DEAN C. KRAMER, M.D.

INTERNAL MEDICINE ● GASTROENTEROLOGY
1155 N.W. 64TH TERRACE
GAINESVILLE, FL 32605
352-331-6736 ● FAX: 352-331-0413
EMAIL: DCKRAMERMD@GMAIL.COM

I ______________________________ give my permission to Dr. Kramer and his staff to communicate with me via email.

Exceptions: ☐ NONE
☐ YES (list any exceptions of things you do **NOT** want sent to you by email)

____

____

____

______________________________ Signature

____________ Date

EMAIL ADDRESS:
____

**Note that receiving emails from Dr. Kramer is optional. Most insurance carriers will pay all or part of the fee for this type of doctor-patient communication. If you prefer not to receive emails from Dr. Kramer, please notify the office so that an office appointment can be scheduled.*

INSURANCE ASSIGNMENT

I authorize payment from any insurance company or any governmental agency (examples: Blue Cross/Blue Shield, Medicare) directly to Dean C. Kramer. M.D. for any medical or surgical benefits otherwise payable to me for the services of Dean C. Kramer, M.D., but not to exceed the reasonable and customary charges for these services.

SIGN HERE: ____ Date: _________________

AUTHORIZATION OF CARE AND ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT

I authorize Dean C. Kramer, M.D. to examine me and make such tests and perform such procedures as are reasonable and necessary in the diagnosis and treatment of my care. I agree to pay Dean C. Kramer, M.D. the professional fees in return for the above services. I agree that should the amount of any insurance benefits be insufficient to cover the professional fees of my care, I will be responsible for the payment of the difference including any deductibles and copayments.

SIGN HERE: ____ Date: _________________

ORIGINAL ASSIGNMENTS, AUTHORIZATIONS, AND RELEASES ON FILE

I permit a copy of the above assignments, authorizations, and releases to be used in the place of the original which have been filed in the office of:
Dean C. Kramer. M.D.

SIGN HERE: ____ Date: _________________

MEDICARE PATIENTS WITH SUPPLEMENTAL INSURANCE

I request that payment of authorized Medigap benefits be made in my behalf to Dean C. Kramer, M.D. for any services furnished me by Dean C. Kramer, M.D. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing the authorization will cause Medicare payment information to cross over automatically.

SIGN HERE: ____ Date: _________________

Patient Financial Responsibility

I understand and agree than I am financially responsible for payment of all office charges including deductibles, coinsurance, and non-covered services.

I understand and agree that I will pay for all deductibles coinsurance and non-covered services at the time of service by check, cash, or credit card.

I understand and agree that as my health care provider, Dr. Kramer's relationship is with me, the patient, not with my insurance company. My insurance policy is a contract between me and my insurance company.

I understand and agree that Dr. Kramer will cooperate fully with all regulations and requests of my primary insurance company that may assist in my claim being paid. Dr. Kramer's office will not, however, enter into a dispute with my insurance company over any claim.

I understand and agree that as a courtesy, Dr. Kramer's office will file a claim to my secondary and/or tertiary insurance company one time. If no payment is received, the balance will be my responsibility.

I understand and agree that it is my responsibility to ensure that all of my insurance information is accurate.

I understand and agree that additional charges my apply. These charges may include the following:

- A $35 charge for all returned checks
- A $75 charge for all missed appointments without 24-hour notice
- A copying charge of one dollar per page for the first 25 pages and $0.25 per page for all subsequent pages for duplicating medical records.

I understand and agree that there is no charge for duplicating my medical record that is to be forwarded to another healthcare provider or healthcare facility.

I understand and agree that failure to pay for my treatment and care may result in collection action taken to collect the debt.

I understand and agree that failure of payment may result in termination of care in Dr. Kramer's office.

I have read, understand, and agree to all provisions of the Patient Financial Responsibility Form.

____ ________________________

Signature Date

DEAN C. KRAMER, M.D.

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HIPAA
PROTECTED HEALTH INFORMATION DISCLOSURE

I hereby give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to those persons listed below:

Name: ____ Relationship: _____________________

Name: ____ Relationship: _____________________

Name: ____ Relationship: _____________________

Name: ____ Relationship: _____________________

Name: ____ Relationship: _____________________

Name: ____ Relationship: _____________________

____ ____________________
Signature of Patient Date

<u>Notice of Privacy Practices</u>

This Notice of Privacy Practices (hereafter referred to as the *Notice*) describes how medical information about Dr. Kramer's patients may be used and disclosed and how patients can get access to this information. *Please review it carefully*.

If you have any questions about this *Notice*, please contact our Privacy Contact, Dean C. Kramer, M.D.

This *Notice* describes how Dr. Kramer and his staff may use and disclose your protected health information to carry out treatment, to obtain payment, or to conduct normal business activities, and for other purposes that are permitted or required by law. It also describes your rights to access and to control your protected health information.

"Protected health information" is defined as information about you, such as your name, address, telephone number, date of birth, etc. that may identify you and that relates to your past, present, or future physical or mental health or condition and related medical services.

