West Orange Endocrinology Research Center
CLINICAL RESEARCH

Jose M Mandry, MD
Maria del Carmen Mandry-Freire PA-C
1510 Citrus Medical Court, Ocoee, FL 34761
(407) 480-4830 fax (407) 480-4834

All New Patients:

Thank you for choosing West Orange Endocrinology P.A. and welcome to our practice.

Please find enclosed information needed for your first visit. Complete all forms entirely and bring them to your appointment. PLEASE ARRIVE AT LEAST 20 MINUTES BEFORE your scheduled appointment time so that we may process your paperwork.

Please remember to bring the following to your appointment:
1. Insurance Card(s)
2. Driver's License or photo ID
3. Labs and/or test results or records from your referring doctor.
4. Bring all your medications or a complete list of your medications with dosages you are currently taking (including over the counter medications), as well as the name and phone number of the pharmacy you use. We will send prescriptions electronically to your pharmacy.
5. A copy of your authorization/referral from your primary care physician (if required by your insurance)
6. Any copay, deductible, and/or coinsurance you are responsible for will be collected upon check-in. Please contact our office or your insurance company prior to appointment if you are not sure what your copay, deductible, or coinsurance might be.

We accept Cash, Visa, MasterCard, American Express, or Discover Card and Debit Cards.

If you have an HMO, EPO, or POS plan and require a referral to see a specialist, please make sure to contact your primary care physician and have this information sent or brought to our office **PRIOR** to your appointment. If we do not have an authorization/referral, we will have to reschedule your appointment.

Thank you for the opportunity and confidence in allowing us to participate in your care. We look forward to meeting you.

Please print and complete pages 2, 3, 6, 20 and 21

Thank you

The Physicians and Staff

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(Please Print Clearly)

Today's date:	Preferred Language: English ☐ Spanish ☐ Other ☐_____

PATIENT INFORMATION

Patient's last name: First: Middle Initial:	❑ Mr. ❑Mrs. ❑ Sr ❑ Sra. ❑ Ms. ❑ Dr.	Marital status: ☐single ☐Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ❑ Yes ❑ No (For insurance purposes, please provide name as it is on social security card.)	Birth date: ☐☐ ☐☐ ☐☐☐☐ M M D D Y Y Y Y Age: ☐☐ Sex: ❑ M❑ F

Street address P.O. box::_____

City:_____ State:_____ Zip: _____County: _____

Home Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐

Cell Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐

Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐	Email Address:
RACE (CHECK ONE) ☐AMERICAN I☐ INDIAN/ALASKAN NATIVE ASIAN ☐ CAUCASIAN/WHITE ☐NATIVEHAWAIIAN/PACIFIC ISLANDER ☐BLACK/AFRICAN AMERICAN ☐DECLINED	ETHNICITY (CHECK ONE) ☐HISPANIC ☐NON-HISPANIC ☐DECLINED
Occupation:	Employer:
Employer Address:	Employee Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Policy holders' name:	Address of policy holder (if different):	Policy holder DOB: ☐☐ ☐☐ ☐☐☐☐ M M D D Y Y Y Y Policy Holder Phone Number.: ☐☐☐ ☐☐☐ ☐☐☐☐

Relationship: ❑ SPOUSE ❑ PARENT ❑ OTHER ❑GUARDIAN ❑ SELF

Policy holder Employer;	Social Security Number OF POLICY HOLDER ☐☐☐ ☐☐ ☐☐☐☐

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Please indicate primary insurance:
❑ Cigna ❑Avmed ❑Anthem BC/BS ❑ United ❑AETNA❑ Wellcare ❑ Humana
❑ Multiplan ❑ Advent Health ❑ Medicare ❑Devoted ❑ Careplus ❑Simply health
❑ First Health ❑Optimum ❑Freedom ❑Other_____

Insurance address:	**INSURANCE PHONE NUMBER:** ☐☐☐ ☐☐☐ ☐☐☐☐

Policy no.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Group no: ☐☐☐☐☐☐☐☐☐

Name of secondary insurance (if applicable): _____ Secondary Insurance Address:	Group no.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Policy no.: ☐☐☐☐☐☐☐☐ Secondary Insurance Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐

