David Greene, MD, LLC
1112 Goodlette Frank Rd. North, Suite 203
Naples, FL 34102

PATIENT REGISTRATION FORM

Patient Information

Patient Information			
First Name:	Last Name:	MI:	
Sex: [ ] Male [ ] Female [ ] Other	Date of Birth:		
Cell Phone:	Email:	Home Phone:	
Home Address:		Work Phone:	
Out-of-Town Address:		Phone (up north/out-of-town):	
Emergency Contact:	Relationship to Patient:	Emergency Contact #:	
Primary Care Provider:	PCP Phone:	Fax:	
Referring Care Provider: (Whom should we thank for referring you to our practice?)			

Additional Information and Responsible Party

Responsible Party - If the patient is a minor (under the age of 18), the parent or guardian bringing the patient it will be listed as the guarantor:		
Last Name:	First Names:	
Date of Birth:		Phone Number:
Address of Responsible Party:		
City/ State/ Zip:		Relationship to Pt:
Pharmacy Name & Location:		
Pharmacy Name:	Pharmacy Address:	Pharmacy Phone #:
Demographics: Preferred Language [ ] English [ ] Spanish [ ] Sign Language [ ] Other:		
Ethnicity/ Race: [ ] Hispanic or Latino [ ] White [ ] Black or African American [ ] Asian [ ] Decline		
[ ] American Indian or Alaska Native [ ] Native Hawaiian or Pacific Islander [ ] Other_____		

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Company Name:	Ins. Company Name:
Policy Holder's Names:	Policy Holder's Names:
Policy Number:	Policy Number:
Patient Relationship to Policyholder:	Patient Relationship to Policyholder:

I certify that I have read and agree to DAVID GREENE MD, LLC (DGMDLLC) payment policy. I am eligible for the insurance indicated on this form and I understand that my payment is my responsibility regardless of insurance coverage. I hear by assign to DGMDLLC all money to which I am entitled for medical expenses related to the services performed from time to time by DGMDLLC, but not to exceed my indebtedness to DGMDLLC. I authorize DGMDLLC to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 return check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from DGMDLLC by text or email at the number or address stated above, included but not limited to communications about appointments, feedback, treatment, and payment. I understand that such emails and texts may not be secure and there is a risk that they may be read by a third-party. Comments submitted on surveys may be anonymously shared by DGMDLLC Public Website. I certified that I have read and received the Notice of Private Practices. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to DGMDLLC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits of the benefits payable for related services.

Signature of Responsible Party:_____ **Date:**_____

Printed Name of Responsible Party:_____

ENT NEW PATIENT MEDICAL HISTORY FORM

David Greene, MD, FACS, FARS

Board Certified, Otolaryngology
Nasal, Sinus & Facial Plastic Surgery

Name_____

Date_____

DOB_____

v.5.13.24

CONSULT SOURCE *Who sent / recommended you to see Dr. Greene?*_____

CHIEF COMPLAINT *What is the #1 reason for this visit?* _____

_____

*How long has this been going on?*_____

*Has this happened in the past?*_____

Have you been treated for this problem at all? Yes No If yes, list what has been done, doctors seen, testing, and medications given.

_____

*What makes this worse?*_____ *What makes this better?*_____

ALLERGIES TO MEDICATION ***YES*** ***NO*** *(please list allergy and reaction to medication. eg.rash, hives, anaphylaxis.)*

_____

MEDICATIONS *(please list all medications you are currently taking including vitamins, supplements & over the counter meds.)*

_____

_____

PAST MEDICAL HISTORY *(all medical conditions you have now or in the past)* _____

_____

_____

PAST SURGICAL HISTORY *(all surgery and procedures you have had)*

_____

_____

HOSPITALIZATIONS & ACCIDENTS No Yes Describe_____

FAMILY HISTORY High blood pressure / Diabetes / Hearing loss / Sleep apnea / Heart attack / Stroke

