Today's Date:_____

Patient Medical Information

Patient Name _____Date of Birth____/____/_____

Age:_____

Sex: ☐M ☐F

Primary Care Physician:_____

Date Last Seen By Primary Care Physician: _____/____/_____

Pharmacy Name and Address :_____

What foot problem(s) are you having?

_____

_____

_____

When did it start? _____

Have you ever had a similar problem(s)? Yes___ No___

Was it treated Yes_____ No_____ When?_____

By whom?_____

- ALLERGIES? ☐Penicillin ☐Aspirin ☐Codeine ☐Novacaine ☐Sulfa ☐ Tape ☐ Iodine

☐Other: _____

MEDICATIONS? ☐Insulin ☐Coumadin ☐Blood Pressure ☐Arthritis

☐Diet ☐Heart ☐Depression ☐Oral Diabetic Medication ☐Birth Control Pills

List All Current Medications _____

_____

_____

_____

Patient Name _____

OPERATIONS?_____

_____

_____

INJURIES?_____

_____

_____

What is your Height _____ & Weight _____

Do you Smoke? ☐Yes ☐ No

Use Alcohol? ☐Yes ☐No

Please Tell Us If You Have Any Medical Problems:

☐Arthritis ☐Bleeding ☐Blood Pressure ☐Bone Cancer

☐Breathing ☐Diabetes ☐Heart ☐Immune Disorders

☐Kidney ☐Liver ☐Lung ☐Muscle

☐Nerve ☐Poor Circulation ☐Seizures

☐Stomach ☐Thyroid ☐Medical, Physical, or Emotional Problems

☐Other_____

Is there a chance of Pregnancy? ☐Yes ☐No

Patient Name _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Billing Address:_____

_____

Home Phone _____ Work Phone _____

Cell Phone _____

Email: _____

I agree to receive notifications from Total Foot Care and Wellness Clinic via the following:
☐email ☐ mobile text ☐ voice messaging

Student Status: ☐Full Time ☐Part Time

Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Retired

Employer Name, Address & Phone:

_____

_____

Emergency Contact: _____

Phone:_____ Relation:_____

Pharmacy Name: _____

Phone: _____

Spouse's Name or Responsible Party _____

Phone:_____

Insurance Information:

Primary Insurance Name _____

Subscriber's (Insured) Name _____

Subscriber's Social Security _____-____-_____

Date of Birth: ____/____/_____

Member ID _____

Group name & number _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Significant Other ☐ Child

Secondary Insurance Name _____

Subscriber's (Insured) Name _____

Subscriber's Social Security _____-____-_____ Date of Birth ____/____/_____

Member ID _____

Group name & number _____

Patient Relationship to Insured:

☐Self ☐Spouse ☐Significant Other ☐Child

Consent for Medical Information Release

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. Please designate which type of information each person may receive by checking the items we may release and any items we should not disclose. Make your own notes if necessary for clarification.

□ All Information: Any and All information we have in our file related to you which may include billing information, appointments, treatment, test results, etc.

□ Appointment Only: Only information related to appointment dates and time.

□ Testing/Lab Results: Only information related to the results of any testing or labs completed by our office.

□ Billing Inquiries: Only information related to the billing of claims, payments, and/or balances on your account with our office.

Relationship Full Name of Person Type of Information

Spouse _____

Parent _____

Child _____

Other _____

Please check if no information should be released

□ NO INFORMATION MAY BE RELEASED

Print Name _____

Signature_____

Date_____/_____/_____

Authorized Benefits and Payments

I request that payment of authorized benefits be made to Total Foot Care and Wellness Clinic for services rendered. I authorize release to the indicated insurance carrier any medical information needed to determine payments for related services.

I hereby agree to pay Total Foot Care and Wellness Clinic in a timely fashion, for all services rendered. This includes all copayment and deductibles as well as any insurance payments that I may receive as a result of services rendered.

In the event your check is returned there will be a fee of $40.00. Payment must be made by; cash or credit card upon returning to the office. Failure to make payment good within 3 business days will result in the account being turned over to the state attorney's office.

In the event that your account becomes delinquent, you will be held responsible for any collection and/or attorney fees.

I understand that if I cancel my office visit without giving a 24 hour notice, I will be billed a fee of $25.00 for in office visits and $50.00 for house calls. For any testing or surgical procedure I understand that the cancellation policy is 5 business days and the fees vary from $50.00 - $200.00 depending on the type of appointment missed. This charge is not covered by the insurance company and will not be waived under any circumstances.

In the event Total Foot Care and Wellness Clinic should refer me to another Physician, I authorize the release of the above information along with any medical documentation deemed necessary Total Foot Care and Wellness Clinic.

I acknowledge that the Notice of Privacy Practices and the Financial Policy are posted and that I have read (or have been given the opportunity to read) and fully understand the notices.

