Notice of Privacy Practices

This notice describes how medical Information about you may be used and disclosed and how you can get access to this Information. Please review it carefully.

When it comes to your health information, you have the right to:

-Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee, -Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. • We may say "no" to your request, but we'll tell you why in writing within 60 days. -Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

-Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

•Get a list of those with whom we've shared information

- You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We may charge a reasonable, cost-based fee.

-Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

-Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

-File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 3. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will NOT retaliate against you for filing a complaint.

In these cases, you have both the right and choice to tell us how to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

-If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Your information may be used to:

-Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition. -Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

-Bill for your services

- We can use and share your health information to bill and get payment from health plans or entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

- We are allowed or required to share your information in ways that contribute to the public good, such as public health and research.
- We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

-Help with public health and safety issues

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

-Do research

- We can use or share your information for health research.
- -Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law,
- -Respond to organ and tissue donation requests
- We can share health information about you with organ procurement organizations.

-Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

-Address workers' compensation, law enforcement, and other government request

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

' For special government functions such as military, national security, and presidential protective services -Respond to lawsuit and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information,
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.zov(ocr/privacv/hipaa/understandinæ/consumers/noticepp.htm).

Changes to the Terms of this Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site: www.healthvresuleaorida.com

Other Instructions for Notice

- Effective Date of this Notice: 3/1/15
- Direct all questions regarding your privacy, or this notice to:

772-800-3037, 1100 SW St Lucie West Blvd, Suite #105, Port St. Lucie, FL 34986

- We will NEVER sell your personal information.

Signature:____ Date:____________

Printed name:______________________________________

Patient Rights and Responsibilities

We consider you a partner in your care. When you are well-informed, participate in treatment decisions, and communicate openly with your physician and other health professionals, you help make your care as safe and effective as possible. Healthy Results Physicians proudly works to respect your rights, values and dignity at all times.

YOUR RIGHTS AS A PATIENT

1. You have the right to considerate care that respects your personal values, beliefs, cultural and spiritual practices.
2. You have the right to be well informed about your illness, possible treatments and likely outcome and to discuss this information with your doctor.
3. You have the right to know the names and roles of people treating you.
4. You have the right to consent to or refuse a treatment, as permitted by law, throughout your visit. If you refuse a recommended treatment, you will receive other needed and available care.
5. You have the right to receive timely assessment and appropriate management of your concerns.
6. You have the right to privacy. Healthy Results Physicians, your doctor, and others caring for you will protect your personal, visual and auditory privacy as much as possible.
7. You have the right to access, request amendment or receive an account of all disclosures regarding your personal health information and to have the information explained or interpreted to you within the limits of the law.
8. You have the right to review your medical records and to have the information in the record explained, except when restricted by law. Review of your records may be restricted if your doctor determines that access may be injurious to the patient or another person.
9. You have the right to file a grievance or lodge a complaint regarding the care and treatment you receive by our staff. If you are not capable of doing this, your family or surrogate decision maker has the right on your behalf.
10. You have the right to expect that Healthy Results will provide necessary health services to the best of its ability. You will be informed of risks, benefits and alternatives to treatments that are offered.
11. You have the right to know if Healthy Results Physicians have relationships with outside parties that may influence your treatment and care. These relationships may be with educational Institutions, other health care providers or insurers.
12. You have the right to consent or decline to take part in research affecting your care. If you choose not to take part, you will receive the most effective care Healthy Results Physicians otherwise provide
13. You have the right to know about charges related to your care and payment options available to you.

14. You have the right to have treatment plan and information explained to you in the language that you understand best. If you do not speak English, or if you have a visual or hearing impairment, Healthy Results will make a reasonable attempt to provide a qualified interpreter when you and your health care provider determine this is needed. If such an interpretor is unavailable, alternative care options may be offered to maintain consistent standards of care.

YOUR RESPONSIBILITIES AS A PATIENT

1. You are responsible for providing information about your health, including past illness, hospital stays and use of medicine.
2. You are responsible for providing a copy of your advance directive to Healthy Results Physicians, if one exists.
3. You are responsible for asking questions, and requesting additional information, when you do not understand your care, treatment or what is expected of you.
4. You are responsible for participating with your doctors and other caregivers in the development of your treatment plan, and for following that treatment plan. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor.
5. You are responsible for providing information for insurance and for working with Healthy Results Physicians to arrange payment when needed.
6. You are responsible to take an active role in your care by taking medications as they are prescribed to you.
7. You are responsible for recognizing the effect of lifestyle on your personal health. Your health depends not just on your outlook, lifestyle, level of physical activity, and adherence to your treatment plan, but also in the long term decisions you make in your daily life.

______________________________ ______________

Patient Signature Date

____

Print Patient Name

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Please read and sign the following policy regarding payment.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of Insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 70 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

______________________________ ____________

Signature of patient or responsible party **Date**

Dr. Dameron

1100 SW Saint Lucie W. Blvd Suite 105

Port St. Lucie, FL 34986

PH: 772-800-3037

FAX: 772-807-1409

Confirming appointments is a courtesy and patients are responsible for canceling their appointments with 24 hours in advance or a CANCELLATION NO SHOW FEE OF $50.00 WILL BE CHARGED TO YOU. This charge must be paid before your next scheduled appointment. Your insurance company is not responsible for canceled or missed appointments.