Bad reaction to anesthesia / Bleeding problems / Other _____

Diseases in Father: _____ Diseases in Mother: _____

SOCIAL HISTORY

- Tobacco: (Circle one): Non-smoker // ex-smoker // light smoker // 1 pack/day (less than or = 20) // 2 packs/day (up to 40)
- Alcohol: Never, monthly, weekly, daily.
- Other: Marijuana // vaping // other_____

OTHER *Any other information not addressed above*_____

CURRENT HEIGHT/WT Height:_____ft _____in Weight:_____lbs

The above information is true and complete.

Name (printed)_____ ***Signature*** _____ ***Date***_____

Name: _____ **Today's Date**: _____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats. Other: _____

Ears ❑ No Problems Difficulty with hearing, ringing in ears, ear pain, ear fullness / pressure ear drainage , ear clogging , dizziness , sense of spinning/rotation , balance problem, poor tolerance of noise, ear surgery, ear tubes.

Other: _____

Nose & Sinuses ❑ No Problems Nasal blockage / congestion / breathing problems , history of broken nose, deviated septum , use of Breathe Rite Strips , prior nasal surgery, prior sinus surgery, post nasal drainage , sinus infections , runny nose , nose bleeding , congestion , decreased sense of smell , sinus pain , discolored nasal discharge , post nasal drip, sinus pressure, mouth breathing, dry throat in morning, facial pain, headache. Other: _____

Mouth & Throat ❑ No Problems Change in voice / hoarseness, vocal problems , trouble swallowing , solids / liquids / pills, sore throat , snoring , phlegm/excess throat mucus , oral sores/growths, dental problems. Other: _____

Neck & Glands ❑ No Problems Neck lump , thyroid problems , saliva problems , swollen glands , enlarged lymph nodes of neck, neck pain , prior thyroid ultrasound. Other**:**

_____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, cough, wheezing, sputum production, prior tuberculosis, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

_____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Neck pain, back pain, Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV, MRSA Other: _____ v.5.13.24

Signature: _____ **Printed Name:** _____ **Date:** _____

AUTHORIZATION, ASSIGNMENT OF BENEFITS & PATIENT FINANCIAL AGREEMENT

DAVID GREENE MD LLC is committed to providing you with the best possible care. Your clear understanding of our financial and administrative work is important to our professional relationship. Please ask if you have any questions about your responsibilities as a patient when receiving care in our offices. Patients must fill out patient information forms prior to seeing the doctor. A current insurance card and valid picture ID is required at each visit. You must inform us of any insurance changes prior to making an appointment or being seen.

Definitions
For purposes of this Agreement, the terms “we”, “our” the "practice" and “DAVID GREENE, MD, LLC ” shall mean DAVID GREENE, MD, LLC (DGMDLLC) and the terms “I”, “my”, “you” and “your” refer to the patient or responsible party for such patient executing this Agreement.

Referrals & Pre-authorizations
If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, you will be personally responsible for that day’s services, and we will file with your insurance on your behalf.

Co-Payments
We are REQUIRED to collect your carrier designated co-pay, co-insurance, and deductibles by the terms of our contract with your insurance company or per CMS rules. This payment is required at the time of service. Please be prepared to pay these required payments at each visit. Should you not pay at the time of service, an administrative fee of $20 may be added to your account.

Commercial Insurance Carriers
We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, copayments, and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated. If your insurance company requires preauthorization for services it is your responsibility to obtain preauthorization before treatment begins.

Coverage Changes
If your insurance changes, please notify us before your next visit so we can make the appropriate changes to obtain insurance coverage. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Out Of Network
It is your responsibility to determine whether our practice is “in network” for your insurance plan or not. If our practice is considered “out of network” with your insurance , then you will be responsible for your out of network copayment and deductibles which are usually higher than your in network responsibilities. If your insurance plan does not have “out of network benefits,” then you will be directly responsible for the cost of your services from this practice.