IN CASE OF EMERGENCY

Name of local friend, significant other or relative:	Relationship to patient: _____ Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐

LIFETIME AUTHORIZATION: I understand that my insurance is a contract between my insurance company and myself. I am responsible for payment of services at the time it is rendered at West Orange Endocrinology, P.A. I authorize my insurance benefits be paid directly to the physician, Dr. José M Mandry, or other physician that may have joined in the practice that rendered care on my behalf. I also authorize West Orange Endocrinology, PA to release any information required to process my claims. I permit a copy of the authorization to be used in place of the original and request payment of medical insurance benefits to the party that accepts assignments. Furthermore, I authorize treatments of my condition. I confirm that the above information is true to the best of my knowledge.

Preferred method of payment: ☐ Cash ☐Debit ☐ Credit (Sorry that we cannot keep credit info on file)

_____ _____
Patient/Guardian signature *Date*

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CONTRACT FOR CARE

BETWEEN West Orange Endocrinology, (WOE) P.A. and Patient

Dr. Mandry and staff of West Orange Endocrinology, WOE are pleased that you have chosen us to provide necessary medical care in the specialty of Endocrinology. To better serve your needs, we want to review important issues and expectations:

1) The physicians and staff will do our best to address your concerns and needs and expect your cooperation to comply with all policies and procedures of this office.
2) WOE provides private patient portal to access to your health information and encourage use of your patient portal to check information about your progress and to retrieve labs, schedules and medical history. You may submit medical questions to the staff through the portal.
3) Your appointment with us is a mutual agreement. In the event that you miss an appointment without giving us at least 24 hours' notice, you will be charged a No Show Fee of $50.00.
4) Repeated RESCHEDULING, CANCELATIONS or NO SHOWS of CONSECUTIVE APPOINTMENTS, may result in TERMINATION of our professional relationship. A notice will be sent to you to consult with another practitioner for your medication requests and continuity of care.
5) Please inform our staff if here is a change in contact, address, insurance, or primary care physician.
6) Our medical personnel specializes in endocrinology, diabetes, and other endocrine metabolic disorders. The physician, staff, and/or research clinicians and do not provide primary care services that a family doctor or internist provides. The only medical clearance we will perform are of an endocrine disorder, such as for diabetes or thyroid disease. Should you require the name of a primary care physician, please contact your insurance company for a provider reference.
7) Your insurance contract is between you and your insurance company. We understand it may be difficult to know all the terms and benefits of your contract, and the staff at WOE will check on the copay and referral prior to your visit. If you are unsure of your benefits, you should contact your PCP or insurance prior to your visit. IF YOU REQUIRE A REFERRAL OR AUTHORIZATION TO SEE US, OUR STAFF WILL DO OUR BEST TO OBTAIN IT AND HAVE IT HERE FOR YOUR VISIT. IF YOUR PCP DOES NOT PROVIDE A REFERRAL OR AUTHORIZATION FOR OUR SERVICES, YOUR APPOINTMENT WILL BE RESCHEDULED UNTIL WE RECEIVE AN APPROVAL BY THE INSURANCE.
8) Please refrain from use of cell phones and other personal electronic devices while being examined by the physician or when being attended to by the staff of West Orange Endocrinology, P.A.
9) The provider will prescribe medications and/or devices to help control, manage or mitigate complications that arise from chronic diseases. Sometimes a prescription may require special forms or a prior authorization from our office. WOE will work to get these submitted, however oftentimes the insurance company will approve a different but similar prescription. Please consult your insurance company or pharmacist to find out which prescription is on the insurance's preferred formulary, and contact our office for the doctor to make an adjustment to the prescription. The provider must be in agreement that this brand of medication will be an appropriate option. Prior authorizations are at the discretion of the physician.
10) Dr. Mandry limits his practice to **IN-HOUSE** care and does not maintain hospital privileges. He will not be admitting or consulting during hospitalizations.

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-Insurances Accepted-

You are encouraged to verify that West Orange Endocrinology is a provider on your plan. Our practice is not on every insurance plan, and if WOE does not have a contract with your insurance, you may be seen with a fee for service, or perhaps as an out of network benefit. If WOE does participate in a plan that requires a Primary Care Physician Referral or Pre-Authorization, we will be unable to provide treatment or testing until authorization or referral is received. Not all services are a covered benefit of all insurance policies, and we recommend you understand any policy exclusions, as payment for non-covered services will be your responsibility.

