

Health and Recovery Institute of Central Florida
Hector D. Barreto, MD, MPH

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

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Hector D. Barreto, MD, MPH and/or the Health and Recovery Institute of Central Florida. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information.

Appointment reminders. Your health information may be used by our staff to send you appointment reminders via postcard or voice mail messages.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights.

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Our duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information.

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Hector D. Barreto, MD, MPH**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints.

If you would like to submit a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: **Health and Recovery Institute of Central Florida, 2205 E. Michigan Street, Orlando, FL 32806.**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person.

The name and address of the person you can contact for further information concerning our privacy practices is:

Hector D. Barreto, MD, MPH
2205 E. Michigan Street
Orlando, FL 32806
Telephone 407-895-6846

Effective Date

This notice is effective on or after January 1, 2005.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Health and Recovery Institute of Central Florida for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Health and Recovery Institute of Central Florida. I understand that diagnosis or treatment of me by Hector D. Barreto, MD, MPH may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Health and Recovery Institute of Central Florida is not required to agree to the restrictions that I may request. However, if Health and Recovery Institute of Central Florida agrees to a restriction that I request, the restriction is binding on Hector D. Barreto, MD, MPH and Health and Recovery Institute of Central Florida.

I have the right to revoke this consent, in writing, at any time, except to the extent that Hector D. Barreto, MD, MPH or Health and Recovery Institute of Central Florida has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Health and Recovery Institute of Central Florida's Notice of Privacy Practices prior to signing this document. The Health and Recovery Institute of Central Florida's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Health and Recovery Institute of Central Florida. This Notice of Privacy Practices also describes my rights and the Health and Recovery Institute of Central Florida's duties with respect to my protected health information.

Health and Recovery Institute of Central Florida reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Patient Information			
Name (First, MI, Last)		Date of Birth	
		SSN:	
Patient Address		Drivers License	State
City	State	ZIP	Email
Telephone Home		Cell	
Work		Fax	
Marital Status		<input type="checkbox"/> Single	<input type="checkbox"/> Divorced
		<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
		<input type="checkbox"/> Separated	<input type="checkbox"/> Other
Responsible Party			Relationship:
<input type="checkbox"/> Check here if same as Patient			
Address			Telephone
Emergency Contact Name and Number (mandatory):			
<p>Insurance Patients: We do not accept insurance or participate in any network plans. Payment is due at the time of service. Some insurances may reimburse out-of-network expenses at their discretion. If you plan to seek insurance reimbursement, please fill the information below. Reimbursement decisions are made by your insurance company, filing a claim does not guarantee reimbursement.</p>			
Insurance Information			
Insurance Plan Name			
(Check box if none) <input type="checkbox"/>			
	Address		Phone
	Group #		ID#
	Insured's name		Insured's Date of Birth
	Effective Date		CoPay
	Deductible		Deductible met? Y <input type="checkbox"/> N <input type="checkbox"/>
Patient Relationship to Insured: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
Secondary Insurance Plan Name			
(Check box if none) <input type="checkbox"/>			
	Address		Phone
	Group #		ID#
	Insured's name		Insured's Date of Birth
	Effective Date		CoPay
	Deductible		Deductible met? Y <input type="checkbox"/> N <input type="checkbox"/>
Patient Relationship to Insured: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
Referring Provider			
Referral Number			

Information Release and Assignment of Benefits

I authorize the release to my insurance company any and all medical information, including any information pertaining substance abuse and chemical dependency diagnosis in treatment, in order to process my claim. A photocopy of this assignment shall be as valid as the original.

Patient Signature

Date

Medical History

Name	Date
MEDICATION ALLERGIES: <input type="checkbox"/> None <input type="checkbox"/> Penicillin <input type="checkbox"/> Aspirin Other: _____	

Do you have history of any of the following? (check only those that apply)

- | | |
|---|--|
| <input type="checkbox"/> Measles
<input type="checkbox"/> Mumps
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Endocarditis (infection of heart valves)
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Hernia
<input type="checkbox"/> Psychiatric Illness <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Schizophrenia or psychosis | <input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Bleeding tendency
<input type="checkbox"/> Blood transfusions
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Anemia
<input type="checkbox"/> Seizures
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Back Pain
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Chronic Pain
Treatment: _____ |
|---|--|
- Hepatitis (if known, specify if A, B, C, or other)
- | | | | |
|---|----|-----|--|
| <input type="checkbox"/> Did you receive any treatment? | No | Yes | |
| <input type="checkbox"/> Have you been vaccinated against Hepatitis A or B? | No | Yes | |
- Have you ever been treated for drug or alcohol problems in the past? No Yes _____
- Have you ever been treated at a methadone clinic? No Yes _____
- Have you ever had a psychiatric hospitalization? No Yes _____