Medicare
Our office is a Medicare participating provider and we will bill Medicare for you. We will also bill your secondary insurance for you. Any balance not paid by Medicare and your secondary insurance will be your responsibility. DAVID GREENE, MD, LLC is a Medicare Part B provider. We will accept assignment on all Medicare Part B claims. By accepting assignment, we agree to adjust your charges to reflect the Medicare approved amount. However, Medicare only pays 80% of the approved amount, and the remaining 20% is your responsibility. If you have supplemental insurance, we will bill your supplement insurance for the 20% balance. If there is any remaining balance after Medicare and the supplement insurance payment, it is the patient’s responsibility.

Self-Pay Patients
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Patients without health insurance will be expected to pay in-full at the time of service. A minimum of $400 will be charged for the visit at the time of check in. An estimate will be provided of the cost of the visit prior to checking in.

Worker's Compensation
If your visit is work- related we will need the case number and carrier name prior to your visit in order to correctly bill your workers compensation insurance carrier. This practice DOES NOT PARTICIPATE in Worker Comp insurance, but does care for Worker's Comp patients on a special basis requiring the carrier to contract with us for each case individually. Your CASE MANAGER or ADJUSTER will need to make the appointment.

Automobile Accidents
If your visit is auto-accident related we will need the case number and carrier name prior to your visit in order to bill the car insurance company. If at any time during your visits you exceed your limit set by the car insurance carrier you will be responsible for the remaining balance. At this time, we can bill your primary health insurance if you would like, but if they do not pay, the balance will be the patient's responsibility. Our office does not accept Letters of Protection for any services that are rendered once your PIP benefits have been exhausted, these services must be paid at time of visit.

Methods of Payment
Our office accepts the following payment methods: Cash, Money Orders, Credit Cards and Care Credit as a credit. WE DO NOT ACCEPT PERSONAL CHECKS. For returned checks, we assess a $30.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office. If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, the patient agrees to pay all additional fees assessed in the collection of debt. These fees include collection agency fees and attorney fees. Unsubstantiated credit card disputes will incur a $35 administrative fee. The patient is ultimately responsible for all fees for services.

Usual, Reasonable and Customary
Some insurance carriers have established "usual" and "reasonable and customary" maximum amounts that they will pay for specific procedures. These amounts may vary with each insurance plan. Any amount considered in excess of the "usual" and "reasonable and customary" amount that is not paid by the insurance company, becomes the patient's responsibility.

Non-Covered Services
Not all services are covered by all insurance health plans. Some services may not be covered by your specific or individual policy. Services not covered or considered not payable by the insurance company become the patient's responsibility.

Insurance Claims
Your insurance is a contract between you and your insurance company. It is your responsibility to understand your insurance plan benefits. We will bill your primary insurance company if we are contracted providers. In order to properly bill your insurance company, we require that you disclose ALL insurance information including primary and secondary insurance, as well as any change of insurance information PRIOR to receiving services. Failure to provide complete and accurate insurance information may result in the entire bill being your responsibility.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Once the claim is processed, if there is any additional liability you will be billed accordingly.

Services unexpectedly denied by your insurance plan due to retroactive terminations, Coordination of Benefits (other health insurance that may be primary) denials, payment offset due to retroactive termination, failure to respond to your insurance plans with requested information or failure to provide our office with any NEW health insurance changes are all reasons patients may be responsible for payment of services received in our office. All of these circumstances are beyond our control. It is the patient's responsibility to resolve any issues that arise with their eligibility and benefits.

Minor Children
The parent who consents to the treatment of a minor child is responsible for payment of services rendered to DAVID GREENE, MD, LLC for any services furnished. We do not promise nor are we obligated to send bills, patient records or related communications to the other parent/legal guardian pertaining to issues of payment or communications.