MEDICARE - We accept assignment on all Medicare claims. We will also file Medicare Supplement claims (except Medicaid). Patients covered by Medicare Part B must bring the Medicare card & Supplemental Policy card to the first visit. If you switch to a Medicare Advantage Plan, please inform us immediately.
MEDICAID - We DO NOT participate in most Medicaid or Medicaid Advantage plans.
HMO/PPO - Patients must bring the HMO/PPO card, their referral or authorization (if required), and be prepared to pay at time of service. For HMO patients, YOU are responsible for making sure your primary care physician has sent us the appropriate referral and YOU WILL BE RESPONSIBLE FOR ANY UNPAID BALANCES DUE TO LACK OF REFERRAL or AUTHORIZATION.
Private Insurances/Out of Network Insurances - We will file private insurance claims and out-of-network claims as a courtesy to our patients if we can verify benefits before time of service.
Payment for the Uninsured Portion (Deductible & Co-Insurance) is due at the time of service.

We will file **PRIMARY INSURANCES ONLY**. If you have multiple insurances YOU will be responsible for submitting necessary forms for reimbursement directly to you. We will only file secondary insurance if Medicare is primary.

Your insurance will send you an explanation of benefits that explains what they paid to our office. This is a record that you must keep on file.

If your insurance denies payment on your claim, you will be asked to pay for services rendered. We accept cash, credit cards, and debit cards as forms of payment. For any unpaid balances, please consult with our financial administrator to set up payments to avoid a collection fee.

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-Uninsured Patients-

Patients not covered by any insurance plans or covered by insurance policies that we are unable to bill directly should expect to pay for services billed at our standard rates. The following estimates are provided as a guideline and are not for contractual purposes:

New Patients should be prepared to pay up to $250 for the initial consultation.

Established Patients should be prepared to pay $85 - $100 for each follow-up visit.

Additional Services, such as diagnostic testing and labs, may be required during any visit. These additional services are not included in the estimates above and are rendered at an additional fee. West Orange Endocrinology, P.A. is independent of and does not have affiliations with third party vendors such as laboratory or other consultant firms.

- NO SHOW POLICY -

Patients that miss their appointments without notification at least twenty-four hours in advance of the appointment will be assessed a $50 no show fee. Patients that show up for their appointment more than 15 minutes late may need to reschedule their appointment or have to wait until the clinician is available for their appointment. In the unlikely event that you have several consecutive no shows or missed appointments, you may receive a letter of termination from the practice. Our staff will try to contact you regarding your noncompliance.

- REQUEST FOR RECORDS –

West Orange Endocrinology, P.A. is partnered with Share Care Health Data Services and they may be contacted at 866-967-0133 for complete medical records requests. Their record request fee are as per Florida Department of Health Statutes.

- FORM COMPLETION -

Our office charges a flat fee of $25 for the completion of any forms which require the physician to review your chart and fill out. Prepayment is required before the form will be completed.

I agree to abide by the financial policy of West Orange Endocrinology, P.A.

_____ _____

Name Date

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Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES
FOR
WEST ORANGE ENDOCRINOLOGY, P.A.

Effective Date: September 5, 2019

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE")
DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact:

Name: Kathy Mandry, Administrator

Title: **Privacy Officer**

Phone Number: (407) 480-4836

Federal regulations, known collectively as the "HIPAA Privacy Rules," require that we provide to you a detailed notice in writing of our privacy practices. Our privacy practices are for West Orange Endocrinology, P.A. (the "Company"). While we know that this Notice is long, the HIPAA Privacy Rules require us to describe in detail the ways that we may use and disclose your protected health information, as well as your legal rights and our legal duties with respect to protected health information.

Section A: Who Will Follow This Notice?

This Notice describes our practices and that of:

Any health care professional authorized by this Company to enter information into your medical record.

Any member of a volunteer group we allow to help you while you are receiving care from this Company.

All our employees, staff and other personnel.

