PERSONALIZED PRIMARY CARE

OVERVIEW:

- **<u>Membership</u>**: An annual membership is required to be established as a patient with Personalized Primary Care. **This membership fee is <u>not</u> covered by insurance, but rather is patient choice**.

- **<u>Insurance:</u>** All office visits will file to the patient's insurance and will process according to the patient's policy, benefits, and terms. ***With the exception of the initial 90 minute and subsequent 60 minute annual comprehensive consultation and physical; the Doctor's services for those visits WILL NOT bill to insurance.*** *However, any other services provided at those comprehensive visits (vaccines, EKG, etc) WILL bill to the patient insurance.** Any co-pay or patient portion remaining after insurance adjustment will be the responsibility of the patient.

- **<u>How to begin:</u> An Annual Membership begins once the Membership Packet is completed by the patient and received by Personalized Primary Care. Records from previous and current providers will be obtained and reviewed by the Doctor, after which the Doctor may request lab work. Once those results are obtained, the initial 90 minute comprehensive consultation and physical will take place. While awaiting the completion of the process for the 90 minute visit, a patient may feel free to contact the office for assistance or any urgent visit needs.**

PERSONALIZED PRIMARY CARE

INSTRUCTIONS:

The following items included in this welcome packet are *required* in order to begin your Membership with Personalized Primary Care.

1. **Membership Agreement:** The membership agreement allows us to obtain your insurance and demographic information and method of payment. It also states the benefits and terms of your membership. Please read the agreement and complete the information requested in its entirety.

2. **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 and sign where noted.

3. **Authorization to Obtain, Release, or Review Protected Health Information:** This form is required to obtain medical records from current and previous physicians/facilities/hospitals in order for the Doctor to review and develop an understanding of your medical history. ****You need only sign this form. We will complete them using the physician-facility records request list that you provide.****

4. **Physician -Facility Records Request List:** Use this form to provide us with the current and previous providers and facilities that we should request your medical records from. Please provide as much information as possible.

5. **Authorization to Disclose Protected Health Information:** This form is required should you contact the Doctor or Staff of Personalized Primary Care to communicate with anyone regarding your care. This includes family, friends, personal assistants, etc. You must indicate WHOM we may communicate with, WHAT we may disclose, and HOW we may disclose it. ***If you do not wish to allow us to disclose any information to anyone, simply write "N/A" on the form.***

For more information: visit **www.personalizedprimarycare.com**

PERSONALIZED PRIMARY CARE

MEMBERSHIP AGREEMENT:

This Membership Agreement (the "Agreement") specifies the terms and conditions under which you, the undersigned member ("Member"), will be enrolled with PERSONALIZED PRIMARY CARE program (the "Program"). This Agreement will become effective as of the date set forth by James G . Scelfo, MD, PA or Katleyn Meade, DO {DBA: PERSONALIZED PRIMARY CARE}, located at **602 Front Street Celebration, FL 34747**, **8976 Conroy WIndermere Road Orlando, FL 32835** at the end of this Agreement (the "Effective Date").

1.PERSONALIZED PRIMARY CARE Benefits and Services. The Program provides the following amenities ("Amenities") to persons who sign up as Members:

- Individual Healthcare with a Focus on Prevention
- 24/7 Direct Access to Physician
- Limited Patient Membership
- Individual, Couple, and Family Plans
- Same Day/Next Day - Urgent/Emergency Appointments
- Fitness Counseling
- Your choice of a 1 Hour consultation with a Nutritionist, Physical Therapist, or Family Counselor
- Referral Coordination and Scheduling
- Preventive Care Focus
- 90 Minute Initial Comprehensive Consultation and Physical
- 1 Hour Annual Physical Examination
- 30 minutes of personal care for each appointment
- Designated parking area
- Upscale Office Design
- Private Reception
- Phone/Fax/Web Access
- In office blood draw for lab work

The Amenities include both non-healthcare service amenities and health-related services usually not covered by insurance. Other service amenities may be offered from time to time, and these may be subject to limitations.

PERSONALIZED PRIMARY CARE

☐ James Scelfo, MD, FAAFP

Location ☐ Celebration

☐ ***Monthly*** (includes a 5% administrative fee)

Monthly memberships will process automatically each month to the credit card provided below.