Hospitalizations/Surgeries

Have you had recently (check only those that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Weight gain
<input type="checkbox"/> Weight loss
<input type="checkbox"/> Fever
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Blurred vision
<input type="checkbox"/> Double vision
<input type="checkbox"/> Earaches
<input type="checkbox"/> Ear drainage
<input type="checkbox"/> Ringing of ears
<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Bleeding gums
<input type="checkbox"/> Sore throat
<input type="checkbox"/> Swollen neck glands
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Palpitations
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Swelling
<input type="checkbox"/> Persistent cough
<input type="checkbox"/> Coughing up blood
<input type="checkbox"/> shortness of breath
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Burning or painful urination
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Sexual difficulty
<input type="checkbox"/> Joint pain
<input type="checkbox"/> Joint swelling
<input type="checkbox"/> Joint stiffness
<input type="checkbox"/> Cold extremities
<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Rashes
<input type="checkbox"/> Itching
<input type="checkbox"/> Change in skin color
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Change in hair or nails
<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Headaches
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Lightheadedness
<input type="checkbox"/> Seizures | <input type="checkbox"/> Numbness
<input type="checkbox"/> Tingling
<input type="checkbox"/> Tremors
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Head Injury
<input type="checkbox"/> Memory loss
<input type="checkbox"/> Confusion
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Violent thoughts
<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Excessive urination
<input type="checkbox"/> Heat intolerance
<input type="checkbox"/> Cold intolerance
<input type="checkbox"/> Slow to heal after cuts or burns
<input type="checkbox"/> Bleeding or bruising tendency
<input type="checkbox"/> Enlarged glands
Females: Number of pregnancies _____
Number of live births _____
Last menstrual period _____
Current birth control _____ |
|---|--|---|

Patient Signature

Physician Signature

Substance Use History

Name:

	No	Yes/Past or Yes/Now	Route (IV, smoked, etc)	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Tobacco							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth- Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Benzos (Valium, Xanax, Ativan, etc)							
Ecstasy							
Steroids							
Other							

Comments:

Drug Testing Policy

Patients beginning Suboxone (Buprenorphine) therapy will be required to undergo an initial drug screen. Females of childbearing age will also undergo pregnancy testing. The cost for self-pay patients is \$30.00, payable at the time of testing. If you cannot pay for the test, you agree to pay the test fee with the next office visit. If you have health insurance, you may choose to have the specimen sent to the ORMC lab which will bill your insurance company. Please be advised that your insurance may not cover laboratory services by ORMC or drug screens done at this office. Patients who are already being drug-tested as part of their counseling program may not be required to undergo initial testing but the treating program must forward results of such testing. We reserve the right to conduct onsite drug testing should there be failure to provide documentation of your drug testing from your counseling program.

For patients who are NOT on the Suboxone program, drug testing will be done at the physician's discretion.

Breathalyzer testing will be done at the physician's discretion to test for the presence of alcohol. There is no charge for this service.

During treatment, drug tests will be done for monitoring purposes on a random basis and/or depending on clinical suspicion of drug use, in order to guide treatment. Drug testing done at Health and Recovery Institute of Central Florida is done for clinical purposes only and are not to be used for other purposes such as pre-employment or law enforcement unless specific arrangements have been made.

Failure to abide by this policy may result in discharge from the Health and Recovery Institute of Central Florida at the discretion of the treating physician.

I have read the above drug testing policy and agree to abide by it.

Signature of patient or responsible party

Date

CONFIDENTIALITY QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY: (This information is MANDATORY)**

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent **if other than your home.** (otherwise write "home address").

IV. Is it OK to send billing statements or other correspondence via e-mail? No Yes Email: _____

V. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "PERSONAL AND CONFIDENTIAL":

YES _____ NO _____

VI. Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information **if other than your home phone number:** () _____

VII. Can confidential messages (ie. appointment reminders) be left on your home answering machine or voicemail?

YES _____ NO _____

VIII. If you do not have voicemail, can a confidential message be left at your place of employment?

YES _____ NO _____

IX. Is it OK to mail or E-mail you informational material on services we may offer in the future?

YES _____ NO _____ (if yes, indicate: Regular mail E-mail Both

PATIENT NAME _____ (guardian if under 18 years)

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

PLEASE NOTE THAT CELL PHONE CONVERSATIONS MAY NOT BE SECURE

PAYMENT POLICY

We do not accept health insurance. Payment is expected at the time of service unless other arrangements have been made, and may be made by cash, check, Visa or Master Card. It is your responsibility to contact your insurance company for reimbursement of fees and services. A \$25.00 fee applies to all returned checks.

Our current fees: (subject to change)

Physician Services:

Initial Assessment:	\$220.00
Brief Follow-up Visit:	\$70.00
Extended Follow-Up Visit (more than 30 minutes):	\$100.00
Urine Drug Screen:	\$30.00
Initial Lab Studies*:	\$50.00

Counseling Services:

Individual Counseling Session:	\$60.00
Group Counseling Session:	\$15.00

Missed appointments without 24 hr notice: \$25.00

*If you have insurance, you may choose to have your labs done at your insurer's preferred laboratory and have the lab bill your insurance directly. If you do not have insurance, the lab fee quoted above covers an initial CBC and Comprehensive Metabolic Profile through Orlando Regional Medical Center. If other labs are required, this will result in additional charges.

Insurance Patients: Since we do not participate in any insurance network, it is your responsibility to obtain any necessary pre-authorization for treatment on an out-of-network basis. Payment in full of services rendered is due at the time of service, however we will assist you in filing your claim so you can be considered for reimbursement by your insurance company. **We do not participate in Medicare or Medicaid.**

Refunds: We do not provide refunds for services already rendered.

I, the undersigned, understand and agree with the payment policy explained above.

Patient or Responsible Party Signature

Date

Print Name