FAU MEDICINE
FLORIDA ATLANTIC UNIVERSITY

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.)*:	Preferred Gender Pronoun: ☐ He/Him ☐ She/Her ☐ Other:	**DOB:**	

Sex at Birth:	☐ M ☐ F ☐Prefer not to answer	Gender Identity: ☐ M ☐ F ☐ Female to Male/Transgender Male ☐ Male to Female/Transgender Female ☐ Neither exclusively Male nor Female ☐Other: ___________________

Relationship status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous Primary Care Physician:		**Date of last physical exam:**	
Physicians you currently see:			
Name		Specialty or why you see them	Phone number
Preferred Pharmacy:		**Phone number: ( )**	
Pharmacy Location (address or nearest intersection):			

REASON FOR TODAY'S VISIT:

PERSONAL HEALTH HISTORY

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

Immunizations and dates:	☐ Tetanus		☐ Pneumonia	
	☐ Hepatitis B		☐ Shingles	
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*	

Medical History

- ☐ None
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease/Heart Attack
- ☐ Irregular heart rhythm (atrial fibrillation)
- ☐ Stroke or Mini Stroke (TIA)
- ☐ Cancer: _____________
- ☐ Thyroid problems
- ☐ Reflux, heart burn
- ☐ Stomach ulcers

- ☐ Blood clots
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Asthma or COPD
- ☐ Allergies
- ☐ Anemia
- ☐ Depression
- ☐ Anxiety
- ☐ Liver disease
- ☐ Seizure
- ☐ Other: ______________________

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

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

Name of Medication	Strength	Frequency Taken

Allergies to medications (Aspirin, Betadine, Codeine, Novocain, Penicillin, Sulfa, etc.)

Name of Medication	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

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

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., less than 60 minutes/week)

	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?	☐	Yes	☐	No
	If yes, are you on a physician prescribed medical diet?	☐	Yes	☐	No
	# of meals you eat in an average day?				
	Rank salt intake ☐ Hi ☐ Med ☐ Low				
Alcohol	Do you drink alcohol?	☐	Yes	☐	No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?	☐	Yes	☐	No
	Have you considered stopping?	☐	Yes	☐	No
	Have you ever experienced blackouts?	☐	Yes	☐	No
	Are you prone to "binge" drinking?	☐	Yes	☐	No
	Do you drive after drinking?	☐	Yes	☐	No
Tobacco	Do you use tobacco?	☐	Yes	☐	No
	If no, have you ever used tobacco products?				
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day				
	☐ # of years ☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?	☐	Yes	☐	No
	Have you ever used recreational or street drugs?	☐	Yes	☐	No
	If so, what drugs? ______________________________				
Sexual Activity	Are you sexually active?	☐	Yes	☐	No
	Are you sexually active with	☐ Male	☐ Female	☐ Both	
	What do you use for protection from Sexually transmitted infections?	☐ Condoms	☐ None		
	What do you use for contraception?	☐ Surgical (vasectomy or tubal ligation)	☐ Hormonal Contraception	☐ Condoms	
		☐ Other: ____________	☐ IUD or implantable contraception		
Personal Safety	Do you live alone?	☐	Yes	☐	No
	Do you have frequent falls?	☐	Yes	☐	No
	Do you have vision or hearing loss?	☐	Yes	☐	No
	Do you have an Advance Directive and/or Living Will?	☐	Yes	☐	No
	Do you drive?	☐	Yes	☐	No
	If No, why not:				
	Are you able to care for yourself, such as bathing or toileting?	☐	Yes	☐	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Siblings**	☐ M ☐ F	
Mother				☐ M ☐ F	

Children	☐ M☐ F		**Grandmother** *Maternal*		
	☐ M☐ F		**Grandfather** *Maternal*		
	☐ M☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
In the past 2 weeks, have you often felt down, depressed or hopeless?	☐ Yes	☐ No
In the past 2 weeks, have you often felt you have little interest or pleasure in doing things?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Do you feel safe at home?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and results?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	Recent changes in:
☐ Head/Neck	☐ Back or Joint	☐ Weight
☐ Ears	☐ Stomach	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Do you have pain/discomfort (Quantify 0-10) (describe):
☐ Lungs/Breathing	☐ Circulation	
☐ Joints/Muscles	☐ Neurologic problems	

Date completed: ______________________

FAU MEDICINE
FLORIDA ATLANTIC UNIVERSITY

Consent for Medical Treatment

I hereby consent to any and all diagnostic procedures, tests, and medical treatment required in the diagnosis of my illness and course of treatment by the physician or his/her designee; other agents, and/or employees of the Florida Atlantic University. I recognize that FAU is a teaching and research facility and that my treatment and care may be observed and in some instances aided by residents, medical students and students from other allied health professions in their course of training. I consent to FAU taking photographs of me in the course of and related to my treatment, and their use of such photographs and my medical data for educational and research purposes. I hereby authorize FAU to retain, preserve, and use for scientific, educational, or research purposes, or to otherwise dispose of, any specimens, tissues, or medical devices removed from my body during treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of tests, examinations, treatments, procedures or any other services rendered.