The following location follows the terms of this Notice. This may not reflect recent acquisitions or sales of entities, sites, or locations. 1510 Citrus Medical Court, Ocoee, FL 34761

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Section B: Our Pledge Regarding Protected Health Information.

The HIPAA Privacy Rules require that we protect the privacy of information that identifies a patient (or where there is a reasonable basis to believe the information can be used to identify a patient) when: (a) the health information is transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium; (b) is created or received by us; and (c) relates to the past, present or future physical or mental health or condition of a patient, the provision of health care to a patient, or the past, present or future payment for the provision of health care to a patient. This information is called "protected health information" or "PHI".

We understand that PHI about you and your health is personal. We are committed to protecting PHI about you. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by this Company.

This Notice will tell you about the ways in which we may use and disclose your PHI. This Notice also describes your rights and certain obligations we have regarding the use and disclosure of PHI.

We are required by law to:

- maintain the privacy of PHI about you, consistent with the requirements of the HIPAA Privacy Rules;
- give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose PHI. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

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USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The following categories describe the different ways we may use and disclose PHI for treatment, payment, or health care operations.

- Treatment. We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. We may consult with other health care providers regarding your treatment and coordinate and manage your healthcare with others. For example, we may use and disclose PHI when you need a prescription, lab work, an x-ray or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider. For example, if you are referred to another physician, we may disclose PHI to your new physician regarding whether you are allergic to any medications. We also may disclose PHI about you for the treatment activities of another health care provider. For example, we may send a report about your care from us to a physician that we refer you to so that the other physician may treat you. We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or medical care at this Company. We also may use and disclose PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- Payment. We may use and disclose PHI about you so that the treatment and services you receive from this Company may be billed to, and payment may be collected from, you, an insurance company or a third party. For example, we may give your health plan information about a medical procedure that we performed for you, so your health plan will pay us or reimburse you for the procedure. We also may tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.

- Health Care Operations. We may use and disclose PHI about you in order to operate this Company. These uses and disclosures are necessary to run this Company and to make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may combine PHI about other patients to decide what additional services we can offer, what services are not needed, and whether certain new treatments are effective. We may use or disclose PHI to an outside organization that evaluates, certifies, or licenses health care providers or staff in a particular field or specialty so that one of our staff members may become certified as having expertise in a specific field or specialty. We may disclose information to doctors, nurses, technicians, medical students, and even personnel from other medical institutions for review and learning purposes; and we may combine the PHI we have with PHI from other medical institutions to compare how we are doing, and to see where we can make improvements in the care and services we offer. We also may remove information that identifies you from this set of PHI, so

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others may use it to study health care and health care delivery without learning who the specific patients are.

We also may contact you as part of our fundraising efforts. The only information about you that will be distributed for any fundraising effort is your demographic information (e.g., name, address, telephone number, etc.) and the dates you received treatment. All fundraising communications will include information about how you may opt out of future fundraising communications. If you elect to opt out of receiving further fundraising communications, such election will be treated as a revocation of authorization and this Company will make reasonable efforts to ensure that no further fundraising communications will be sent to you.

We sometimes contract with third-party business associates for services. Services may include answering services, transcriptionists, billing services, electronic health record, practice management and revenue cycle services, interoperability, data liquidity, data aggregation and population health management services, consultants and legal counsel. For example, we have contracted with Greenway Health, LLC ("Greenway Health"), so that Greenway Health (and its affiliates and related parties, including, but not limited to, any subsidiaries) can provide electronic health record, practice management and revenue cycle services and interoperability, data liquidity, data aggregation and population health management services. Our business associates may sometimes subcontract with a third party to perform the services we have asked them to do. For example, Greenway Health may use the following subcontractors in connection with the services it performs: GH Holdco, Inc., GEHS Holdco, Inc., Greenway EHS, Inc., Greenway IPS, LLC, Greenway Health, Inc. and Greenway Health Services, LLC. We disclose your PHI to our business associates (and our business associates may disclose your PHI to their subcontractors), so that they can perform the job we have asked them to do, and they may disclose your PHI to such third party. To protect your PHI, however, we require our business associates and their subcontractors to appropriately safeguard your information and comply with the HIPAA Privacy Rules.

