

PATIENT INFORMATION (PLEASE PRINT)			
NAME (LAST NAME, FIRST NAME, MI)		TODAY'S DATE	
PARENT/GUARDIAN NAME (IF MINOR) (LAST NAME, FIRST NAME, MI)		HOME PHONE	CELL/ALT PHONE
CURRENT ADDRESS		CITY	STATE ZIP
PERMANENT ADDRESS (IF DIFFERENT)		CITY	STATE ZIP
EMAIL ADDRESS		DATE OF BIRTH	
PRIMARY CARE PHYSICIAN	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <input type="checkbox"/> Legally Separated	
RACE <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White	ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino PREFERRED LANGUAGE
EMPLOYER NAME	WORK PHONE	OCCUPATION:	

EMERGENCY CONTACT INFORMATION			
NAME	HOME PHONE	WORK PHONE	CELL/ALT PHONE

PRIMARY INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD)			
SUBSCRIBER/GUARANTOR'S NAME	SUB. DATE OF BIRTH	RELATIONSHIP TO INSURED	SEX <input type="checkbox"/> M <input type="checkbox"/> F
PRIMARY INSURANCE NAME	INSURANCE PLAN ID#	GROUP #	

SECONDARY INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD)			
SUBSCRIBER/GUARANTOR'S NAME	SUB. DATE OF BIRTH	RELATIONSHIP TO INSURED	SEX <input type="checkbox"/> M <input type="checkbox"/> F
SECONDARY INSURANCE NAME	INSURANCE PLAN ID#	GROUP #	

IF YOU ARE HERE FOR A WORK COMP OR AUTO INJURY PLEASE INDICATE BELOW			
DATE OF INJURY	PLACE OF INJURY	NAME OF ATTORNEY/ADJUSTOR	ATTNY/ADJUSTOR PHONE

REFERRAL INFORMATION HOW DID YOU HEAR ABOUT SIMED? HOW WERE YOU REFERRED?	
<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> ER/URGENT CARE <input type="checkbox"/> FRIEND/FAMILY <input type="checkbox"/> EMPLOYER <input type="checkbox"/> INSURANCE <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> MAILING <input type="checkbox"/> ONLINE <input type="checkbox"/> OTHER: _____ NAME OF PERSON WHO REFERRED YOU: _____	
PATIENT (GUARDIAN) SIGNATURE	DATE



AUTHORIZATION FOR TREATMENT,
ASSIGNMENT OF BENEFITS
AND USE/DISCLOSURE OF MEDICAL RECORDS

I. AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I do hereby consent to medical evaluation and treatment by my physician, physician representatives and technicians. In the case of diagnostic studies, laboratory tests, psychology and physical therapy treatment, as prescribed by my physician, I hereby consent to treatment by the technologist, psychologist and physical therapist (and their representatives).

I do hereby authorize SIMEDHealth, LLC to release to any third party payer (such as an insurance company or government agency) any necessary medical and/or psychiatric information and records concerning diagnosis and treatment when requested by such a third party for use in determining payment for medical services.

I do hereby authorize payment directly to any SIMEDHealth Provider examining and/or treating me, from any group or individual medical benefits herein specified and otherwise payable to me for their services.

I certify that the information given to me in applying for payment under the Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Health Care Financing Administration, Social Security Administration/Division of Family Services, Blue Cross Blue Shield of Florida, Medicare/Medicaid/MediGap or its intermediaries or any other carriers any additional information needed for this or a related Medicare/Medicaid claim. I hereby certify that all insurance pertaining to treatment shall be assigned to the SIMEDHealth provider treating me.

I permit a copy of these authorizations and assignments to be used in place of the original, which is on file with SIMEDHealth. I understand this is a lifetime authorization remaining in effect until revoked by me in writing.

I agree that payment for professional services is due and payable when services are rendered. I agree that should the amount of the insurance benefits be insufficient to cover the amount of the claim, I will be responsible for payment of the balance of my account for any professional services rendered. **I agree to be responsible for any co-payment and/or deductible associated with my insurance policy. I understand a \$10.00 billing fee will be charged for co-pays and deductibles not paid at time of service.** I also understand SIMEDHealth will help in billing my insurance company for payment but it is my responsibility to follow-up on any claim submitted if any payment is not received in a reasonable amount of time. A finance charge of 1.5% periodic will be added to all patient account balances left outstanding for more than 30 days. I agree that I will be responsible for any collection fees if it becomes necessary to send my account for collections. I agree that I will be responsible for any fees for returned checks.

If this is in regards to an auto accident and I am pursuing treatment under my auto insurance, I permit SIMEDHealth to obtain pertinent information from the insurance company and provide information to the insurance company when requested.

