A LA AGENCIA QUE RECIBA LA INFORMACION: PROHIBICION DE REVELAR

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED. ANY FURTHER REDISCLOSURE IS STRICTLY PROHIBITED UNLESS THE PATIENT PROVIDES SPECIFIC WRITTEN CONSENT FOR THE SUBSEQUENT DISCLOSURE OF THIS INFORMATION.

Esta informacion ha sido proporcionada a usted de documentos cuya confidencialidad es protegida. Cualquier declaracion adicional es estrictamente prohibida a menos que el pacient de su consentimiento especificamente por escrito permitiendolo.

THE INDIVIDUAL AUTHORIZING THE RELEASE OF SUCH INDIVIDUAL'S INFORMATION, OR THE PERSON AUTHORIZED TO ACT ON BEHALF OF THE INDIVIDUAL, OR THE INDIVIDUAL'S AUTHORIZED REPRESENTATIVE IS ENTITLED TO RECEIVE A COPY OF THIS AUTHORIZATION FORM, UPON PRESENTING DOCUMENTATION SETTING OUT THE AUTHORIZATION TO ACT ON BEHALF OF SUCH INDIVIDUAL.

La persona que autoriza el suministro de informacion correspondiente a si misma, o la persona autorizada para actuar en representacion de dicha persona, o la persona autorizada como su representante tiene derecho a recibir una copia de este formulario de autorizacion al presentar la documentacion necesaria que compruebe que ha sido autorizada para actuar en representacion de dicha persona.

**BIRJIS K. ALAM, M.D., P.A.**

12781 Miramar Parkway, Suite 101  
Miramar, FL 33027

PATIENT NAME: \_\_\_\_\_

**CONSENT FOR DIAGNOSTIC, PRESCRIPTION HISTORY  
AND/OR THERAPEUTIC PROCEDURES**

I hereby consent to and authorize the physician and any other health professional as designated to perform a physical examination and routine diagnostic procedure upon me, I also, consent to and authorize the physician and any other health professional to view my prescription history from external sources and to prescribe a therapeutic regime which I shall follow.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

**REFERRAL POLICY**

**All referrals requests must comply with the referral policy due to software changes.**  
If a patient is currently contacted with an insurance company that requires a referral to either a specialist, diagnostic facility, therapy facility or durable medical equipment, the following protocol shall be followed to ensure all referrals are generated in the proper order according to medical need, date seen and/or date referral was requested.

- Only “Dr.-determined” referral of absolute **emergent** necessity -issued same day
- Only “Dr.-determined” referral of **urgent** necessity -24-hour time limit
- **Routine referral request by either physician, specialist or patient - 5-10 business days. If not requested with in the timeframe listed above the appointment must be rescheduled.**

**There will be no exceptions to the policy. Please make sure you contact our referral department with ample time for all your referral needs.**

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NO SHOW POLICY**

We understand that there are reasons for having to cancel an appointment, we ask you to show consideration by calling well in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor. Please let this notice serve to notify you that if you fail to give us a 24-hour notice of cancellation, there will be a \$50.00 cancellation fee.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

# NOTICE OF PRIVACY PRACTICES

**BIRJIS K. ALAM, M.D., P.A.**

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

PLEASE REVIEW IT CAREFULLY.

## **I. Our Duty to Safeguard Your Protected Health Information.**

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. if we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy for Protected Health information available upon request.

## **II. How We May Use or Disclose Your Protected Health Information.**

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information.

**For treatment:** We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment is best for you. Your medical information might also be shared among members of your treatment team, or with pharmacy(s).

**To obtain payment:** We may use and/or disclose your medical information in order to bill and collect payment for your health care services. For Example, we may release portions of your medical information to Medicare and/or a private insurer to get paid for services that we delivered to you, or to obtain permission for an anticipated plan of treatment.

**For health care operations:** We may use and/or disclose your medical information in the course of operating our **practice**. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or attorney for audit purposes.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- ❖ Unless you object, we may send appointment reminders, information about treatment alternatives and other health-related benefits and services that may be interest to you.
- ❖ We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.

- ❖ We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- ❖ We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- ❖ We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organization relating to organ, eye, or tissue donations or transplants.
- ❖ In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- ❖ In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help the coordination of disaster relief efforts.
- ❖ We may share with these people information directly related to your family's, friend's or other person's involvement in your care, or payment of your care. We may also share medical information with these people to notify them about your location, general condition, or death.
- ❖ We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- ❖ We may contact you for certain fund raising events.
- ❖ We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

### **III. Your Rights Regarding Your Medical Information.**

You have the following rights relating to your protected health information:

- ❖ You have the right to ask that we limit how we use or disclose your medical information. We will consider your request, but are not legally bound to agree to the restriction. You have the right to ask that we send you information at an alternative address or by an alternative means. We will agree to your request as long as it is reasonably easy for us to do so.
- ❖ Unless your access is restricted for clear and documented treatment reasons, you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your medical information, a charge of copying may be imposed, but may be waived, depending on your circumstances. you have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- ❖ If you believe that there is a mistake or missing information in our record of your medical information, you may request, in writing, that we correct or add to the record. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will change the medical information and so inform you.

- ❖ You have the right to an accounting of the disclosures of your medical information other than instances of disclosure for which you gave consent. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.
- ❖ You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

**IV. How to Complain about our Privacy Protection:**

- ❖ If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, you may file a complaint with the person listed in Section V. below. You may also file a written complaint with Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington, DC 20201. We will take no retaliatory action against you if you make such complains.