We also may disclose PHI for the health care operations activities of an organized health care arrangement in which we may participate to other participants in the organized health care arrangement. An example of an "organized health care arrangement" is the joint care provided by a hospital and the doctors who see patients at the hospital.

USES AND DISCLOSURES FOR WHICH AN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT IS NOT REQUIRED

In addition to the various uses and disclosures of your PHI which routinely occur incident to treatment, payment, and health care operations activities, we are sometimes required or permitted by law to make

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the following types of uses and disclosures of your PHI, in which it is not necessary for us to receive your authorization or to give you the opportunity to agree or object when we use and disclose your PHI.

- Uses and Disclosures Required by Law. We will disclose PHI about you when required to do so by federal, state or local law and the use or disclosure complies with and is limited to the relevant requirements of such law.

- Uses and Disclosures for Public Health Activities. We may disclose your PHI for public health activities, including:

    - The reporting of information for the purpose of preventing or controlling disease, injury, or disability;

    - The reporting of child abuse or neglect;

    - To an individual having responsibility for the purpose of activities related to the quality, safety or effectiveness of a FDA-regulated product or activity;

    - To a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if we or a public health authority is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation;

    - An employer, about an individual who is a member of the workforce of the employer, if we provide care at the request of the employer; or

    - A school, about an individual who is a student or prospective student of the school, limited to proof of immunization.

- Disclosures about Victims of Abuse, Neglect or Domestic Violence. We may disclose your PHI to a government authority if we reasonably believe you to be a victim of abuse, neglect, or domestic violence.

- Uses and disclosures for Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure or disciplinary actions. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

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- Disclosures for Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- Disclosures for Law Enforcement Purposes. We may disclose PHI if asked to do so by a law enforcement official for a law enforcement purpose:

    - As required by law or in compliance with a court order, subpoena, warrant, summons, administrative request or similar process;

    - In response to a law enforcement official's request for such information to identify or locate a suspect, fugitive, material witness, or missing person, provided that we will only disclose limited information (which shall not include PHI related to your DNA or DNA analysis, dental records, typing or samples or analysis of body fluids or tissue);

    - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement because of incapacity or other emergency circumstance, provided that certain requirements are met;

    - To alert law enforcement about a death we believe may be the result of criminal conduct;

    - About criminal conduct at our facility or at the hospital; and

    - In emergency circumstances, to report a crime, the location of the crime or the victims; or to report the identity, description or location of the person who committed the crime.

- Uses and Disclosures to Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We also may release PHI about patients to funeral directors as necessary to carry out their duties.

- Uses and Disclosures for Cadaveric Organ, Eye or Tissue Donation Purposes. If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation. We also may release PHI to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

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- Uses and Disclosures to Prevent a Serious Threat to Health or Safety. We may use and disclose PHI about you when necessary to prevent a serious threat to your health or safety, or the health or safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- Uses and Disclosures for Specialized Government Functions. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We also may release PHI about foreign military personnel to the appropriate foreign military authority. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We may disclose PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

- Disclosures for Workers' Compensation. We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION, FOR WHICH YOU HAVE THE OPPORTUNITY TO AGREE OR OBJECT

We may use and disclose PHI about you in some situations where you have the opportunity to agree or object to certain uses and disclosures of PHI about you. If you do not object, then we may make these types of uses and disclosures of PHI.

- Uses and Disclosures for Directory. We may include certain limited information about you in our directory. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

- Uses and Disclosures to Individuals Involved in Your Care or Payment for Your Care. We may disclose PHI about you to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care. If you are present and able to consent or object (or if you are available in advance), then we may only use or disclose PHI if you do not object after you have been informed of your

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opportunity to object. If you are not present or you are unable to consent or object, we may exercise professional judgment in determining whether the use or disclosure of PHI is in your best interests. For example, if you are brought into this office and are unable to communicate normally with your physician for some reason, we may find it is in your best interest to give your prescription and other medical supplies to the friend or relative who brought you in for treatment. We also may use and disclose PHI to notify such persons of your location, general condition, or death. We may use professional judgment and our experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other things that contain PHI about you.

- Uses and Disclosures for Disaster Relief Purposes. We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such disaster relief agencies to make this type of notification.