Payment in Full
Payment in full is required at the time of service. Copays, deductibles, and co-insurance are collected at check-in. All outstanding patient balances from prior visits and services must be paid in full prior to scheduling additional appointments, or receiving further services with our practice. This policy exists to help people avoid running up large bills.

Nonpayment
If your account is over 90 days, you may receive a courtesy phone call to remind you that payment is due in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if this courtesy call is unanswered, or the balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed Appointments
We require cancellation at least 24 hours in advance of the appointment time, so as to provide appointments to care for other patients. Therefore, we reserve the right to charge for "no-shows," and missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. No-shows (with no notice) will be charged a fee of $75. Late cancellations (with less than 24 hours' notice) will be charged a fee of $50.00. Multiple "no shows" and late cancellations will result in termination from our practice. Please help us to serve you better by keeping your regularly scheduled appointment and calling at least 24 hours in advance if you need to cancel or reschedule.

Other Non-Covered Services
There will be a professional fee for the completion of Disability, Insurance Forms, and Other Forms as insurance does not cover this service. Alternatively, you may be required to schedule an appointment. Payment is due prior to performance of the service. We transmit copies of our medical records to your other physicians from our office free of charge, to facilitate continuity of care. It is your responsibility to provide exact information to us to facilitate this transfer of records. If you want a hard copy of your medical records, the cost is not covered by insurance, and there is a charge to defray the expense of up to $1.00 per page to produce the chart. A signed release of medical records request form is required, and payment must be received prior to the printing and production of your medical records for release. Please allow up to 30 days for this request to be processed.

Communication
From time to time, we may need to communicate with you electronically. Your signature is your consent to receive calls, text messages and emails from DAVID GREENE, MD, LLC and its Business Associates regarding your account information, which may contain Personal Health Information (PHI), at the listed phone number(s) below, including my wireless number provided. You understand you may be charged for such calls by your wireless carrier and that such calls may be generated by an automated dialing system.

Notice to Patients
We will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary.

Acknowledgement of Insurance Rules Regarding Office Diagnostic & Medically Necessary ENT Procedures
Please be aware that certain diagnoses cannot be made without your ENT doctor performing certain in-office procedures, to make the correct diagnosis to guide appropriate treatment for your medical condition. These procedures are not part of the basic examination, and your insurance may include them in your deductible. Every insurance is different, and your doctor has no control in this matter. Your insurance requires that these diagnostic procedures are billed as an additional item charge on your office visit statement. Although these procedures are purely diagnostic in nature, your particular insurance carrier may classify them as "surgical procedures." If so, the charge may be subject to the surgical deductible of your particular insurance plan. As per the rules of your insurance carrier, you may be responsible for covering any deductible payment. Also note that sinus debridement, by insurance and federal rules, is not included as part of the sinus surgery done in the operating room. It is an independent and separately billed procedure per insurance and federal rules. We follow strict federal and state billing and coding guidelines. The most common diagnostic procedures which may fall under your surgical deductible are *Nasal Endoscopy, Nasopharyngoscopy, Flexible Laryngoscopy, and Sinus Debridement.*

Telemedicine Visits
DAVID GREENE MD LLC offers Telemedicine visits. This means that patients can have visits with Dr. Greene via audiovisual equipment. I hereby consent to Telemedicine Visits terms and conditions. I also understand that: I can decline the Telemedicine Visit service at any time without affecting my right to future care or treatment. Dr. Greene cannot provide all services remotely and I may have to travel to see Dr. Greene in person for these services. The same confidentiality protections that apply to my other medical care also apply to the Telemedicine service. I will have access to all medical information resulting from the Telemedicine service as provided by law. The information from the Telemedicine service is protected the same as all other medical records. I will be informed of all people who will be present at all sites during my Telehealth service. I may exclude anyone from any site during my Telemedicine service. I also understand that my insurance will be billed for this visit, that I may be billed for what my insurance does not cover.