We are required by law to abide by the terms of this *Notice*. We may; however, change the terms of the *Notice* at any time. The new *Notice* will be effective for all protected health information that we maintain at the time. Upon your request, we will provide you with any revision of the *Notice*.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent: You will be asked by Dr. Kramer or one of his staff members to sign a consent form. By signing this form, you consent to the use and disclosure of your protected health information as described in the following sections.

Your protected health information may be used and disclosed by Dr. Kramer, his office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the usual business operation of Dr. Kramer's medical practice.

The following are examples of the types of use and disclosure of your protected health care information that Dr. Kramer's office is permitted to make once you have signed the consent form. These examples are not meant to be all inclusive, but to describe some of the types of uses and disclosures that may be made by Dr. Kramer once you have provided consent.

<u>TREATMENT:</u> We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you.

We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician

to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) at Dr. Kramer's request.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. These services may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination, of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of Dr. Kramer's practice. These activities include, but are not limited to, quality assessment activities as well as training of medical and paramedical personnel.

For example, we may use a sign-in sheet at the registration desk where you might be asked to sign your name. We may also call you by name in the patient lobby when Dr. Kramer is ready to see you. We may use your name, address, or telephone, as necessary, to contact you to remind you of an appointment.

We will share your protected health information with third party "business associates" that perform various activities for the operation of business associate that contains terms that will protect the privacy of your protected health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATINO BASED UPON YOUR WRITTEN AUTHORIZATION: Other used and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except when Dr. Kramer and his staff have taken an action in reliance on the use or disclosure indicated in the authorization.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT: We may use and disclose your protected health information in the following instances: You have the opportunity to agree or object to the use of disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then Dr. Kramer may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

OTHERS INVOLVED IN YOUR HEALTHCARE: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary, if we determine that it is in your best interest based on Dr. Kramer's professional judgement.

We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death.

Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

EMERGENCIES: We may use or disclose your protected health information in any emergency treatment situation. If this happens, Dr. Kramer will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If Dr. Kramer is required by law to treat you and he has attempted to obtain your consent but is unable to obtain your consent, he may still use or disclose your protected health information to treat you.

COMMUNICATION BARRIERS: We may use and disclose your protected health information if Dr. Kramer attempts to obtain consent from you but is unable to do so due to substantial communication barriers and Dr. Kramer determines, using professional judgement, that you would consent to use or disclosure under the circumstances.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT: We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

REQUIRED BY LAW: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

PUBLIC HEALTH: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if directed by a public health authority or to a foreign government agency that is collaborating with the public health authority.

COMMUNICABLE DISEASES: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise ne at risk of contracting or spreading the disease or condition.

HEALTH OVERSIGHT: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil right laws.

ABUSE OR NEGLECT: We may disclose protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

FOOD AND DRUG ADMINISTRATION: We may disclose your protected health information to a person or company as required by the Food and Drug Administration in order to report adverse events, product defects or problems, biologic product deviations, or track products to enable product recalls.

LEGAL PROCEEDINGS: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosures are expressly authorized), in certain conditions in response to subpoena, discovery request, or other lawful process.

LAW ENFORCEMENT: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, (6) medical emergency (not in Dr. Kramer's office) and it is likely that a crime has occurred.
CORONER, FUNERAL DIRECTORS, AND ORGAN DONATIONS: We may disclose protected health information to a coroner or medical examiner for identification purposed, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye, or tissue donation purposes.
CRIMINAL ACTIVITY: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
MILITARY ACTIVITY AND NATIONAL SECURITY: When The appropriate conditions apply, we may use of disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority, if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.
WORKER'S COMPENSATION: Your protected health information may be disclosed by us to comply with Worker's Compensation laws and other similar legally established programs.
INMATES: We may use or disclose your protected health information if you are an inmate of a correctional facility and Dr. Kramer created or received your protected health information in the course of providing care to you.
REQUIRED USES AND DISCLOSURES: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

YOUR RIGHTS: Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that Dr. Kramer and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation or, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact, Dean C. Kramer, M.D. if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposed as described in this *Notice*. Your request must state the specific restriction requested and to whom you want the restriction to apply. Dr. Kramer is not required to agree to a restriction that you may request. If Dr. Kramer believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If Dr. Kramer does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Please discuss any restrictions you wish to request with Dr. Kramer. You may request a restriction by submitting your request in writing to Dr. Kramer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information concerning how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you concerning the basis for the request. Please make this request in writing to our Privacy Contact, Dean C. Kramer, M.D.

You may have the right to have Dr. Kramer amend your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact, Dean C. Kramer, M.D. if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this *Notice*. If excludes disclosures we may have made to you, for a facility directory, to family members, to friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2002. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy right have been violated by us. You may file a complaint with us by notifying our Privacy Contact, Dean C. Kramer. M.D. of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Contact, Dean C. Kramer, M.D. at 352-331-6736 for further information about the complaint process.

