Monica Bedi, MD
Ann Neff, MD
Dahlia Saleh, DO
Brittony Blakey, DO
Paul Stevenson, DO
Margarita Givens, PA-C
Laura De Oliveira, PA-C
Anna Heck, PA-C
Sarah Puccinelli, PA-C
Jennifer Crews, PA-C

Dear New Patient,

Welcome to our practice! I would like to take this opportunity to thank you for choosing us to participate in your dermatologic care. We know that there are many choices out there and we are honored that you have entrusted us with the opportunity to be your dermatologist. We strive to give you complete and thorough care in a warm and friendly environment. I believe you will enjoy working with our providers.

We offer comprehensive dermatologic care for your whole family including Mohs Surgery. We have offices in Sarasota, Bradenton, Lakewood Ranch, Ellenton and Venice. In addition to myself, I am pleased to have several providers to meet all of your dermatologic and skin cancer concerns. Dr. Ann Neff is a board certified dermatologist and fellowship trained Mohs Surgeon. Dr. Dahlia Saleh, Dr. Brittony Blakey and Dr Paul Stevenson are board certified dermatologists and provide superior general dermatologic and surgical care. We also have Certified Physician Assistants, Margarita Givens, Laura De Oliveira, Anna Heck, Sarah Puccinelli and Jennifer Crews who have extensive dermatology training and experience and are available to help with continuity of care and urgent visits. I have the upmost confidence in their abilities and am sure you will enjoy getting to know all of them.

We offer skin care rejuvenation/sun damage prevention treatments and services. I am excited to offer the latest treatments in a medical setting, under my direction, but with a more private and personalized touch. Some of the exciting treatments include photofacial rejuvenation (IPL), laser hair removal, Botox, dermal fillers, chemical peels, SculpSure body sculpting, HydraFacial and custom facials and much MORE! We also offer our own medical grade skin care line, Reflections. All products have been hand picked by me for their efficacy and safety. We strive to individualize our recommendations based on a detailed analysis of your skin type and your needs. We offer complimentary consultations to help address your specific concerns and customize your treatment. Please feel free to ask about any of these options or schedule a consultation today.

We continue to strive to make your visit here enjoyable, while giving you the best care possible. We try to treat every patient as we would a family member. I would like to personally thank you again for allowing us to participate in your care. If you have any questions or concerns, I am always available to discuss them.

Sincerely,

Monica Bedi, MD

3830 Bee Ridge Road - Suite 200, Sarasota FL 34233
4351 Cortez Road W - Suite 101, Bradenton FL 34210
11505 Palmbrush Trail - Suite 220, Lakewood Ranch FL 34202
7901 US 301 – Suite 107, Ellenton FL 34222
1211 Jacaranda Blvd - Suite 2, Venice, FL 34292
6106 State Road 70 East (53rd Ave), Bradenton, FL 34203

dermsarasota.com 941.927.5178
fax 941.921.6838

DERMATOLOGY associates

We are required by Federal law to obtain your email and invite you to our patient portal. You do not have to accept this invitation but we must invite you. Your email will not be used for any other purpose without your consent.

As a patient of our practice, enrolling in the patient portal is free and will allow you to:

- Securely Message with Your Physician
- Request Appointments
- Review Your Lab Results
- Update Personal Information
- Request Prescription Renewals
- Pre-register for Your Visit
- View Visit History via Clinical Summaries

Additionally, we are legally bound to electronically send your prescriptions and need your pharmacy information.

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PLEASE PRINT. Date: _____

PATIENT INFORMATION

Name: _____ Social Security: _____
Birthdate: _____ Age: _____ Sex: Male ☐ Female ☐
Address: _____
State/City/Zip: _____
Home phone: _____ Cell Phone: _____ Work phone: _____
Which is your primary number? _____ Email: _____

Parent/Guardian Name (if under 18): _____
Address: _____
State/City/Zip: _____
Home phone: _____ Cell Phone: _____ Work phone: _____
Which is your primary number? _____ Email: _____