- Uses and Disclosures when the Individual is Deceased. If you are deceased, we may disclose to a family member, close friend, or any other person identified by you who was involved in your care or payment for health care prior to your death, your PHI that is relevant to such person's involvement, unless doing so is inconsistent with any prior expressed preference by you that is known by us.

USES AND DISCLOSURES REQUIRING WRITTEN AUTHORIZATION OR CONSENT

We may not use or disclosure PHI about you without your written authorization in certain situations. If you provide us with written authorization, then we may make these types of uses and disclosures of PHI. We will not make other uses or disclosures of your PHI without your written authorization other than as described in this Notice. Authorizations which are required for such purposes must contain, in plain language, specific descriptions of the information you want disclosed, to whom, your authorized purposes, and the duration of such authorization. Any written authorization you give us for such purposes may be revoked by you at any time, except to the extent we have taken action in reliance thereon.

- Uses and Disclosures for Research Purposes. We will not disclose PHI about you for research purposes without your authorization unless we receive a waiver from a permissible institutional review board or privacy board. For example, we may disclose PHI about you to people preparing to conduct a research project about patients with specific medical needs, so long as we receive an Authorization from you allowing us to do so prior to disclosing PHI about you or we receive a waiver from an institutional review board or privacy board. We may use or disclose PHI for research without your authorization if we receive an approved waiver.

- Uses and Disclosures of Psychotherapy Notes. We need your authorization for any use or

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disclosure of psychotherapy notes except to carry out certain treatment, payment or health care operations, when required by the Secretary of the U.S. Department of Health and Human Services (the "Secretary") to investigate our compliance with the HIPAA Privacy Rules, or when permitted as required by law, for health oversight, to coroners and medical directors, and to prevent serious threat to health or safety.

- Use and Disclosure for Marketing. We need your authorization to use your PHI for any use or disclosure of PHI for solicitation or marketing the sale of goods or services, unless we have a face-to-face communication with you or we provide you with a promotional gift of nominal value.

- Sale of Protected Health Information. We need your authorization to disclose your PHI in connection with a sale of PHI.

Section D: Your Rights Regarding PHI About You

You have the following rights regarding PHI we maintain about you:

- Right to Inspect and Copy. You have the right to inspect and copy some of the PHI that may be used to make decisions about your care. Usually, this includes medical, billing and electronic health records, but does not include psychotherapy notes. To inspect and copy PHI, please contact our Privacy Officer at the contact information below. Please note if you request a copy of the information, we may charge a fee consistent with the HIPAA Privacy Rules.

- Denial of Request to Inspect and Copy. We may deny your request to inspect and copy PHI in certain circumstances. If you are denied access to PHI, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Company will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- Right to Amend. If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information by submitting your request in writing to our Privacy Officer at the contact information below. You have the right to request an amendment for as long as the information is kept by or for this Company. You must provide a reason that supports your request.

- Denial of Request to Amend. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

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- Is not part of the PHI kept by or for this Company;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of PHI about you. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. We are not required to provide you with an accounting of disclosures of PHI that were made:
  - For treatment, payment, and health care operations;
  - For use in or related to facility directory;
  - To family members or friends involved in your care;
  - To you directly;
  - To create a limited data set, pursuant to an authorization by you or your personal representative; or
  - For certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes).

  You also can request disclosures documented in an electronic health record for treatment, payment and health care operations (if applicable) for the last three (3) years. Your request should indicate in what form you want the list (for example, on paper, electronically). If you wish to make such a request, please contact our Privacy Officer at the contact information below. The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have

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the right to request a limit on the PHI we disclose about you to someone who is involved in your care, or the payment for your care (for example, a family member or friend). You also could request us not use or disclose information about a surgery you had. Your requested restriction must be in writing to our Privacy Officer and include: (1) the information that you want to restrict; (2) how you want to restrict the information (for example, restricting use to this office, only restricting disclosure to persons outside this office, or restricting both); (3) to whom you want those restrictions to apply (for example, disclosures to your spouse); and (4) how long the restrictions shall apply.

