Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text. Responsibilities as follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial recourses for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate for failure to provide treatment.

Patient Rights and Responsibilities

- Considerate and respectful care from the staff at South Palm Beach Health Group, PLLC
- The names and positions of the people who take care of you at South Palm Beach Health Group, PLLC
- Be told about you problem(s), how your problem(s) can be treated, and how serious your problem is in words you can understand
- Be asked if you want a treatment or procedure before it is done unless it is an emergency
- Refuse treatment and be told what may happen if you do not get treatment
- Be examined and treated in private
- A clean and safe environment during your office visit
- Know what your responsibilities are as a patient with South Palm Beach Health Group, PLLC
- Your communication and records concerning your care are treated confidentially
- Make decisions by completing a Living Will or by appointing a person to make health care decisions on your behalf
- See your medical bills and have them explained to you
- Be told what Medicare will not pay
- Voice your concerns or grievances regarding your care and to know how these complaints are being handled
- As a minor and not accompanied by an adult to be seen and treated for the following
    - Medical or health services to diagnose or treat a venereal disease
    - Medical or health service for birth control, pregnancy, or family planning – not for purposes of sterilization
    - Medical or health services related to outpatient care of substance abuse
    - Medical or health services related to mental illness or emotional disturbance
- Have the provider of your choice deliver home care services
- Know that the services, appliance or device for which you have been referred may be available from other suppliers in the community
- Providing our health care team with accurate and complete information regarding your health
- Asking questions if you do not understand what you have been told or what you need to do next
- Following your agreed upon treatment plan and taking your medication as prescribed
- Expressing any complaints or problems regarding your health care
- Calling your doctor's office if you:
    - Are having problems regarding your therapy
    - Become sick and need to go to the hospital
    - Cannot come in for your appointment
- Contacting your doctor's office regarding referrals to outside specialists and delivering those referrals at the time of the appointment
- Meeting the financial obligations of your policy contract
- Being respectful and considerate of the rights of other patients and office personnel
- Telling us if you have a Living Will or Durable Power of Attorney for Health Care so that we may follow your wishes

HIPPA Patient Consent Form

I hereby authorize treatment by South Palm Beach Health Group, PLLC or affiliated staff member(s) on behalf of myself. The possibility exists (during treatment) for healthcare workers to become directly exposed to my blood or bodily fluids. In the event of such exposure, State law requires a sample of my blood to be tested for the presence of infectious disease.

I hereby authorize release of any and all medical and/or charge information as is necessary for reimbursement from any third party or governmental agency involved in the payment of my treatment including but not limited to Insurance Payors, Workers Compensation carriers, Medicare and Medicaid. I also authorize the taking and use of photographs. I understand these photos will become part of my medical record.

I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits, and assignments of procedures from all settlements, judgments or verdicts in favor of the undersigned from third party liability claims for injuries treated hereunder, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, costs and interest) due hereunder is to be made to South Palm Beach Health Group, PLLC. I understand that if I have insurance, my insurance policy is a contract between me and my insurance company. I am responsible to South Palm Beach Health Group, PLLC for any charges not covered by my insurance, including, but not limited to, co payments, deductibles, and fees for non-covered services. The patient and undersigned guarantor are primarily liable for payment of the patients account and unless otherwise indicated by initialing here, South Palm Beach Health Group, PLLC will send all appointment reminders and billing information to the person responsible for payment of my bill. _____ (initials)
It is their sole responsibility to comply timely and with all requirements, and supply all information and documents necessary to obtain payment of benefits by any third party or governmental entity as listed above. Some insurance plans (i.e., Medicare, Blue Cross, and Champus) require lab work to be billed directly by the laboratory performing the testing. In these instances, a separate statement and bill will be sent from the lab performing the test.

Any balance remaining on the account after any insurance pays will be due upon receipt of my statement. Charges for non-covered services are due at the time of service. The undersigned agree(s) to pay all charges made by medical providers at the their current rate. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each undersigned, and is not a collateral or contingent promise to answer for the debt of another. If payment is not made, I understand that South Palm Beach Health Group, PLLC may take action to collect fees. I agree to pay all costs incurred by South Palm Beach Health Group, PLLC for collecting its fees, including attorney fees.

I, the Patient/Guardian acknowledge that I was provided with a South Palm Beach Health Group, PLLC Patient Rights and Responsibilities form and given an opportunity to ask questions about the information provided in this form.

NOTICE OF PRIVACY PRACTICES: Effective October 1, 2009, I acknowledge that I have received, have previously received, or have been offered to receive the South Palm Beach Health Group, PLLC Notice of Privacy Practices. _____ (initials).

In providing my email address, I authorize South Palm Beach Health Group, PLLC to use the e-mail address for the purpose of communicating health related information or services. I acknowledge that I may opt-out of such communication at any time and my e-mail information will not be shared with any organization outside of South Palm Beach Health Group, PLLC and its affiliates.

Please list anyone you would like to allow us to speak to regarding your protected health information, and please include the relation to you:

_____ _____

_____ _____

_____ _____

Thank you for selecting South Palm Beach Health Group, PLLC as your healthcare partner.

Patient name (please print) _____

Patient signature: _____

Date: _____

Witness: _____

South Palm Beach Health Group, PLLC.

Dr. Richard Martinoff Dr. JoAnn Yi

Welcome to South Palm Beach Health Group, PLLC!

We look forward to working with you on maintaining your health and diagnosing and treating your health conditions in a comprehensive and healing manner.
Please familiarize yourself with he way our practice works and sign below to acknowledge receipt:

1. Our office is open Monday through Friday, 9:00am to 5:00pm and are closed 12:00-1:00 for lunch.
2. When the office is closed, we have a telephone answering service. If you have an emergency, do not contact the answering service, but call 911 or go to the Emergency Room. For most situations, we cannot diagnose or treat over the phone and we would like to see you in the office. If the issue can wait until the office reopens, please call us after 9:00am. We are usually able to accommodate you with a same day appointment for acute problems.
3. We do not refill medications or narcotics when the office is closed. Please notify the office if you need medication refills 72 hours in advance of running out. Pease provide us with the phone or fax number of your pharmacy.
4. Sometimes you will need to see a specialist. We are happy to refer you to medical specialists we trust to provide you with the best care. We will provide you with the contact information for the specialists and it is your responsibility to contact them to make an appointment. Please let them know at the time of your visit that we are your primary care group so they can communicate their finding with us. Please contact the specialist for results of any tests or procedures they performed.
5. Blood work is drawn in our office or at one of the national lab offices. You do not need to contact us to get the results of your blood work unless more than 7 days have passed. To ensure quality care, lab results are always discussed during a follow-up office visit with the physician.
6. Co-pays are due at the time of service. Patients with outstanding balances of more than 30 days cannot be seen until those balances are paid.
7. We realize unexpected circumstances may force you to change or cancel an appointment. Please inform us at least 24 hours in advance if you cannot keep a scheduled appointment. After the first "no-show," subsequent "no-shows" will be charged $25 per visit. If you have 4 no-shows within a years time you may be dismissed from the practice, at the physician's discretion.
8. Rude behavior will not be tolerated and will be a cause for dismissal from the practice. However, please let us know if we can provide you with better service so we can use this as an opportunity to improve.`

Thank you!

I acknowledge receipt of the above.

Patient signature_____