**V. Contact Person for Information, or to Submit a Complaint:**

- ❖ If you have any questions about this Notice or any complaints, about our privacy practices, please contact our Privacy Compliance officer at (954) 437-2020.

**VI. Effective Date: This Notice was effective April 14, 2003.**

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's name: \_\_\_\_\_ Account # \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

**BIRJIS K. ALAM, M.D., P.A.**  
12781 Miramar Parkway, Suite 101  
Miramar, FL 33027

3. The type and amount of information to be used or disclosed is as follows:  
(Include dates where appropriate).

Demographic information (such as name, address, telephone number, e-mail address, etc.)

Problem list

Medication list

List of allergies

Immunization record

Most recent history and physical

Most recent discharge summary

Laboratory results from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

X-Ray and imaging reports from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

Consultation reports from (doctor's names) \_\_\_\_\_

Entire record

Other \_\_\_\_\_

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health Services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual

Names: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual/organization noted in #2 above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_ . If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have question about disclosure of my health information, I can contact **Maxine** at (954) 437-2020.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness

A. Notifier: BIRJIS K. ALAM, MD PA

B. Patient Name:

C. Identification Number:

### Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If INSURANCE doesn't pay for **D.** Listed below, you may have to pay.

Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Insurance may not pay for the **D. Services** below.

D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
<b>OFFICE VISIT</b> <b>EKG</b> <b>BLOOD TEST</b> <b>STOOL TEST</b> <b>SPIROMETRY/OXYMETRY</b> <b>PAPSMEAR</b> <b>IMMUNIZATION</b>	<b>NON-COVERED SERVICES</b> <b>DEDUCTIBLES</b> <b>COINSURANCE</b>	<b>OPEN</b>

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but insurance cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

- OPTION 1.** I want the **D.** \_\_\_\_\_ listed above. You may ask to be paid now, but I also want insurance billed for an official decision on payment, which is sent to me on a Insurance Summary Notice (MSN). I understand that if insurance doesn't pay, I am responsible for payment, but **I can appeal to Insurance** by following the directions on the MSN. If Insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the **D.** \_\_\_\_\_ listed above, but do not bill insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Insurance is not billed.**
- OPTION 3.** I don't want the **D.** \_\_\_\_\_ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if insurance would pay.**

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare or Insurance decision**

Signing below means that you have received and understand this notice. You also receive a copy.

<b>I. Signature:</b>	<b>J. Date:</b>
----------------------	-----------------

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

# NOTICE OF PRIVACY PRACTICES

BIRJIS K. ALAM, M.D., P.A.

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.

## I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practice for Protected Health Information available upon request.

## II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information.

**For treatment:** We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

**To obtain payment:** We may use and/or disclose your medical information in order to bill and collect payment for your health care services. For example, we may release portions of your medical information to Medicare and/or a private insurer to get paid for services that we delivered to you, or to obtain permission for an anticipated plan of treatment.

**For health care operations:** We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or attorney for audit purposes.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- Unless you object, we may send appointment reminders, information about treatment alternatives and other health-related benefits and services that may be of interest to you.
- We may disclose your medical information to law enforcement or other specialized government law enforcement in response to a court order, subpoena, warrant, summons, or similar process.

- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.

- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.

- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.

- We may share with these people information directly related to your family's, friend's or other person's involvement in your care, or payment for your care. We may also share medical information with these people to notify them about your location, general condition or death.

- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.

- We may contact you for certain fund raising events.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made without your permission, and that we are required to retain our records of the care that we provided you.

## III. Your Rights Regarding Your Medical Information.

You have the following rights relating to your protected health information:

- You have the right to ask that we limit how we use or disclose your medical information. We will consider your request, but are not legally bound to agree to the restriction. You have the right to ask that we send you information at an alternative address or by an alternative means. We will agree to your request as long as it is reasonably easy for us to do so.
- Unless your access is restricted for clear and documented treatment reasons, you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your medical information, a charge for copying may be imposed, but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- If you believe that there is a mistake or missing information in our record of your medical information, you may request, in writing, that we correct or add to the record. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical

information. If we approve the request for amendment, we will change the medical information and so inform you.

You have the right to an accounting of the disclosures of your medical information, more than instances of disclosure for which you gave consent. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such each year. There may be a charge for more frequent requests.

You have a right to receive a paper copy of this Notice and/or an electronic copy by e-mail upon request.

## IV. How to complain about our Privacy Practices:

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, you may file a complaint with the person listed in Section V, below. You may also file a written complaint with Secretaries of the U.S. Department of Health and Human Services at 200 Independence Avenue, Washington, DC 20201. We will take no retaliatory action against you if you make a complaint.

## V. Contact Person for Information, or to Submit a Complaint:

If you have questions about this Notice or any complaints, about our privacy practices please contact our Privacy Compliance Officer at (954) 437-2020.

## VI. Effective Date: This Notice was effective April 14, 2003.

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

ADVANCE CARE PLANNING

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse to be artificially prolonged or to not be artificially prolonged.

**In the event that I have been determined to be unable to provide and express an informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

\_\_\_\_\_ **I CHOOSE TO NOT BE PROLONGED**

\_\_\_\_\_ **I CHOOSE TO BE PROLONGED**

\_\_\_\_\_ **I CHOOSE TO NOT MAKE THIS DECISION AT THIS TIME**

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Witness: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Phone: \_\_\_\_\_