Please Print Name: _____

Signature _____

Date ____/____/_____

Telephone (904) 323-0954 Fax (904) 660-2125

I hereby authorize professional podiatry services rendered by the Total Foot Care & Wellness Clinic. If insurance is filled on my behalf, I authorize and assign insurance payment directly to Total Foot Care & Wellness Clinic. I understand that I am financially responsible for all amounts not covered by insurance.

I also authorize the release of any medical information necessary to process insurance claims. A copy of this authorization shall be valid as the original.

_____ Signature of patient or authorized representative

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I have reviewed/received a copy of TOTAL FOOT CARE & WELLNESS CLINIC Notice of Privacy Practices.

Signature (PATIENT/GUARDIAN)_____

DATE: _____/_____/_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE: _____

INITIALS: _____

REASON: _____

TOTAL FOOT CARE
& WELLNESS CLINIC

CONSENT FOR TRANSFER AND DISPOSAL OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Total Foot Care and Wellness Clinic it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Total Foot Care and Wellness Clinic to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Patient Print Name _____

Patient Signature _____

Date_____

8021 Philips Hwy Ste 1 - Jacksonville, FL 32256
Phone: 904-323-0954 Fax: 904-660-2125
www.thetfclinic.com

Medication Assistance Program

Page 1

MEDICATION ASSISTANCE PROGRAM

Complete the information requested below and sign this form to enroll to Sagebrush Health Medication Assistance Program.

PATIENT TO COMPLETE *Fill out the patient information section.*

First Name *

Last Name *

Date of Birth *
MM/dd/yyyy

Phone *
(___) ___-____

Email *

Address *

City *

State *
Please sel...

Zip Code *
_____

PATIENT TO COMPLETE RISK A SSESSMENT SCREENING

Sagebrush is dedicated to the whole health and wellness of patients. Certain medications weaken the immune system and therefore compromise the body's ability to fight infections. Total Foot Care partnered with Sagebrush Health Services who specialize in comprehensive preventative care for sexually transmitted injections (STIs) and sexual health. We are committed to promoting the well-being and sexual health of individuals through a range of services, including STI testing, education, and prevention. These questions adhere to CDC guidelines and aim to provide a comprehensive and personalized approach to care.

Do you have a rash on the palms of your hands or legs that has been present for longer than a month? *

○ YES ○ NO

Have you ever been diagnosed with a sexually transmitted infection (STI)? *

○ YES ○ NO

Have you been exposed to Syphilis, Gonorrhea, Chlamydia, HIV or Hepatitis C through social activities, blood transfusions or needle usage in the recent past? *

○ YES ○ NO

Sagebrush Health Services provides FREE STI/HIV testing, treatment, and prevention services. Are you interested in receiving more information or counseling regarding these services? *

○ YES ○ NO

Signature *

Date

For Clinic Use

Patient MRN

Clinical Representative

HEALTHCARE STAFF

Primary ICD-10:

Secondary ICD-10:
Z70.8 - other sex counseling

ICD-10: Z70.8 - other sex counseling (non-billable) must be added to patients' chart for audits pertaining to the medication assistance program.

Prescribers Full Name

Clinic Contact

For Clinic Use: Patients interested in receiving more information or counseling regarding these services please send email to STI@sagebrushhealth.com with the following: Patient Name, Patient DOB, Patient Phone#, Patient Email, and Clinic Name .

ABI Screening Sheet for PAD

TOTAL FOOT CARE
PODIATRY & WOUND CLINIC

- [ ] Do you have a Cardiologist that treats you and if so any recent or future appointments?
- [ ] Have you had any recent ABI/Doppler Studies?
- [ ] Do you have a history of blood clots ?

ABI Screening Sheet for PAD

*One box must be checked for patient to be eligible for an ABI exam

- [ ] Are you 65 years of age or older?
- [ ] Do you experience any Pain in your legs or feet while at rest?
- [ ] Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking exercise?
- [ ] Do your feet get pale, discolored or bluish at any time during the day?
- [ ] Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?

*2 boxes must checked for patient to be eligible for an ABI exam

- [ ] Are you 50 years of age or older?
- [ ] Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?
- [ ] Do you have high blood pressure or take medication to reduce blood pressure?
- [ ] Do you have diabetes?
- [ ] Do you have a history of chronic kidney disease?
- [ ] Do you currently or have you ever smoked?
- [ ] Do you have a history of stroke or mini-stroke (TIA)?
- [ ] Do you have a history of heart disease (heart attack, MI)?
- [ ] Do you have a history of carotid stenosis, AA (Abdominal aortic aneurysm), and/or stent placement?