In the case that my services are related to a **Worker's Compensation** case, I understand that I am still responsible for certain charges as allowed by Worker's Compensation law.

Patient or Responsible Party Signature

Date

PLEASE READ THE OTHER SIDE OF THIS DOCUMENT

Effective 04/1/2018



AUTHORIZATION FOR TREATMENT,
ASSIGNMENT OF BENEFITS
AND USE/DISCLOSURE OF MEDICAL RECORDS

II. USE AND DISCLOSURE OF HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is this corporation's policy to require your reading and signing this consent form prior to the provision of treatment or any other medical services. If you have any questions, please ask for the Privacy Officer of this corporation.

I, _____, currently residing at _____ of

(City) _____, (county) _____ (state) _____ do hereby consent to the use and disclosure of my individually identifiable health information ("Health Information") by **SIMEDHealth, LLC and its Professional Providers** ("Provider") for the purposes of providing treatment to me, receiving payment from responsible parties for health care services rendered by the Provider, and/or engaging in health care operations, such as office management, credentialing, case management, and quality assessment. This authorizes the release of my Health Information or copies of such to be transferred to myself and/or any physician that I am referred to by a SIMEDHealth Provider.

I understand that Provider's Notice of Privacy Practices ("Notice") describes in more detail the types of uses of disclosures of Health Information involved in treatment, payment or health care operations, and that I have a right to request and review such Notice prior to signing this consent.

I understand that the Provider has reserved the right to change its privacy practices as described in the Notice. In the event of any change in the Provider's privacy practices, Provider will revise the Notice. I understand that I can obtain a copy of the revised Notice by writing to Provider.

I understand that if I choose to not sign this consent, Provider may withhold medical services, other than emergency services.

I understand that I have the right to request a restriction (ask for and see Patient Authorization to Use/Disclose Health Information) on Provider's use or disclosure of any and/or all Health Information to any and/or all locations, entities, or persons (including family members I wish to have or not have access to my Health Information). I further understand that Provider is not obligated to agree to my request. However, if Provider does agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has relied on this consent, and that any revocation will become effective on the date it has been received by Provider and will apply to uses and disclosures of the Health Information after the date of receipt.

Dated this _____ day of _____, 20____. _____

Patient's Signature

If not signed by the patient, please print name & indicate relationship: _____
Name Relationship

OFFICE USE ONLY

- Patient requested and received the Notice of Health Information Practices. Date: _____: Initials: _____
 - Patient requested and filled out restrictions on Patient Authorization to Use/Disclose Health Information form (see chart).
-

Effective 04/01/2018



Notice of Health Information Practices

Original Printing: April 1, 2018

Introduction

At **SIMEDHealth, LLC**, we are committed to treating and using protected health information about you responsibly. This “Notice” is effective April 1, 2018 and describes the personal information we collect, and how and when we use or disclose that information; describes your rights as they relate to your protected health information; and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit **SIMEDHealth**, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Legal document describing the care you received
- A tool in educating health professionals
- A source of data for our planning and marketing
- Means of communication among the many health professionals who contribute to your care
- Means by which you or a third-party payer can verify that services billed were actually provided
- A source of information for public health officials charged with improving the health of this state and the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of **SIMEDHealth**, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

SIMEDHealth is required to:

- Abide by the terms of this notice
- Maintain the privacy of your health information
- Notify you if we are unable to agree to a requested restriction
- Provide you, when requested, this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our “Notice” change, we will provide you a copy upon request. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice’s Privacy Officer, P.O. Box 357010, Gainesville, FL. 32635 at (352) 224-2200. If you believe your privacy rights have been violated, you can file a complaint with the practice’s Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either party. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. **For example:** Information obtained by a nurse, physician, or other member of your health care team will be recorded in your health record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physicians or a subsequent health care provider with copies of various reports that should assist in treating you once you’re discharged from SIMEDHealth. Relevant records provided to us from an outside provider or healthcare entity may be forwarded on for treatment purposes if those records were used in the medical decision making by the SIMEDHealth team.

Information obtained by SIMEDHealth’s pharmacist may be used to dispense medications and may be used to monitor safety, compliance and effectiveness of your drug therapy. We may contact you to provide refill reminders, counseling, treatment alternatives, drug utilization review and other services we provide.

We will use your health information for payment. **For example:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, medications and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff, pharmacy, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Possible examples include outside billing services and crediting agencies, outside vendors for certain laboratory tests or courier services, or copy services we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Communication from offices: We may call your home or other designated location and leave a message on voice mail or in person in reference to any Items that assist the Practice in carrying out Treatment, Payment and Operations (TPO), such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked PERSONAL.