This notice was published and became effective on September 1, 2002.

Consent for Purposed of Treatment, Payment of Health Care Bills, and Conduct of Healthcare Related Matters in Dr. Kramer's Office

I consent to the use or disclosure of my protected health information by Dean C. Kramer, M.D. for the purpose of:

a) Diagnosing or providing treatment to me
b) Obtaining payment for my health care bills
c) Conducting healthcare related matters

I understand that diagnosis and treatment of my condition by Dr. Kramer may be conditioned upon my signing this document granting him the right to exam and treat me.

I understand that I have the right to request a restriction as to how my protected health care information is used. Although I have the right to place restrictions on how my health care information is used or disclosed, Dr. Kramer is nor required to agree to my requested restrictions. However, if Dr. Kramer does agree to a restriction that I request, that restriction shall be binding on him.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Kramer has already taken action in reliance on my consent.

My "protected health information" means health information, including, but not limited, to such things as my name, address, telephone number, and date of birth. This protected health information may relate to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that I have a right to review Dr. Kramer's Notice of Privacy Practices prior to signing this document. Dr. Kramer's Notice of Privacy Practice has been provided to me. The Notice describes the types of uses and disclosures of my protected health information that may occur in my treatment, in the payment of my bills and in the performance of health care related matters in Dr. Kramer's office. A copy of the Notice of Privacy Practices is also located in Dr. Kramer's business office. The Notice of Privacy Practices describes my rights and Dr. Kramer's duties with respect to my protected health information.

Dr. Kramer reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy of the Notice of Privacy Practices by calling the office (352-331-6736) and requesting that a revised copy be sent to me in the mail or by asking for a copy at the time of my next appointment.

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Signature of Patient or Personal Representative Date

____

Printed Name of Patient or Personal Representative Date

PROFESSIONAL FEES

Since the onset of the COVID epidemic, the delivery and payment for healthcare providers has changed dramatically. Since social distancing has become a key component to controlling this viral disease, patients have been encouraged to limit close contacts with others. Patients, therefore, have complied by reducing or eliminating appointments with their healthcare providers.

Federal healthcare administrators have responded to the challenges of the epidemic by allowing care providers to provide medical care by telephone, email, or audio-visual contacts as a substitute for in-person office appointments. As such, a new billing structure has been approved.

Patients may, therefore, see charges submitted to their insurance carrier for services such as:

- Review of records
- Telehealth phone consultations
- Prescription refills
- Completion of health and disability forms
- Email telehealth communications, and
- ZOOM® audiovisual communications

NEW ALLOWABLE CHARGES

Code	Medicare fee allowance	Description
G2012	$14.23	5-10 MINUTE CARE PROVIDER ENCOUNTERS SUCH AS BRIEF PHONE CALLS, EMAIL COMMUNICATIONS, OR PRESCRIPTION REFILLS
99214 (Office) 99214 (Telehealth)	$127.97 $98.07	30+ MINUTES CONTACT TIME FOR RECORD REVIEW, REVIEW OF INTERVAL HISTORY TREATMENT PLAN, AND FOLLOW-UP CARE
99215 (Office) 99215 (Telehealth)	$178.30 $143.90	40+ MINUTES CONTACT TIME FOR RECORD REVIEW, REVIEW OF INTERVAL HISTORY TREATMENT PLAN, AND FOLLOW-UP CARE
G2212	$32.19	EXTENDED TIME CONTACT BASED ON 15 MINUTE INCREMENTS

Insurers other than Medicare may have different allowable fees.
Please discuss any questions regarding office fees with the front office staff.

I have read and understand the new billing guidelines and accept them for my care.

_________________________________ (Signature) ____________________ (Date)

____ (Printed name)

Authorization for Release of Information

I, hereby authorize ____ to disclose the following protected health information to:

Dean C. Kramer, M.D.
1155 NW 64th Terrace
Gainesville, FL 32605
352-331-6736
FAX 352-331-0413
Email: dckramermd@gmail.com

PATIENT IDENTIFICATION

The information to be disclosed includes:
[ ] Office medical records [ ] Hospital summaries [ ] Laboratory reports [ ] X-ray reports
[ ] Operative summaries [ ] Pathology reports

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This protected health care information is being used for diagnosis and treatment.

This authorization shall be in force and effect for one (1) year from the date of signing at which time this authorization to use or disclose this protected health information shall expire.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dean C. Kramer, M.D., at his above noted address or to his e-mail address. I understand that my revocation of this authorization is not effective to the extent that Dean C. Kramer, M.D. has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed to Dean C. Kramer, M.D. as a result of this authorization may be subject to redisclosure by Dean C. Kamer, M.D. in which case it may no longer be protected by state or federal law.

Dean C. Kramer, M.D. will not condition my treatment on whether I provide authorization for the requested use or disclosure of information.

I understand that I have the right to refuse to sign this authorization.

____
Signature of Patient or Personal Representative Date

____
Printed Name of Patient or Personal Representative Date