Patient Signature *

Date

8021 Philips Hwy Ste 1 - Jacksonville, FL 32256
Phone: 904-323-0954 Fax: 904-660-2125
www.thetfclinic.com

Fall Risk Screening Form

TOTAL FOOT CARE
PODIATRY & WOUND CLINIC

Fall Risk Screening Form

Complete only for pts that are 65 and older

- [ ] Are you older than 65?
- [ ] Have you had any falls in the past year?
- [ ] No falls in the past year
- [ ] One fall with injury in the past year
- [ ] Two or more falls with injury in the past year
- [ ] One fall without injury in the past year
- [ ] Two or more falls without injury in the past year
- [ ] Are you taking any medications that cause cognitive impairment?
- [ ] Are you taking any medications for anxiety or depression?
- [ ] Are you taking any medications that cause sedation or confusion?
- [ ] Are you taking any medications that cause hypotension?
- [ ] Is your vision less than 20/40?
- [ ] Have you had an eye exam in the past year?

Do you have any of the following medical conditions?

- [ ] Problems with heart rate and/or rhythm Incontinence
- [ ] Foot problems
- [ ] Any difficulty walking
- [ ] Any muscle weakness
- [ ] Do you suffer from Postural hypotension

Patient Signature *

Date

8021 Philips Hwy Ste 1 - Jacksonville, FL 32256
Phone: 904-323-0954 Fax: 904-660-2125
www.thetfclinic.com

FINANCIAL POLICY

Thank you for choosing us as your podiatrist. We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read prior to any treatment.

All patients must complete our Registration and history forms before seeing the doctor. You must supply us with your insurance card, social security number and driver's license prior to your visit.

Any insurance information given to our office incorrectly will result in a charge of $10.00 per claim billed out with the incorrect information. This fee is not covered by insurance nor is it able to be waived for any circumstances. This fee will cover our cost to resubmit the claim to the correct insurance company for you. It is very important that you provide us with the correct insurance information at the time of services.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE WE ACCEPT CASH, CHECKS OR VISA / MASTERCARD / DISCOVER / AMEX

Regarding Insurance:

Regarding insurance plans where we are a participating provider: Although we have contracted with the insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays and deductibles are due prior to treatment, along with a valid referral from your primary care provider, if your insurance plan requires it. Please note that if you require treatment that is not deemed medically necessary or is not a covered service with you insurance carrier, you will be responsible for payment in full prior to that treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, you will be responsible for payment in full at time of service.

Certain procedures such as x-rays and/or ultrasounds are necessary for the evaluation or management of your condition. These procedures may or may not be covered under your office visit co-pay. Some insurance companies apply these charges toward your deductible and in some instances these services have separate co-pays. You will be responsible for these additional charges.

Regarding insurance plans where we are not participating providers: You are responsible for payment of

your office visits in full.

REMINDER: We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

If your insurance company has not paid your account in full within 45 days., you will be responsible for payment within 30 days upon receipt of the bill. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under Medicare Program and/or other medical insurance. You are responsible for these charges.

Surgery:

We will ask you to pay 100% of any outstanding deductible and co-insurance prior to surgery. This is due no later than 5 business days prior to your surgery. For any differences in amount collected and amount owed you will be responsible for the balance within 3 months after surgery but monthly payments must be made toward the balance to keep your account current. Please contact the office if you are due a refund. We will make every effort to return any refund to you 7-10 days after you have requested a refund.

Usual and Customary Charges:

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You will be responsible for payment if your insurance carrier authorizes and certifies care but fails to pay as agreed upon.

Minor Patients:

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

Collections:

You may be dismissed from the practice if you fail to meet your financial responsibilities and/or we must use a collection agency to bring your account up-to-date. If it is necessary to turn the account over to collections and you wish to return to the practice, you will be responsible for all charges, including those incurred to collect the amount owed, i.e. collections agent's fees. Your account must be paid in full before you are able to return to the office.

Missed Appointments:

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate listed below:

$25.00 in office visit $50.00 house call Returned checks

If your bank returns your unpaid check for any reason, such as insufficient funds or closed account, you will be charged $40.00. Payment must be made by; cash or credit card prior to your return to the office and we will not accept any more personal checks. Failure to pay the non-sufficient fees within 3 business days will result in you being turned into the state attorney's office.

NOTICE OF PRIVACY PRACTICES:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty:

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 11/19/15, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information:

We will use and disclose your protected health information about you for treatment, payment, and healthcare operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will 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. 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. 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 (eg, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This 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 protected health 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 the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training or students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (i.e. billing services, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.

You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless your 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 our professional judgment. 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.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless that information is provided to you by a general newsletter or in person or for products or services of nominal value, you may opt out of receiving further

such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

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 rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your 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 required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious 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.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information or a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected

health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. Even though you are entitled to a copy of your protected health information, there may be a charge for each page copied including the cost of copying and handling (postage if copies are to be mailed). If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee policy.

Accounting of Disclosures: You have the right to receive a list of instances in which Total Foot Care and Wellness Clinic or a business associate has disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after 11/19/15. After 11/19/2021, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specify the alternative means or location, and continue to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request. We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Title of Contact Person: Practice Manager Telephone: 904-323-0954 E-mail: tfteam@thetfclinic.com Address: 8021 Philips Hwy Suite 1 Jacksonville Fl 32256