AUTHORIZATIONS & ASSIGNMENT OF BENEFITS

I authorize DAVID GREENE, MD, LLC to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to DAVID GREENE, MD, LLC. I understand that I am financially responsible to the Provider for all charges, for any balance or fee not covered in the event that I have no insurance, or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

Private Insurance Authorization for Assignment of Benefits / Information Release – I, the undersigned, authorize payment of medical benefits to DAVID GREENE, MD, LLC for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to DAVID GREENE, MD, LLC for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

I declare that all information presented at the date of service is complete and accurate. In the event that insurance is inaccurate or incomplete the patient will be responsible for all charges incurred.

I have read and fully understand this information and I agree to accept financial responsibility for the unpaid balance of all accounts in the event the following authorization is insufficient to liquidate the account.

I consent to retrieving my prescription and immunization history into my medical record in the electronic medical record system of this practice.

I hereby assign and transfer any insurance benefit due me for the professional services that I have received to DAVID GREENE, MD, LLC. My practice has documented that this Patient has provided their prior express consent to receive automated text and voice messages at the phone number(s) above.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you, including but not limited to home phone, work phone, cell phone, text, email, or any other phone numbers, in compliance with the Telephone Consumer Protection Act (TCPA).

I have read and understand the practice's financial and administrative policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Patient Name (Printed) _____

Patient Signature_____ **Date**_____

Responsible party name *(if other than patient)*_____

Relationship_____

Signature_____ **Date**_____

ACKNOWLEDGEMENT OF MEDICALLY NECESSARY PROCEDURES THAT YOUR INSURANCE MAY APPLY TO YOUR DEDUCTIBLE

Please be aware that, in order to determine the correct diagnosis so that the most appropriate treatment can be recommended for your medical condition, your physician may need to perform certain in-office procedures which enable that diagnosis to be made.

If performed, these diagnostic procedures are billed as an additional item charge on your office visit statement. Although these procedures are purely diagnostic in nature, your particular insurance carrier may classify them as "surgical procedures." If so, the charge may be subject to the surgical deductible of your particular insurance plan. **As per the rules of your insurance carrier, you will be responsible for covering any deductible payment.**

DAVID GREENE, MD, LLC and the Florida Sinus Institute follow strict federal and state billing and coding guidelines. The most common diagnostic procedures which may fall under your surgical deductible are Nasal Endoscopy, Nasopharyngoscopy, Flexible Laryngoscopy, Cerumen (Wax) Removal, Ear Microscopy, and Sinus Debridement.

I acknowledge that I have read and understand the above disclosure.

Name _____

Signature _____

Date _____

AUTHORIZATION TO LEAVE PATIENT MESSAGES

The HIPAA Privacy Rule permits healthcare providers to communicate with patients regarding their healthcare. This includes communicating with patients at their homes, whether through the mail, by phone, or in some other manner. In addition, the Rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individuals privacy, covered entities should take care to limit the amount of information disclosed on the answering machine. For example, a covered entity might want to consider leaving only its name and number and other information necessary to confirm an appointment and ask the individual to call back later.

A covered entity also may leave a message with a family member or other person who answers the phone when a patient is not home. The Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present; however, professional judgment should be exercised.

The HIPAA Privacy Rule also prohibits the practice from using or disclosing patient protected health information (PHI) outside the Notice of Privacy Practice without the authorization of the patient. Messages that contain patient PH I require the patient to sign an authorization form to receive messages by phone, fax, email, voicemail, or any other means by which someone other than the patient might reasonably have access to the message, thereby potentially violating the patient's privacy rights under HIPAA. For example, messages that contain PHI would be test results, medication information, payment information, treatment plans, patient condition information, and anything else that is considered patient condition, treatment, or payment related.

You may elect to have your PHI provided to you by a message from the physician's office by signing this form in the space provided below. Once you have signed the form, future communication with you concerning your PHI may be provided to the designated relative or friend, sent by email, fax, or left on your voicemail at the number you provide to this office.