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein.

If other than the patient signing, I _______________am the legal guardian, custodian or have Power of Attorney for this patient, for purpose of treatment, payment or health care operations

Signature of Patient:_______________________________________
(For patients 18 and older)

Signature of Guardian:_____________________________________
(For patients 17 or younger)

Printed Name of Signer:_____________________________________

Relationship to Patient:_____________________________________

Date:____

Patient Name: _______________________
Patient DOB: ________________________

FAU Notice of Privacy Practices

Revised: February 1, 2019

NOTICE OF PRIVACY PRACTICES
AND NOTICE OF HYBRID STATUS
for
Florida Atlantic University Board of Trustees,
a public body corporate of the State of Florida
777 Glades Road, Boca Raton, Florida 33431
Website: http://www.fau.edu/hipaa

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.

Hybrid Entity Status – Under HIPAA, a Hybrid Entity is a single legal entity with business activities that include both medical services (also known as "Covered Components") and non-medical activities (also known as "Non-Covered Components"). Florida Atlantic University has designated its College of Medicine, College of Nursing, Student Health Center and Pharmacy (and its clinics) as its Covered Components. All other components of Florida Atlantic University are designated as Non-Covered Components. All activities conducted by Workforce Members of the Covered Components are subject to our HIPAA policies and procedures. However, if Workforce Members of the Non-Covered Components need access to or use of your Protected Health Information (PHI), they also will be subject to our policies for the privacy and security of your information.

Your Information. Your Rights. Our Responsibilities.
A Quick Summary

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication and even choose someone to act for you
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief and/or raise funds
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Treat you, operate our organization and obtain payment for our services
- Help with public health and safety issues and do research and teach
- Comply with the law, law enforcement or oversight entities, and respond to lawsuits and legal actions
- Work with organ and tissue donation, medical examiner or funeral director requests
- Address workers' compensation, law enforcement, and other government requests

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Exercising Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities:

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you, except in very limited cases. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct your health information that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days and include information about your request in your record. We will describe your rights to give us a statement disagreeing with the denial.

Request confidential communications

- You can ask us to contact you in a specific way (for example, at your home phone or office phone) or to send mail to a different address. You can request that we communicate with you about health matters in a certain way or at a certain location.
- We will say "yes" to all reasonable requests.

Ask us to restrict what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If we agree with your request, we will comply unless the information is needed to

provide emergency treatment, is required by law, or otherwise required to be disclosed as listed in this notice.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

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

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee for additional requests within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.
- You may obtain an electronic copy of this notice from our website at: [http://www.fau.edu/hipaa].

Right to breach notification

- You have the right to, and will receive notification in the event of, a breach of your information, unless such notification is exempted by law.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

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

Exercising Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, let us know. We will follow your instructions and require individuals to provide proof of their identity.

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

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

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

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes (except under certain circumstances)

We may use certain information (name, address, telephone numbers, e-mail information, age, date of birth, gender, health insurance status, dates of health care services, department of service information, treating physician information or general outcome information) to contact you for fundraising efforts, and we may share this information with our Foundation for the same purpose. If we contact you for fundraising purposes, you can tell us not to contact you again at any time. If you do not want to be contacted for fundraising efforts, **please contact us by email: OPTOUT@fau.edu or telephone toll free: 888-605-0459.** There is no requirement that you agree to accept fundraising communications from us, and we will honor your request not to receive any fundraising communications from us after the date we receive your decision. Your decision will have no impact on your treatment or payment for services.

Our Permitted and Required Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information without your written permission in the following ways.

Treat you and coordinate/manage your health care - We can use your health information and share it with other professionals who are treating you.

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

Operate our organization - We can use and share your health information to run our practice, operate our Patient Safety Organization, improve our services and your care, teach students, and contact you when necessary.

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

Payment for our services to you - We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways without your permission– usually in ways that contribute to the public good, such as public health and research. Some of the ways are listed below. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Notifying someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting births and deaths
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research and teach

We can use or share your information for health research or to collect information in databases to be used later for research (subject to review and approval by an independent review board) and, unless you object, have students and resident physicians studying in the medical profession observe and participate in our interactions, examinations and treatments.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services or other oversight entities if they want to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ and tissue procurement organizations.