Open Treatment Areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, some patient information may be overheard by others while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our medical staff and request to speak with our privacy officer.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed their research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We are prohibited from selling your PHI without your authorization and have limitations on the use and disclosure of your PHI for marketing and fundraising purposes.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Disclosures

We will make every effort to meet the obligations required of us as a covered entity to protect your PHI. However, should a breach occur, you have the right to be notified. We will follow all laws and regulations in reporting any breach.

Employment

It is impermissible for the use of genetic information for underwriting and employment purposes.

****Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.**

(THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY)



Disclosure of Ownership SIMEDHealth Imaging and SIMEDHealth Laboratory

Patient Name _____

MR# or DOB _____

You are being, or may be, referred to SIMEDHealth Imaging and SIMEDHealth Laboratory, departments supervised and owned by SIMEDHealth LLC, for an MRI, CT study or laboratory services.

We are required by law to inform you about alternative radiology providers of similar services. These providers include, but are not limited to:

Gainesville

- Diagnostic Imaging Group
- North Florida Radiology
- Gainesville Open MRI
- Invision at North Florida
- Shands Medical Plaza
- Shands North Campus
- UF Orthopedics & Sports Medicine Institute

Ocala

- Advanced Imaging
- Clinical PET of Ocala
- Ocala Radiology Assoc.
- Ocala Regional Hospital
- Munroe Regional Hospital

Lake City

- Lake City Medical Center
- Lake Shore Medical Center
- Invision Lake City

Lady Lake / The Villages

- Lake Medical Imaging
- Advanced Imaging
- The Villages Regional Medical Center

Alternative providers for similar laboratory services include, but are not limited to: **Doctor's Lab of Gainesville, Quest Diagnostics, and Laboratory Corp of America.**

Actual charges for your laboratory tests may vary. You may receive a bill from SIMEDHealth after your insurance has paid their portion of the bill. If you have a secondary or other health insurance that you wish us to bill, please provide this information to us.

Patient/Guardian

Date

SIMEDHealth

Date

Please Note: Your monthly statement received from SIMEDHealth will include both physician and diagnostic procedure charges.

381.026 Florida Patient's Bill of Rights and Responsibilities.

(1) **SHORT TITLE.**--This section may be cited as the "Florida Patient's Bill of Rights and Responsibilities."

(2) **DEFINITIONS.**--As used in this section and s. 381.0261, the term:

(a) "Department" means the Department of Health.

(b) "Health care facility" means a facility licensed under chapter 395.

(c) "Health care provider" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, or a podiatric physician licensed under chapter 461.

(d) "Responsible provider" means a health care provider who is primarily responsible for patient care in a health care facility or provider's office.

(3) **PURPOSE.**--It is the purpose of this section to promote the interests and well-being of the patients of health care providers and health care facilities and to promote better communication between the patient and the health care provider. It is the intent of the Legislature that health care providers understand their responsibility to give their patients a general understanding of the procedures to be performed on them and to provide information pertaining to their health care so that they may make decisions in an informed manner after considering the information relating to their condition, the available treatment alternatives, and substantial risks and hazards inherent in the treatments. It is the intent of the Legislature that patients have a general understanding of their responsibilities toward health care providers and health care facilities. It is the intent of the Legislature that the provision of such information to a patient eliminate potential misunderstandings between patients and health care providers. It is a public policy of the state that the interests of patients be recognized in a patient's bill of rights and responsibilities and that a health care facility or health care provider may not require a patient to waive his or her rights as a condition of treatment. This section shall not be used for any purpose in any civil or administrative action and neither expands nor limits any rights or remedies provided under any other law.

(4) **RIGHTS OF PATIENTS.**--Each health care facility or provider shall observe the following standards:

(a) *Individual dignity.*--

1. The individual dignity of a patient must be respected at all times and upon all occasions.

2. Every patient who is provided health care services retains certain rights to privacy, which must be respected without regard to the patient's economic status or

source of payment for his or her care. The patient's rights to privacy must be respected to the extent consistent with providing adequate medical care to the patient and with the efficient administration of the health care facility or provider's office. However, this subparagraph does not preclude necessary and discreet discussion of a patient's case or examination by appropriate medical personnel.

3. A patient has the right to a prompt and reasonable response to a question or request. A health care facility shall respond in a reasonable manner to the request of a patient's health care provider for medical services to the patient. The health care facility shall also respond in a reasonable manner to the patient's request for other services customarily rendered by the health care facility to the extent such services do not require the approval of the patient's health care provider or are not inconsistent with the patient's treatment.

4. A patient in a health care facility has the right to retain and use personal clothing or possessions as space permits, unless for him or her to do so would infringe upon the right of another patient or is medically or programmatically contraindicated for documented medical, safety, or programmatic reasons.