(This form is optional. We make follow-up appointments for all patients to discuss their test results with the Doctor, and you have the option of waiting until your visit for this information).

I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, for me with either of the two individuals listed below or by email, fax, or voicemail at the numbers noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information.

_____ _____

Patient Name Date

_____ _____

Relative/ Friend #1 Phone

_____ _____

Relative/ Friend #2 Phone

Patient's Contact Information

Fax # _____ Phone _____

Patient Email _____

David Greene, MD, FACS
Otolaryngology,
Nasal & Facial Plastic Surgery
Florida Sinus Institute
1112 Goodlette Road N. #203
Naples, FL 34102

Patient Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____Cell #: _____Other: _____

I authorize _____ to release healthcare Information to:
Facility/ Company: David Greene, MD, FACS
Address: 1112 Goodlette Frank Rd. North Suite 203 City: Naples State: FL Zip: 34102
Phone Number: (239) 263 - 8444 Fax Number: (239) 308 - 0894 .

I authorize the release/ disclosure of the following healthcare information:

[X] Visit Note(s)	[X] ED Records	[X] Diagnostic Imaging Report(s)	[X] Laboratory Reports
[X] Pertinent Records	[X] Immunization Record(s)	[ ] Diagnostic Imaging Film(s)	[ ] Billing Record(s)
[X] Plan of Care	[X] Medication Record(s)	Other (describe) _____	

Dates of Information to be disclosed: from _____to _____
Purpose of disclosure: [ ] Insurance [ ] Legal [X] Physician [ ] Self [ ] Research [ ] AFH/ALF [ ] Other _____
Is disclosure to an employer or financial institution? [ ] Yes [ ] No (if yes, authorization expires 1 year after signing)

This authorization may include the release of the following sensitive medical information unless specifically excluded (please check if you do NOT want this information released):
[ ] Sexually Transmitted Disease [ ] AIDS/HIV Diagnosis Reports(s) [ ] Alcohol/ Drug Abuse or Treatment [ ] Mental Health

DAVID GREENE MD LLC is hereby released for all legal responsibilities or liability for the release of the above-mentioned information.

REDISCLOSURE: Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of Alcohol and Drug Abuse records, which are protected by Federal Confidential Rules that prohibit the recipient from making any further disclosure of this information unless further disclosed is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 CFR part 2.

I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing to DAVID GREENE MD LLC at the address listed above. I understand that I do not have to sign as authorization in order to receive Health Care treatment. I further understand that if I request records for personal use, or for parties not involved in my health care, there may be a change.
This authorization expires on _____ or when the following event occurs _____ if there is no expiration date given, this authorization will expire one year from the date of signature. if the disclosure is to an employer or financial institution this authorization expires one year after signing.

Signature: _____ Date: _____
(if signed by a personal representative of the patient, please complete the following)
Personal Representative's Name: _____
Relationship to Patient: [ ] Parent [ ] Legal Guardian* [ ] Holder of a Power of Attorney* [ ] Executor of Estate*
*Please attach Legal Documentation if you are the Legal Guardian, Power of Attorney, or Executor of Estate
PLEASE PROVIDE A COPY OF GOVERNMENT ISSUED PHOTO ID

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION
FORM ID ADM 536
Approved 06/2020

APPLY PATIENT LABEL HERE

HIPAA NOTICE OF PRIVACY PRACTICES (NPP)
David Greene, MD, LLC
Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other

- Effective Date of this Notice: April 29, 2024.
- Privacy official: Angela Kehl, 239-263-8444. Angela@davidgreenemdnaples.com. 1112 Goodlette Rd. North, Suite 203, Naples FL, 34102.
- Note: We never market or sell personal information."
- We are not part of an OHCA (organized health care arrangement) that has agreed to a joint notice, and DO NOT share information with an OHCA.