☐ $258.50 Individual Membership

☐ $472.50 Couple Membership

☐ $43.75 Child up to age 18

☐ $225.00 per Additional Family Member (up to 2 additional family members with couple membership)

☐ ***Quarterly***

Quarterly memberships will process automatically each quarter to the credit card provided below.

☐ $737.50 Individual Membership

☐ $1,350.00 Couple Membership

☐ $125.00 Child up to age 18

☐ $625.00 per Additional Family Member (up to 2 additional family members with couple membership)

☐ ***Annual***

Annual memberships will bill to you on a yearly basis according to your anniversary date/effective date.

☐ $2,950.00 Individual Membership

☐ $5,400.00 Couple Membership

☐ $500.00 Child up to age 18

☐ $2,600.00 per Additional Family Member (up to 2 additional family members with couple membership)

☐ Katelyn Meade, DO

Location ☐ Celebration

☐ ***Monthly*** (includes a 5% administrative fee)

Monthly memberships will process automatically each month to the credit card provided below.

☐ $210.00 Individual Membership

☐ $367.50 Couple Membership

☐ $43.75 Child up to age 18

☐ $175.00 per Additional Family Member (up to 2 additional family members with couple membership)

☐ ***Quarterly***

Quarterly memberships will process automatically each quarter to the credit card provided below.

☐ $600.00 Individual Membership

☐ $1,050.00 Couple Membership

☐ $125.00 Child up to age 18

☐ $475.00 per Additional Family Member (up to 2 additional family members with couple membership)

☐ ***Annual***

Annual memberships will bill to you on a yearly basis according to your anniversary date/effective date.

☐ $2,400.00 Individual Membership

☐ $4,200.00 Couple Membership

☐ $500.00 Child up to age 18

☐ $2,100.00 per Additional Family Member (up to 2 additional family members with couple membership)

MEMBER BILLING - Include your payment along with the signed membership agreement

VISA MASTERCARD AMERICAN EXPRESS CHECK CASH

Name on Card: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Expiration Date: _____ CVV Code: _____

Signature of Cardholder: _____

Check #_____

3. Renewals and Termination: The annual membership fee covers a period of one (1) year. Failure to pay the renewal annual membership fee within 30 days from the anniversary of the Effective Date shall result in termination of your membership in the Program, (For example, if the Effective Date is May 15, 2016 then you must renew on or before June 14, 2017). You may terminate your participation at any time upon 30 days prior written notice to PERSONALIZED PRIMARY CARE. **If you terminate this Agreement for any reason, you will be entitled to a refund of any unused portion of your annual membership fee.** PERSONALIZED PRIMARY CARE may terminate this Agreement at any time on 30 days written notice to you. If PERSONALIZED PRIMARY CARE terminates this Agreement for any reason, you will be entitled to a prorated refund of your annual membership fee. Such a prorated refund will be based on the number of days you have participated in the Program. Upon PERSONALIZED PRIMARY CARE'S receipt of this Agreement and the membership fee, PERSONALIZED PRIMARY CARE shall have the option, in its sole and absolute discretion, not to accept this Agreement and to return your payment to you (e.g., due to limitations on the number of Members).

4. Medical Care Services Excluded from Annual Membership Fee: The membership fees specified above cover only the defined PERSONALIZED PRIMARY CARE Amenities and the annual comprehensive physical examination and personalized preventative healthcare plan visit. Except for your physical examination and preventative visit, you and/or your insurer, as the case may be, will be financially responsible for paying all the healthcare and medical care services received by you from the physicians at PERSONALIZED PRIMARY CARE. As necessary, PERSONALIZED PRIMARY CARE will bill you and/or your insurer, as the case may be, for such other medical or health care services provided to you.

5. Copayments and Deductibles: The membership fee does not affect the co-payments, co-insurance, or deductibles that you are required to pay pursuant to the terms of your health or other insurance coverage. You will be financially responsible for any co-payments, coinsurance or deductible amounts required by your insurer.