Work with a medical examiner or funeral director when an individual dies

We can share health information with a coroner, medical examiner, or funeral director.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law (e.g., agencies that enforce compliance with licensure or accreditation requirements)
- For special government functions (e.g. military, national security, and presidential protective services)
- With military command authorities, if you are a member of the armed forces
- With correctional institutions having lawful custody of you, as necessary for your health and the safety of others

Respond to lawsuits and legal actions

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

Business Associates

- We can share information with our business associates to carry out treatment, payment or healthcare operations on our behalf.

Other Uses

- Provide appointment reminders
- Describe or recommend treatment alternatives
- Provide information about health related benefits and services that may be of interest

Our Responsibilities

- We are required by law to maintain the privacy and security of your Protected Health Information and to provide you with notice of our legal duties and privacy practices regarding your health information.
- You have the right to know, and we will let you know promptly, if a breach occurs that may have compromised the privacy or security of your information, unless such notification is exempted by law. Our notice to you may be delayed if we are so instructed by law enforcement.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- Other uses and disclosures of health information not covered by this notice or applicable law will be made only with your written permission. If you provide permission to use or disclose health information, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. We are unable to take back any disclosures already made with your permission.

Note you should keep us informed of any changes to your contact information such as your address and phone number so that we can contact you if it becomes necessary.
For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. If the change is a significant change, we will provide an updated notice. The new notice will be available upon request, in our offices, and on our web site.

Contact Information for Questions or Comments

Chief Privacy Officer:
561-297-3004
privacy@fau.edu

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Florida Atlantic University Notice of Privacy Practices and have thereby been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

Signature of Patient (or Authorized Personal Representative)	Date
Print Name of Patient (or Authorized Personal Representative)	Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate)

NOTICE OF LIMITED LIABILITY PURSUANT TO SECTION 1012.965, FLORIDA STATUTES

I, on behalf of myself, my child, and/or my ward, acknowledge that I have been notified that:

I, my child, and/or my ward, will receive medical care and treatment provided by employees and/or agents of the Florida Atlantic University Board of Trustees (hereafter referred to as "FAU") at this facility.

The FAU employees and/or agents providing this medical care and treatment may include, but are not limited to: physicians, residents, fellows, healthcare students, physician assistants, advanced registered nurse practitioners, perfusionists, nurses, pharmacists, and technicians, who will at all times be under the exclusive supervision and control of FAU.

I, on behalf of myself, my child, and/or my ward, understand that the employees of FAU are not employees or agents of any entity other than FAU.

Additionally, I, on behalf of myself, my child, and/or my ward, understand that liability, if any, which may arise from the care rendered by FAU health care providers is limited as provided by law. The law provides that "Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $200,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence, exceeds the sum of $300,000." (Section 768.28(5), Florida Statutes)

Signature of Patient (or Authorized Personal Representative)	Date
Print Name of Patient (or Authorized Personal Representative)	Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate)
Printed Name of Witness	Date

AGREEMENT TO MEDIATE

In accepting care at this facility where FAU employees and/or agents provide medical care and treatment, I agree that before I file any lawsuit against the FAU Board of Trustees for medical care and treatment rendered by its health care providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party who has been certified to be a mediator tries to help settle claims. FAU will pay the cost of the mediator. I further agree that any mediation must take place in the state and county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain time period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

Signature of Patient (or Authorized Personal Representative)	Date
Print Name of Patient (or Authorized Personal Representative)	Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate)
Witness	Date

COPIES OF THIS STATEMENT SHALL BE VALID AS THE ORIGINAL/ORIGINAL SIGNATURES ON FILE WITH FAU

FLORIDA ATLANTIC UNIVERSITY- FACULTY PRACTICE

SELF-PAY/INSURANCE PROCESSING AGREEMENT

Between FAU Faculty Practice and ________________________________
PATIENT NAME

FAU Faculty Practice will provide insurance claim processing for qualified patients under the terms set forth below:

1. The patient must provide the front and back of current insurance card. **PRE-AUTHORIZATION IS THE RESPONSIBILITY OF THE PATIENT.**
2. Claims will be filed only for medical services rendered by FAU Faculty Practice.
3. FAU Faculty Practice is non-participating with most insurance companies. For these companies, insurance plans will not be verified and claims will be processed as out-of-network.
4. External laboratory services are billed to your insurance by an outside lab company (e.g. Quest Diagnostics) and will appear as separate charges on your insurance. If there is a balance due, it will be billed directly to you.

PATIENT INFORMATION

Name: ____
LAST FIRST MIDDLE INITIAL

SSN*: ______________ Sex: ______ Date of Birth: ____________

*Florida Statute 119.071(5)(a)6 and 7 authorize the use in processing medical claims.