We are not required to agree to your request unless the disclosure is to a health plan for purposes of carrying out payment or health care operations (not for purposes of carrying out treatment), except as otherwise required by law or the information pertains solely to a health care item or service for which we have been paid out of pocket in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. In the event we deny any requested restriction, we will inform you of such denial in writing. A restriction is not effective to prevent uses or disclosures permitted or required by the Secretary to investigate our compliance with the HIPAA Privacy Rules, for a directory, or other situations where you have the opportunity to agree or object to certain uses and disclosures of PHI about you.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. You must make your request in writing to our Privacy Officer at the contact information below. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests, but we reserve the right to deny any requested alternative means to contact you. In the event of such denial, we will inform you of our denial in writing.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. To obtain a paper copy of this Notice, please contact our Privacy Officer at the contact information below. You also may obtain a copy of this Notice at our website, www.jmandry.com.

- Right to Receive Notice of a Breach. We are required to notify you first class mail or by e-mail (if you have indicated a preference to receive information by e-mail) following a breach of unsecured PHI, if your PHI has been, or we reasonably believe your PHI to have been, accessed, acquired, used, or disclosed as a result of such breach, as soon as possible, but in any event, no later than 60 days following the discovery of the breach. The notification of breach will include the following information:

    - a brief description of the breach, including the date of the breach and the date of its discovery, if known;

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- a description of the type of Unsecured Protected Health Information involved in the breach;

- steps you should take to protect yourself from potential harm resulting from the breach;

- a brief description of actions we are taking to investigate the breach, mitigate losses and protect against further breaches; and

- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date, we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

To exercise the above rights, please contact the following individual to obtain a copy of the relevant form you will need to complete to make your request:

Name:	Kathy Mandry, Administrator
Title:	Privacy Officer
Phone Number:	(407) 480-4830

Section E: Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our offices. The Notice will contain on the first page, in the top right hand corner, the effective date.

West Orange Endocrinology Research Center
CLINICAL RESEARCH

Jose M Mandry, MD
Maria del Carmen Mandry-Freire PA-C
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(407) 480-4830 fax (407) 480-4834

Section F: Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, contact the individual identified on the first page of this notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** The Secretary of the U.S. Department of Health and Human Services contact information is as follows:

Region IV, Office for Civil Rights

U.S. Department of Health and Human Services

Atlanta Federal Center

Suite 3B70, 61 Forsyth Street, SW.

Atlanta, GA 30303-8909

Voice Phone: (404) 562-7886

FAX: (404) 562-7881

TDD: (404) 331-2867

ACKNOWLEDGMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices (the "Notice") of West Orange Endocrinology, P.A. (the "Company"), which describes how my protected health information may be used or disclosed. I have read the Notice carefully, and I consent to the use and disclosure of my protected health information as described in the Notice. In addition, I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling the Company's Privacy Officer at (407) 480-4836 on the Company's website at www.jmandry.com, or by requesting one at our Company's offices.

Signature of patient or patient representative: _____

Printed name of patient or patient representative: _____

Relationship to patient:_____

Date: _____

West Orange Endocrinology Research Center

CLINICAL RESEARCH

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize and request release of the following:

_____ A copy of the most recent doctor notes, laboratory results, imaging.

_____ Complete chart including reports, laboratory results, imaging, and medication.

MEDICAL RECORDS FROM:
Name of facility/person
to receive information from: _____

Address: _____

City, State, Zip: _____

TO RECEIVING PARTY: The information is disclosed to you from records whose confidentiality is protected by law. Re-disclosure is prohibited without the written permission of the patient/client/legal representative listed above.

TO REQUESTING PARTY: I understand signing this document releases West Orange Endocrinology, P.A., from all legal responsibility and/or liability arising from the release of such records.
Florida Statute has established guidelines and cost rates for copying of medical records. Your signature indicates your knowledge of this statement.
NOTE: PATIENT/REPRESENTATIVE MUST INITIAL APPLICABLE AREAS FOR RELEASE.

Psychiatric/psychological Information _____ (initials)
Alcohol, drug, chemical dependency Information _____ (initials)
HIV tests and information relating to tests/information _____ (initials)

Patient's Name (printed): _____ Date: _____

Address: _____ DOB_____

Patient/Guardian Signature: _____ Account # _____

Witness Signature: _____ Date: _____