6. Insurance Information: Please provide your health insurance information in the box provided below.

INSURANCE INFORMATION
Insurance Policy Information (as printed on your I.D. card)

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD FRONT AND BACK

Person Responsible for Account: Last Name:_____ First Name: _____

Relationship to Member: _____ Date of Birth: ___/____/_____

Social Security #_____

Address (if different from member's) _____

City :_____ State: _____ Zip: _____

Phone:_____

Person Responsible Employed By: _____ Occupation: _____

Business Address: _____Business Phone: _____

Insurance Company: _____

Contact #: _____ Group #: _____ Subscriber #: _____

7. E-Mail Communications; Privacy: If you wish to send email communications to and receive email responses from PERSONALIZED PRIMARY CARE'S physicians, staff, employees, agents, and representatives, you should be aware that email is not a secure medium for sending and receiving potentially sensitive personal health information. Although PERSONALIZED PRIMARY CARE will take steps to keep your communications with PERSONALIZED PRIMARY CARE and its physicians, staff, employees, agents, and representatives, confidential and secure, the confidentiality of e-mail communications cannot be assured or guaranteed. You also acknowledge and understand that email is not a good medium for urgent or time-sensitive communication. In the event a communication is time sensitive, you must communicate with PERSONALIZED PRIMARY CARE'S physicians by telephone or in person. You acknowledge and understand that, at the discretion of PERSONALIZED PRIMARY CARE and/or as required by law, your e-mail communications may become part of your permanent medical record.

8. Consent: You agree to complete and sign the Consent section below.

9. Entire Agreement: Each of the undersigned agrees to the terms of this Agreement, all of which are expressed herein. There are no promises or representations except as set forth herein.

10. Notices: Any communication required or permitted to be sent under this Membership Agreement shall be in writing and sent to the party to be notified via certified mail, return receipt requested, or provided via hand delivery, to the address set forth herein. Any changes in address shall be communicated in accordance with the provisions of this Section 9.

11. Governing Law: The validity, interpretation and performance of this Agreement shall be governed by the laws of the State of Florida without giving effect to the principles of comity or conflicts of laws thereof. Each party hereto agrees to submit to the personal jurisdiction and venue of the state and federal courts having jurisdiction over Osceola and Orange County, Florida for the resolution of all disputes arising in connection with the interpretation, construction, and enforcement of this Agreement, and hereby waivers the claim or defense therein that such courts constitute an inconvenient or invalid forum.

12. Amendments and Waivers. This Agreement may only be revoked, altered, amended, or modified by the written agreement of both parties hereto. No waiver of any provisions of this Agreement shall be valid unless in writing and signed by the party against whom such waiver is sought. One or more waivers of any covenant or condition of this Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach or of other covenants or conditions.

13. Section Headings. Any section, section title, or caption contained in this agreement is for convenience only, and in no way defines, limits, or describes the scope or intent of this Agreement or any of the provisions hereof.

14. Invalid Provisions. The invalidity or unenforceability of any particular provisions of this Agreement shall not affect any other provision hereof. This Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

15. Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which shall constitute a single Agreement.

CONSENT:

By signing your name below, you authorize

(i) Personalized Primary Care, and/or its physicians, staff, employees, agents, and representatives to share your confidential Personal Health Information with other treating physicians, hospitals, health care facilities, and licensed health care practitioners for the purpose of performing Personalized Primary Care's obligations under the agreement; and

(ii) Personalized Primary Care and/or its physicians, staff, employees, agents, and representatives to release any mental health, substance abuse, and HIV/AIDS information contained in your Personal Health Information, but only if Personalized Primary Care first obtains your separate, written consent to do so. Additionally, after receiving your consent to do so, Personalized Primary Care shall only release such mental health, substance abuse, and HIV/AIDS information for treatment, payment, and health care operations purposes.

(iii) Personalized Primary Care and/or its physicians, staff, employees, agents, and representatives to send your Personal Health Information to you via e-mail to the e-mail address listed below.

Personalized Primary Care's policies and practices governing its use and disclosure of Personal Health Information are available to you upon request, and such policies and practices may be changed as necessary by Personalized Primary Care as continued therein.You may request that Personalized Primary Care restrict the use or disclosure of your Personal Health Information to only treatment, payment, and health care operations purposes. You may revoke this consent at any time by providing written notice to Personalized Primary Care in accordance with Section 9 of this Agreement. However, if Personalized Primary Care has taken any action in reliance on your previously unrevoked consent (For example if Personalized Primary Care had released your Personal Health Information to your insurance company as part of a claim for reimbursement) your revocation of this consent shall not apply to such previous actions taken by Personalized Primary Care.