Patient signature_________________________________ Date_________________________

CREDIT CARD AUTHORIZATION FORM

I authorize Healthy Results, Dr. Dana Dameron to charge my credit card listed below:

Amount charged ____________ Type of card____ Visa____ MC____ AME_____ Discover ______

Card Number____

Expiration Date_____________ Security Code (3 digit # on back of card) ___________________

Full imprinted name as appears on card____

Zip Code of Cardholder____________

__________Please keep this card on file

__________I authorize this credit card to automatically be billed for services (including NO SHOWS, LATE CANCELLATIONS (less than 24 hours notice) INSURANCE DENIALS.

SIGNATURE____ DATE___________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
TO INDIVIDUALS OR FAMILY MEMBERS

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of the practice to discuss your condition or finances with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so in the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

____________________ I DO NOT authorize the practice to release any or all information concerning my medical care or finances to any individual except as set forth above.

____________________ I AUTHORIZE the practice to verbally release any or all information concerning my medical care or finances to the following individuals.

____________________ I AUTHORIZE the practice to leave a message on my voice mail regarding medical results, appointments, or other related business matters.

____

NAME RELATIONSHIP TO PATIENT

____

NAME RELATIONSHIP TO PATIENT

____

NAME RELATIONSHIP TO PATIENT

____

NAME RELATIONSHIP TO PATIENT

____

PATIENT SIGNATURE DATE

DR DAMERON-HEALTHY RESULTS 1100 SW SAINT LUCIE W. BLVD SUITE 105, PORT ST LUCIE, FL 34986

PHONE- 772-800-3037

Dr. Dana Dameron, DO
Amy Paine, APRN-C
475 NW Prima Vista Blvd
Port St. Lucie, Fl 34983
Office: 772-800-3037
Fax 772-807-1409

Patient Name: ____

(LAST) (FIRST) (MIDDLE)

Phone: (______) ______-__________

SS#:______________________________ Date of Birth:____________________

Guarantor (If patient is a child):______________________________________

Fl. Address:____________________________________ Apt#:______________

City: ______________________ State:__________ Zip Code:______________

Secondary Address:____

Marital Status:______________ Drivers License #:____________________

Employer:________________________ Occupation:____________________

Address:________________________________ Phone number:(____) _____-________

Preferred Pharmacy: ____

Emergency Contact:__________________________ Phone number:(____) ____-________

Contacts address:____

City:______________________ State:______________ Zip Code:______________

Insurance Information

Primary Insurance:

Name of Insured:____________________ SS# of Insured:______________ DOB:__________

Secondary Insurance:

Name of Insured:____________________ SS# of Insured:______________ DOB:__________

Assignment of Benefits

I authorize the release of any payment and medical information necessary to process this claim and related claims. I request payment of benefits to Healthy Results, LLC. who accepts assignment of Benefits.

______________________________________ Date:____________________

(Patient or Authorized Person's Signature)

Dr. Dana Dameron, DO
Amy Paine, APRN-C
475 NW Prima Vista Blvd
Por St. Lucie, FL 34983
Office: 772-800-3037
Fax 772-807-1409

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia Vaccine
	☐ Shingles	
	☐ Influenza	

Check any medical problems that other doctors have diagnosed you with:

☐ Anemia	☐ Asthma	☐ Anxiety
☐ Cancer	☐ Diabetes (Type 1) or (Type 2)	☐ Depression
☐ Diverticulitis	☐ Emphysema/COPD	☐ Epilepsy/ Seizures
☐ GERD/Peptic Ulcers	☐ Gout	☐ Heart Disease/Heart Attack
☐ Hepatitis/Liver Disease	☐ High Cholesterol	☐ High Blood Pressure
☐ Kidney Problems	☐ Pneumonia	☐ Stroke/TIA
☐ Suicide Attempt	☐ Thyroid Problems	☐ Other (please list)
☐ Bladder Issues	☐ Circulation Issues	

Surgeries

Year	Procedure	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week? How many drinks per occasion?		
	Are you concerned about the amount you drink?	☐ Yes	☐ No
	Have you considered stopping?	☐ Yes	☐ No
	Have you ever experienced blackouts?	☐ Yes	☐ No
	Are you prone to "binge" drinking?	☐ Yes	☐ No
	Do you drive after drinking?	☐ Yes	☐ No
Tobacco	Do you use tobacco? # of years you've used tobacco ________ Former Smoker? _______ Year you quit ______	☐ Yes	☐ No
	☐ Cigarettes – # pks/day ☐ Chew- #/day ☐ Pipe- #/day ☐ Cigars- #/day		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal	Do you live alone?	☐ Yes	☐ No

Safety	Have you had a fall in the last 12 months?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Question	Yes	No
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Question	Yes	No
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

	☐	☐

Question	Yes	No
Do you usually get up to urinate during the night?	Yes	No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam? Or PSA level? ____________________	☐ Yes	☐ No