David B. Simmons M.D., P.A.
Board Certified in Gastroenterology
Winter Haven Medical Complex
320 First Street N, Winter Haven, Florida 33881
Phone (863) 299-5300 Fax (863) 299-5322

Welcome to our office!

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____City: _____ Zip Code: _____

Sex: _____ Race: _____ Ethnicity: _____ Language: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Home Phone #: _____ Cellular #:_____Work#: _____

Email Address: _____
(We will not sell or give out your e-mail address)

Pharmacy Information: Name: _____ City: _____ Phone: _____

Primary Physician: _____ Phone: _____

Whom may we thank for referring you? _____

Emergency Contact: _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION

****A copy of your insurance card and Driver's license is required for identification purposes****

****We are required by law to collect your deductible or co-payment at the moment of service. This payment cannot be waived. ****

Primary Insurance: _____

Secondary Insurance: _____

I consent to treatment as necessary by Dr. David Simmons, to the patient named above, including, but not restricted to whatever services, medications, and conduct of lab, x-ray, and other diagnostic procedures.

I hereby give authorization for payment of insurance benefits to be made directly to David B. Simmons, MD, PA for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

David B. Simmons M.D., P.A.
Board Certified in Gastroenterology.
Winter Haven Medical Complex
320 1st Street N, Winter Haven, Florida 33881
Phone (863) 299-5300 ~ Fax (863) 299-5322

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I acknowledge and agree that David B. Simmons MD, P.A and any affiliates or vendor therefore, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify David B. Simmons MD, P.A. if I have given up ownership or control of any such telephone number.

I wish to be contacted in the following manner (check all that apply)

□ Home Telephone_____
_____ Ok to leave message with detailed information
_____ Leave message with call back number only

□ Work Telephone _____
_____ Ok to leave message with detailed information
_____ Leave message with call-back number only

□ Written Communication
_____ Ok to mail my home address

□ Other _____

_____
Patient Signature

_____
Date

_____
Print Name

Please allow the following individuals to have complete access to any and all information contained in my medical chart: (Please note, we cannot release <u>any</u> information to individuals not listed below.)

Name	**Relationship**	**Phone number**
Name	**Relationship**	**Phone number**
Name	**Relationship**	**Phone number**

David B. Simmons M.D., P.A.
Board Certified in Gastroenterology
Winter Haven Medical Complex
320 First Street N, Winter Haven, Florida 33881
Phone (863) 299-5300 Fax (863) 299-5322

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Last 4 of SS#_____ DOB: ____/_____/_____

I HEREBY Authorize the office of David B. Simmons M.D., P.A. and The Winter Haven Ambulatory Surgical Center, to release and / or obtain any and all the information it possesses relating to my evaluation(s), treatment and illness (es) including the psychiatric and psychological information which may be part of the medical records to / from:

Name: _____
(Name of Physician, legal representative / agency, or facility)

Address: _____
Street

_____
City State Zip

( )_____-_____( )_____-_____
Phone Fax

1.) I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2.) I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the office of Dr. David B. Simmons. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3.) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CRF 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosures of my health information, I can contact Dr. David B. Simmons' office at (863) 299-5300.

For medical practices, the copy charge per Florida Administrative Code 64B8-10.003 is $1.00 for the first 25 pages and $.25 for each additional page thereafter.

_____ _____
Signature of patient or legal guardian Date

Please FAX the following: _____

David B Simmons MD
320 1st Street N, Suite 5
Winter Haven, FL 33881
(863)299-5300

I _____ hereby acknowledge that I have reviewed and received a copy of this practice's Notice of Privacy Practices, which has been updated for the new Omnibus Rule and has an effective date of (08/10/2015).

The notice describes:

*The ways that the Privacy Rule allows our practice to use and disclose protected health information. How our practice will get your permission, or authorization, before using your health records for any other reason.
*The practice's duties to protect health information privacy.
*The patient's privacy rights, including the right to complain to HHS and to the Covered entity if you believe your privacy rights have been violated.
*How to contact our practice for more information and to make a complaint.

I understand that the Notice of Privacy Practices may be revised from time to time and that I have a right to receive an updated copy upon request.

_____
Patient Signature

_____
Date