Patient/Member's Signature: _____ Date: _____

MEMBER INFORMATION:

Please Provide a Copy of a Photo ID

Each of the undersigned Members acknowledges that he or she freely and voluntarily executed this Membership Agreement

Patient Name:_____
Last Name First Name Initial

Address: _____ Apt #: _____

City: _____ State: _____ Zip:_____

Age: _____ Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email Address: _____

Patient Occupation: _____ Employed By: _____

Business Address: _____ Business Phone: (_____) _____-_____

Spouse Name: _____
Last Name First Name Initial

Age: _____ Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Spouse's Occupation: _____ Employed By: _____

Number of Children: _____ Whom may we thank for referring you?_____

In case of an emergency who should be notified?
_____

Phone: (_____) _____-_____

FOR INTERNAL USE

Date accepted by Personalized Primary Care _____

602 Front Street Celebration, Florida 34747
8976 Conroy Windermere Road Orlando, Florida 32835

Signature: _____ _____
(Effective Date)

NOTICE OF PRIVACY PRACTICES:

James G. Scelfo, MD, PA and Katelyn Meade, DO {Personalized Primary Care}

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.

1. Introduction

James G. Scelfo, MD, PA and Katelyn Meade, DO {DBA: Personalized Primary Care} are required by law to maintain the privacy and security of your health information and provide individuals with notice of its legal duties and privacy practices with respect to health information. James G. Scelfo, MD, PA and Katelyn Meade, DO {DBA: Personalized Primary Care} are required to abide by the terms of the Notice currently in effect. James G. Scelfo, MD, PA and Katelyn Meade, DO {DBA: Personalized Primary Care} reserve the right to change the terms of this Notice at any time and to make new Notice provisions effective for all health information that it maintains. Upon your request, we will provide you with a current copy of this Notice.

This Notice of Privacy Practices outlines our practices and legal duties to maintain the confidentiality of your protected health information ("PHI") under the privacy and security regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").

PHI includes demographic information that can be used to identify you such as your name, address, and telephone number; information concerning your past, present, or future physical or mental health condition; information concerning the provision of health care to you; and information concerning the past, present, and future payment for health care. Your PHI may be maintained by us electronically and/or on paper.

This Notice describes uses and disclosures of PHI to which you have consented, that you may be asked to authorize in the future, and that are permitted or required by state or federal law. Also, it advises you of your rights to access and control your PHI.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with James G. Scelfo, MD, PA and Katelyn Meade, DO {DBA: Personalized Primary Care}.

If you have any questions about James G. Scelfo, MD, PA or Katelyn Meade, DO {DBA: Personalized Primary Care}'s Notice of Privacy Practices, please contact Sabrina Carballo 407-566-2454.

2. Safeguarding Your PHI

We have in place appropriate administrative, technical, and physical safeguards to protect and secure the privacy and security of your PHI. We train our employees on the regulations and policies that are in place to protect the privacy and security of your PHI. Medical records are maintained in secure areas within our practice and electronic medical record systems are monitored and updated to address security risks in compliance with the HIPAA Security Rule. Only employees who have a legitimate "need to know" are permitted access to your medical records and PHI. Our employees understand their legal and ethical obligations to protect your PHI and that a violation of this Notice of Privacy Practices may result in disciplinary action.

3. Uses and Disclosures of PHI

As part of our registration materials, we will request your written consent for our practice to use and disclose your PHI for the following types of activities:

- **Treatment.** Treatment means the provision, coordination, or management of your health care and related services by James G. Scelfo, MD, PA or Katelyn Meade, DO {DBA: Personalized Primary Care} and health care providers involved in your care. It includes the coordination or management of health care by a provider with a third party insurance carrier, communication with lab or imaging providers for test results, consultation between our clinical staff and other health care providers relating to your care, or our referral of you to a specialist physician or facility.
- **Payment.** Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims management, and collection activities. Payment also may include your insurance carrier's efforts in determining eligibility, claims processing, assessing medical necessity, and utilization review. Payment may also include activities carried out on our behalf by one or more of our collection agencies or agents in order to secure payment on delinquent bills.
- **Health Care Operations.** Health care operations means the legitimate business activities of our practice. These activities may include quality assessment and improvement activities; fraud and abuse compliance; business planning and development; and business management and general administrative activities. These can also include telephoning, texting and emailing you to remind you of appointments, or using a translation service if we need to communicate with you in person, or on the telephone, in a language other than English. When we involve third parties in our business activities, we will have them sign a Business Associate Agreement obligating them to safeguard your PHI according to the same legal standards we follow.