Local Phone: ____________________ Home Phone: ____________________

INSURANCE COVERAGE

I understand that charges will apply to all FAU Faculty Practice visits. Charges not covered by my insurance or other third party payors, including but not limited to non-covered or out-of-network services, deductibles, co-insurance and co-payments, will be my personal responsibility. If I'm a self-pay patient, all charges for the visit will be my personal responsibility. If I am more than 120 days overdue on the payment of any final bill, I am be declared in default, and the overdue account may be referred to a collection agency.

Patient Signature: ____________________________ Date: ____________

Parent/Legal Guardian Signature: ________________________ Date: ____________

PARENT/LEGAL GUARDIAN SIGNATURE REQUIRED IF THE PATIENT IS A UNDER 18 YEARS OF AGE

POLICY HOLDER INFORMATION

If the insurance policy holder is not the patient, please provide the following information about the policyholder.

Policy Holder's Name ____________________ ____________________

Policy Holder's DOB: ____________________ Relationship to Patient: ____________________

Policy Holder's Address: ____
ADDRESS CITY STATE ZIP

Policy Holder's Phone: ____________________

AUTHORIZATION

- I authorize my insurance company to pay to FAU all benefits otherwise payable to me for services rendered.
- I authorize the use of the signature on all insurance submissions.
- I authorize FAU to release all information necessary to secure payment of benefits.

Patient Signature: ____________________________ Date: ____________

Parent/Legal Guardian/Policy Holder
Signature: ________________________ Date: ____________

PARENT/LEGAL GUARDIAN SIGNATURE REQUIRED IF THE PATIENT IS UNDER 18 YEARS OF AGE

FAU MEDICINE
FLORIDA ATLANTIC UNIVERSITY

PATIENT RIGHTS AND RESPONSIBILITIES

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please read the following information before completing this form

Name: ____Date of Birth: ______________________
(Please Print)
Address: ____ Telephone: ________________________

Verification of identity: ☐ Driver's License/State ID ☐ Personally known ☐ Other

I hereby authorize Florida Atlantic University to (choose one):

☐ use or disclose my protected health information as indicated below to:
☐ obtain my protected health information from:

Name: ____ ___ Will pick-up in person
___ Please mail to address noted
Address: ____ ___ Please fax to # __________________

For purposes of (describe purpose) and time period (dates): ____

Records requested: ☐ Immunization records
☐ Partial record, as specified (include date of visit if applicable):_____________________________
____
☐ Other (describe record and/or information):____
____

I understand that this health information may include sensitive information. By signing this area below, I am specifically authorizing the release of information relating to:

_______ (initial here) HIV/AIDS information
_______ (initial here) Sexually transmitted disease information
_______ (initial here) Alcohol and substance abuse information
_______ (initial here) Mental health treatment records (**NOT** including Psychotherapy Notes)

NOTE: If you are requesting the release of Psychotherapy Notes, then a separate Authorization is required.

Signature: ____ Date: ______________________

I have read and understand the following statements of my rights:

- This authorization will remain in effect for the earlier of one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time by providing written notice to: Chief Compliance Officer, FAU, 777 Glades Road, AD-10, Room 370, Boca Raton, FL 33431. However, the revocation will not have any effect on any actions taken before its receipt and processing.

- I may see and copy the information described on this form, if requested.

- I am not required to sign this form to receive treatment or health care benefits, and my refusal to sign this Authorization will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.

- I received the Notice of Privacy Practices and had the opportunity to ask questions about it, as well as about the use and disclosure of my health information before signing. The Notice of Privacy Practices is subject to change at any time.

- I understand that information released pursuant to this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.

- I am aware that the charge for copying records is $1.00 per page for the first twenty-five (25) pages and $0.25 for each additional page thereafter. Please allow up to five (5) business days for copies to be made. Fees are waived when health information is released directly to a health care provider for treatment purposes.

- A copy of this authorization is as valid as the original and is subject to its terms and conditions.

Authorization and Signature

I hereby authorize the use of disclosure of my individually identifiable health information as described herein. I understand that this Authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this Authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release **Florida Atlantic University** from all liability arising from this disclosure of my health information.

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. *For patients and governmental entities*: $1.00 per page for the first twenty-five (25) pages and $0.25 per page for each page in excess of the first twenty-five (25) pages. *For other entities*: up to $1.00 per page for each page copied, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Printed Name of Patient: ______________________________ Date: ________________________

Patient Signature: ____

Printed Name of Parent, Guardian or Legal Representative: _____________________________________

Parent, Guardian or Legal Representative Signature: _______________________________________

Relationship to Patient: ______________________________________

For Office Use Only:	
Date picked up/mailed/faxed:	Staff Initial