(b) *Information.*--

1. A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. A patient may request such information from his or her responsible provider or the health care facility in which he or she is receiving medical services.

2. A patient in a health care facility has the right to know what patient support services are available in the facility.

3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.

4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.

5. A patient in a health care facility has the right to know what facility rules and regulations apply to patient conduct.

6. A patient has the right to express grievances to a health care provider, a health care facility, or the appropriate state licensing agency regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance.

7. A patient in a health care facility who does not speak English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

(c) *Financial information and disclosure.*--

1. A patient has the right to be given, upon request, by the responsible provider, his or her designee, or a representative of the health care facility full information and necessary counseling on the availability of known financial resources for the patient's health care.

2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, in advance of treatment, whether the health care provider or the health care facility in which the patient is receiving medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility.

3. A health care provider or a health care facility shall, upon request, furnish a patient, prior to provision of medical services, a reasonable estimate of charges for such services. Such reasonable estimate shall not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.

4. A patient has the right to receive a copy of an itemized bill upon request. A patient has a right to be given an explanation of charges upon request.

(d) *Access to health care.*--

1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

2. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment.

3. A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her health care practitioner, in the best interests of the patient, including complementary or alternative health care

treatments, in accordance with the provisions of s. [456.41](#).

(e) *Experimental research.*--In addition to the provisions of s. [766.103](#), a patient has the right to know if medical treatment is for purposes of experimental research and to consent prior to participation in such experimental research. For any patient, regardless of ability to pay or source of payment for his or her care, participation must be a voluntary matter; and a patient has the right to refuse to participate. The patient's consent or refusal must be documented in the patient's care record.

(f) *Patient's knowledge of rights and responsibilities.*--In receiving health care, patients have the right to know what their rights and responsibilities are.

(5) **RESPONSIBILITIES OF PATIENTS.**--Each patient of a health care provider or health care facility shall respect the health care provider's and health care facility's right to expect behavior on the part of patients which, considering the nature of their illness, is reasonable and responsible. Each patient shall observe the responsibilities described in the following summary.

(6) **SUMMARY OF RIGHTS AND RESPONSIBILITIES.**--Any health care provider who treats a patient in an office or any health care facility licensed under chapter [395](#) that provides emergency services and care or outpatient services and care to a patient, or admits and treats a patient, shall adopt and make available to the patient, in writing, a statement of the rights and responsibilities of patients, including the following:

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 of this law from your health care provider or health care facility.

A summary of your rights and responsibilities 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 resources 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 a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Thank you for choosing SIMEDHealth as your healthcare provider. We are committed to fulfilling our responsibilities in your successful treatment. However, in order for our relationship to be successful, it is important that you understand your responsibilities as a patient. They are as follows:

Patient Responsibilities

1. You need to keep your appointment, however if for some reason you cannot, it is your responsibility to give a minimum of forty-eight (48) hours' notice. Repeated failure to give appropriate notice could result in your doctor discharging you from his or her care.
2. It is your responsibility to pay patient co-pays, deductibles and other appropriate fees at the time of service. Failure to pay in a prompt fashion could result in charging of interest. If charged interest it is your responsibility to pay it promptly.
3. It is your responsibility to follow to treatment plan established by your doctor and you. This means going to appointments for tests, attending recommended therapies and doing home activities that have been recommended to you.
4. Prescription medicine might be part of your treatment. It is your responsibility to follow instructions closely. Requests for routine prescription refills will only be processed during regular business hours. No early refills requests for narcotics will be provided.

I pledge to fulfill my responsibilities as patient:

Signature: _____ Date: _____



SIMEDHealth

Guiding You Towards Wellness

SIMEDHealth combines primary care physicians, specialists, diagnostic and therapeutic services, plus over 450 dedicated and skilled staff members, in an integrated team approach to provide the best possible medical treatment for North Central Florida area residents and families.

Health Care Services & Specialties

- Allergy & Asthma
- Arthritis (Rheumatology) Center
- Digestive Diseases
- Family Practice / Internal Medicine
- Geriatric Medicine
- Gynecology
- Hand Surgery
- Interventional Pain Management
- Neurology
- Orthopaedics
- Spine & Neurosurgery
- Pulmonology
- Plastic Surgery
- Podiatry
- Psychiatry
- Psychology
- Rehabilitation Medicine
- Sleep Medicine
- Spine Center
- Urgent Care/ Occupational Med
- Urology

Integrated Services

- Clinical Research
- Imaging & Diagnostics
- Laboratory
- Pharmacy
- Physical Therapy
- Sleep Center

SIMEDHealth offices are located in Gainesville, Lake City, Chiefland, Ocala, Lady Lake and McIntosh. Please visit our website today for a complete list of services or to schedule your appointment



SIMEDHealth.com