4. Electronic Exchange of PHI

We may transfer your PHI to other treating health care providers electronically. We may also transmit your information to your insurance carrier electronically.

5. Uses and Disclosures of PHI Requiring Your Written Authorization

Uses and disclosures of your PHI made for purposes of psychotherapy, marketing, and disclosures that constitute a sale of PHI will be made only with your written authorization.

Other uses and disclosures of your PHI will be made only with your specific written authorization. This allows you to request that James G. Scelfo, MD, PA or Katelyn Meade, DO {DBA: Personalized Primary Care} disclose limited PHI to specified individuals or companies for a defined purpose and timeframe. For example, you may wish to authorize disclosures to individuals who are not involved in treatment, payment, or health care operations, such as a family member or a school physical education program. If you wish us to make disclosures in these situations, we will ask you to sign an authorization allowing us to disclose this PHI to the designated parties.

If James G. Scelfo, MD, PA or Katelyn Meade, DO {DBA: Personalized Primary Care} intend to engage in fundraising, you have the right to opt out of receiving such communications. If you authorize us to use or disclose your PHI for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose your PHI for the reasons contained within your authorization. However, we cannot take back disclosures already made with your permission.

6. Uses and Disclosures of PHI Permitted or Required by Law

In some circumstances, we may be legally permitted or required to use or disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization in certain situations, including, but not limited to:

- **Emergencies.** If you are incapacitated and require emergency medical treatment, we will use and disclose your PHI to ensure you receive the necessary medical services. We will attempt to obtain your consent as soon as practical following your treatment.
- **Others Involved in Your Healthcare**. Upon your verbal authorization, we may disclose to a family member, close friend, or other person you designate only that PHI that directly relates to that individual's involvement in your health care and treatment. We may also need to use PHI to notify a family member, personal representative, or someone else responsible for your care of your location and general condition.
- **Communication Barriers.** If we try but cannot obtain your consent to use or disclose your PHI because of substantial communication barriers and your physician, using his or her professional judgment, infers that you consent to such use or disclosure, or the physician determines that a limited disclosure is in your best interest, we may permit such use or disclosure.
- **Required by Law.** We may disclose your PHI to the extent that its use or disclosure is required by law. This disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Public Health/Regulatory Activities.** We may disclose your PHI to an authorized public health authority to prevent or control disease, injury, or disability or to comply with state child or adult abuse or neglect law. We are obligated to report suspicion of abuse and neglect to appropriate regulatory agencies.

- **Food and Drug Administration.** We may disclose your PHI to a person or company as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations as well as to track product usage, enable product recalls, make repairs or replacements, or to conduct post-marketing surveillance.
- **Health Oversight Activities.** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, and other activities necessary for the appropriate oversight of the health care system and government benefit programs such as Medicare and Medicaid.
- **Judicial and Administrative Proceedings.** We may only disclose your PHI in the course of any judicial or administrative proceeding in response to a court order expressly directing disclosure, or in accordance with specific statutory obligations compelling us to do so, or with your permission.
- **Law Enforcement Activities.** We may disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, or missing person, or complying with a court order or other law enforcement purpose. Under some limited circumstances we will request your authorization prior to permitting disclosure.
- **Coroners and Medical Examiners.** We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other lawful purpose.
- **Funeral Directors and Organ Donation Organizations.** We may disclose your PHI to enable a funeral director to carry out his or her lawful duties. PHI may also be disclosed to organ banks for cadaveric organ, eye, bone, tissue, and other donation purposes.
- **Research.** We may disclose your PHI for certain medical or scientific research where approved by an institutional review board and where the researchers have a protocol to ensure the privacy and security of your PHI.
- **Serious Threats to Health or Safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military and National Security Services.** We may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military authorities to assure proper execution of military missions. We may also disclose your PHI to certain federal officials for lawful intelligence and other national security activities.
- **Worker's Compensation.** We may disclose your PHI as authorized to comply with worker's compensation laws.
- **Inmates of a Correctional Facility.** We may use or disclose PHI if you are an inmate of a correctional facility and our practice created or received your PHI in the course of providing care to you while in custody.
- **US Department of Health and Human Services.** We must disclose your PHI to you upon request and to the Secretary of the United States Department of Health and Human Services to investigate or determine our compliance with privacy and security laws.
- **Disaster Relief Activities.** We may disclose your PHI to local, state, or federal agencies engaged in disaster relief and to private disaster relief assistance organizations (such as the Red Cross if authorized to assist in disaster relief efforts).

