NOTICE OF PRIVACY PRACTICES*

We Care About Your Privacy

LUIS HINES & ASSOCIATES, PA
1250 SW 27th Ave., Suite 402
Miami, FL 33135
12550 Biscayne Blvd., Suite 212
Miami, FL 33181

Telephone: (305) 642-5255

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:
We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:
We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:
We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:
In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:
Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:
We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:
We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:
We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:
We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:
To help them carry out their duties, we may share the med-

ical information of a person who has d[illegible]with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical 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 share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement officia[illegible]ports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. 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. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice.

REGISTRATION

(PLEASE PRINT)

LUIS HINES & ASSOCIATES, P.A.

1250 S.W. 27th Ave., Suite 404
Miami, FL 33135

Telephone: (305) 642-5255
Fax: (305) 642-8850

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

(Vers.M2ISS04)

Luis Hines & Associates

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection. I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicios deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de crédito. Su seguro médico es un contrato entre usted y su compañía de seguro. Pagos por nuestros servicios dependen de los términos de su póliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar acción legal para cobrar esta deuda, usted es responsable de los gastos legales.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially liable to the physician for any and all charges that the carrier declines to pay. I hereby authorize to release any medical records as deemed necessary for payment of insurance benefit.

Por la presente autorizo el pago directamente a el médico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendría derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento médico a mi compañía de seguro para procesar mi reclamación. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro médico.

Patient's / Guarantor's Signature
Firma del Paciente o Persona Responsable

Date
Fecha

Patient's / Guarantor's Name
Nombre del Paciente o Persona Responsable

LUIS HINES & ASSOCIATES, P. A.

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name: _____ Date of Birth: _____

I, the above patient, voluntarily consent and authorize the representative(s) of Luis Hines and Associates to provide an initial assessment and upon the determination through a discussion with me, authorize psychotherapy treatment, psychological testing and/or medication management. The goal of the assessment process is to determine the best course of treatment for me. I understand the information shared with clinicians at Luis Hines and Associates is confidential and no information will be released without my written consent. I understand that it may be necessary for my therapist to communicate with my healthcare carrier or another healthcare provider.

I, the above patient, authorize Luis Hines and Associates permission to seek payments when service is rendered from clients and/or healthcare insurance (HMO, PPO, Medicaid or Medicare). I understand that I am responsible for any co-payments that are determined by my healthcare insurance.

I understand that psychotherapy services are provided by a range of mental health professionals, some of whom are in training. All professionals-in-training are supervised by a licensed mental health professional.

I understand that psychotherapy and/or psychotropic medications may provide significant benefits. They may also pose some risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recollection of troubling memories. Medications may have unwanted side effects that will be discussed by the psychiatrist.

If I have any questions regarding this consent form or about services offered at Luis Hines and Associates, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the assessment and treatment offered to me by the representative(s) of Luis Hines and Associates. I understand that I may stop treatment at any time without prejudice to my case.

_____ _____

Signature Date

FORM 101 – 11/16/06

LUIS HINES & ASSOCIATES, P. A.

NOTICE OF PRIVACY PRACTICES

ACKNOWLEGEMENT OF RECEIPT

Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Print Name Relationship to Patient

_____

Interpreter (if applicable)

INTEROFFICE USE.

I, _____ provided the patient during initial
Clinician Signature

visit to read, understand, ask questions and discuss the above information.

Date: _____

LUIS HINES & ASSOCIATES, P. A.

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Name: _____ Date of Birth: _____

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Signature Date