PRESCRIPTION HISTORY CONSENT

I agree that Vascular Specialists of Central Florida may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

SIGNATURE _____ DATE ____/____/____

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____

PRIVACY NOTICE

In accordance with the Health Insurance Portability and Accountability Act, patients of Vascular Specialists of Central Florida are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. Vascular Specialists of Central Florida will strive to ensure that patient information is used for purposes authorized by the patient and as otherwise required by law. Upon request we can provide you with a complete copy of our Privacy Policies. Additionally, patients have a right to review their medical records and furnish comments to their records during normal business hours, upon providing reasonable advance notice. Our office policy is to protect the rights of this office and our patients. Therefore the use of cellular phones and/or other electronic devices to record audio, video or still images within this office is strictly prohibited. Please see our website to obtain additional information regarding our Privacy Policies.

SIGNATURE _____ DATE ____/____/____

RESEARCH

Initial _____

Under certain circumstances with your permission, we may use and disclose information about you for research purposes. (For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition). All research projects are subject to a special approval process that evaluates a proposed research project and its use of medical information, trying to balance the research needs with the patient's need for privacy of their medical information. Before we use or disclose information for research, the project will have been approved through this research approval process; however, we may disclose information about you to a team preparing to conduct a research project to help them look for patients with specific needs, so long as the information they review does not leave Vascular Specialists of Central Florida. When our staff recommends you for a research project, they look back at old medical records. Your personal information will not be disclosed outside our office nor will you be identified by name in any reports. If a research project is conducted where your information cannot be held confidential, a separate process is in place for you to consent for this type of research.

RETURNED CHECK POLICY

IF YOUR CHECK OR OTHER PAYMENT IS RETURNED UNPAID by your bank, we will charge a RETURNED PAYMENT FEE of: Amount $25.00 per check.

SIGNATURE _____ DATE ____/____/____

NON-PAYMENT ON ACCOUNT

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understand that Vascular Specialists of Central Florida has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to all court costs and Attorney fees.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

PATIENT'S SIGNATURE	PRINTED NAME	DATE
PATIENT'S SIGNATURE	PRINTED NAME	DATE