7. Your Rights Regarding PHI

- **Right to Request Restrictions for Certain Uses and Disclosures.** You have the right to request that we not use or disclose your PHI unless such a use or disclosure is required by law. Such a request must be made in writing and include the specific PHI you wish to restrict as well as the individual(s) who should not receive the restricted PHI. If we agree to your request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. However, we are not required to agree to your requested restriction except in the case of restricting disclosure of PHI to a health plan as described below. If you request a restriction on certain uses and disclosures of your PHI to a health plan for a particular health care item or service where said health care item or service is paid for out of pocket and in full, we will abide by your request. Such a request must be made in writing to the practice Privacy Officer. Your request must describe in a clear and concise fashion the health care item or service you wish restricted.
- **Right to Access.** You have the right to inspect and obtain a full copy of your PHI. You may request copies of your PHI in either paper or electronic form. In very limited circumstances, we may deny access to your PHI. To request access to your PHI, please submit a request in writing to the practice Privacy Officer including whether you want your copy in electronic or paper form. We will respond to your request as soon as possible, but no later than 30 days from the date of your request. If access is denied you will receive a denial letter within 30 days. If access is denied, an appeals process may be available in certain cases. We have the right to charge a reasonable fee for providing copies of your PHI (and for electronic media, if applicable). Furthermore, you may request that a copy of your PHI be transmitted directly to a third party provided such request is made in writing, signed by you and clearly identifies the designated third party and location to send your PHI.
- **Right to Confidential Communications.** You have the right to request to receive communication from PHI by alternative means or at alternative locations. For example, you may wish your bill to be sent to an address other than your home. Such requests must be made in writing to the practice Privacy Officer. We will not require an explanation of your reasons for the request, and will accommodate reasonable requests.
- **Right to Amend.** You have the right to request that we amend your PHI. Your request must be made in writing. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for an amendment, you have the right to submit a written statement disagreeing with the denial. James G. Scelfo, MD, PA and Kaeltyn Meade, DO {DBA: Personalized Primary Care} have the right to submit a rebuttal statement. A record of any disagreement regarding amendments will become part of your medical record and may be included in subsequent disclosures of your PHI.
- **Right to an Accounting of Disclosures.** Subject to certain limitations, you have the right to a written accounting of disclosures by us of your PHI for no more than 6 years prior to the date of your request. Your right to an accounting applies to disclosures other than those made for purposes of treatment, payment, or health care operations. Please make your request in writing to the practice Privacy Officer. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. We will provide you with one accounting every 12 months free of charge. We will charge a reasonable fee based upon our costs for any subsequent accounting requests.

- **Right to a Copy of our Notice of Privacy Practices.** We will ask you to sign a written acknowledgement of receipt for our Notice of Privacy Practices. We may update this Notice of Privacy Practices at any time. Upon your request, we will provide you with a current copy of this Notice.
- **Right to Notice of Breach.** You have a right to receive notice if there has been a breach of your unsecured PHI.

8. Complaint Procedure

- **Within our Practice.** If you have a complaint about the denial of any of the specific rights listed above, about our Notice of Privacy Practices, or about our compliance with state and federal privacy laws you may receive more information about the complaint process by contacting the Privacy Officer at 407-876-0073 (Windermere) or 407-566-2454 (Celebration).
- **Outside our Practice.** If you believe that James G. Scelfo, MD, PA or Katelyn Mease, DO {DBA: Personalized Primary Care} are not complying with its legal obligations to protect the privacy of your PHI, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights.
- We will not retaliate against you for filing a complaint.

9. Effective Date. This Notice is effective as of September 23, 2013.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand James G. Scelfo, MD, PA and Katelyn Meade, DO {DBA: Personalized Primary Care}'s *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that James G. Scelfo, MD, PA and Katelyn Meade, DO {DBA: Personalized Primary Care} may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of James G. Scelfo, MD, PA and Katelyn Meade, DO {DBA: Personalized Primary Care}'s *Notice of Privacy Practices* by submitting a request in writing for a current copy of James G. Scelfo, MD, PA and Katelyn Meade, DO {DBA: Personalized Primary Care}'s *Notice of Privacy Practices.*

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print and sign below

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

For James G. Scelfo, MD, PA and Katelyn Meade, DO {DBA: Personalized Primary Care} Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

James G. Scelfo, MD, PA and Katelyn Meade, DO {DBA: Personalized Primary Care} made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ❑ Patient or a patient's personal representative refused to sign
- ❑ Patient or patient's personal representative unable to sign
- ❑ Other: _____

_____
Employee Name (printed)

_____ _____
Employee Signature Date

James G. Scelfo, MD, FAAFP
Katelyn Meade, DO

602 Front Street
Celebration, FL 34747
Telephone: 407-566-2454
Fax: 407-566-2572

PERSONALIZED PRIMARY CARE

AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name: _____ Phone #: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

SSN#: _____-_____-_____ Date of Birth: _____/_____/_____

I hereby authorize Personalized Primary Care to use and *disclose to:* □ *obtain from:* □ *or allow review:* □

Name of Facility or Person:_____

Phone #: _____-_____-_____ Fax: _____-_____-_____

Address: _____ City: _____ State: _____ Zip:_____

The following information contained in my medical record regarding my care and treatment (please initial)

____ Complete Record ____ All Diagnostic Test Results ____Pathology Report ____ Abstract of Record

____ Consultations ____Medications ____Lab Only

____Radiology Only____Operative Report ____Progress Note(s)

____ Appointments ____Therapy Records ____ Other (specify): _____

The purpose for the release of information at the request of the individual is:

□ Continued Treatment □ Legal Action □ Insurance □ Personal Use □ Other: _____

This authorization will expire 1 year from the date signed unless otherwise stated: _____

I understand that this authorization extends to all or any part of the record designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test of the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initiated below or otherwise required by law.

May NOT include information related to (please initial):

____ HIV/AIDS ____ Mental Health ____ Drug/Alcohol Abuse ____ Genetic Counseling/Testing

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that PERSONALIZED PRIMARY CARE may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form upon request.

Patient/legal representative or Parent/legal guardian Signature: _____ Date: _____/_____/_____

Name of Person Witnessing Authorization Signature: _____ Date: _____/_____/_____

PERSONALIZED PRIMARY CARE

Physician / Facility Records Request List:

Name of Provider/Facility:	Phone:	Fax:	Address:	Specialty:

PERSONALIZED PRIMARY CARE

Authorization to Disclose Protected Health Information

Printed Name: _____ Date: _____

Patient Signature: _____

This authorization will remain in effect until revoked or at specified expiration date.

Expiration date: _____

In effort to ensure your privacy of your Protected Health Information (PHI) we are asking for you to provide information on any family, friends, or physicians whom you wish to allow access to your information.

Name of Person you are allowing access to your PHI	Information that may be disclosed	Method in which it can be released
	__ Medical __ Financial __ Appointment	__ Fax __ Voice __ Electronic
	__ Medical __ Financial __ Appointment	__ Fax __ Voice __ Electronic
	__ Medical __ Financial __ Appointment	__ Fax __ Voice __ Electronic
	__ Medical __ Financial __ Appointment	__ Fax __ Voice __ Electronic
	__ Medical __ Financial __ Appointment	__ Fax __ Voice __ Electronic
	__ Medical __ Financial __ Appointment	__ Fax __ Voice __ Electronic
	__ Medical __ Financial __ Appointment	__ Fax __ Voice __ Electronic
	__ Medical __ Financial __ Appointment	__ Fax __ Voice __ Electronic