Employer: _____
Address/State/City/Zip: _____

INSURANCE INFORMATION

Primary Insurance Name: _____
Insurance ID Number: _____ Group Number: _____
Subscriber Name: _____ Subscriber Social Security Number: _____
Subscriber Date of Birth: _____ Subscriber Relation to Patient: _____

Secondary Insurance Name: _____
Insurance ID Number: _____
Subscriber Name: _____ Subscriber Social Security Number: _____
Subscriber Date of Birth: _____Subscriber Relation to Patient: _____

Primary Care Physician: _____ Phone Number: _____
Referred to us by: _____ Phone Number: _____

Preferred Pharmacy: _____
Address or cross streets: _____
Phone Number: _____ Fax Number: _____

Do we have permission to:

Leave a message on your home answering machine? ☐ Yes ☐ No
Leave a message at your place of employment? ☐ Yes ☐ No
Discuss your medical information with anyone else? ☐ Yes ☐ No
If so, to whom: _____ Relationship: _____

In an emergency, please contact: _____ Phone Number: _____

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MEDICAL QUESTIONNAIRE

Patient Name: _____ **DOB:** _____ **Date:** _____

Email address:_____**Reason for Today's Visit:** _____

DO YOU HAVE NOW OR HAVE YOU HAD A HISTORY OF THE FOLLOWING CONDITIONS? PLEASE CHECK ONLY THOSE THAT APPLY:

- ☐ Immunosupression
- ☐ Skin Pre-cancers (actinic keratosis)
- ☐ Irregular Moles (dysplastic nevus)
- ☐ Melanoma
- ☐ Skin Cancer (basal or squamous)
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Atrial Fib/Flutter
- ☐ Heart Attack/Stents
- ☐ High Cholesterol
- ☐ Joint Replacement
  Site _____
  Year _____
- ☐ Asthma
- ☐ Lung Disease
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ MSRA
- ☐ Multiple Sclerosis
- ☐ Bowel Disease
- ☐ Kidney Disease
- ☐ Pacemaker
- ☐ Hayfever / Allergies
- ☐ Lupus
- ☐ HIV
- ☐ Stroke
- ☐ Seizures
- ☐ Depression
- ☐ Rheumatologic Disorder
- ☐ Organ Transplant
  *Type:*_____
- ☐ Glaucoma
- ☐ Cancer (ex. breast)
  *Type:*_____
- ☐ Radiation Treatment
- ☐ Blood disorders
- ☐ Eczema
- ☐ Psoriasis
- ☐ Have you had a pneumoccal vaccine?
- ☐ Completed the COVID vaccine?

Are you allergic to any medications? If yes, please list:
_____
_____

Are you allergic to tape/ointments? Yes / No

Previous surgeries: _____
_____

Please list your current medications, including herbs and vitamins, or give a list:
_____
_____
_____
_____
_____
_____

Any additional comments or something we should know:
_____
_____

DO YOU HAVE A HISTORY OF BLISTERING SUNBURNS? Yes / No **DO YOU HAVE A HISTORY OF TANNING BED USE?** Yes / No

ARE YOU INTERESTED IN ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY)

- ☐ BOTOX® Cosmetic
- ☐ Chemical Peels
- ☐ Laser Hair Removal
- ☐ Skin Care Products
- ☐ SculpSure Fat Sculpting
- ☐ Facials

DO ANY FAMILY MEMBERS HAVE A HISTORY OF THE FOLLOWING CONDITIONS?:

Melanoma Yes / No Skin Cancer Yes / No Psoriasis Yes / No Lupus Yes / No
Eczema Yes / No Hair Loss Yes / No Thyroid Disease Yes / No

WHERE DID YOU GROW UP? _____ **I HAVE LIVED IN FLORIDA SINCE WHAT YEAR?** _____

DO YOU PERSONALLY USE THE FOLLOWING?: Sunscreen Yes / No Alcohol Yes / No Tobacco Yes / No

MARITAL STATUS: Single ☐ Married ☐ Divorced ☐ Widowed ☐

OCCUPATION: _____ **RACE/ETHNICITY:** _____

WHAT OUTDOOR ACTIVITIES ARE YOU INVOLVED IN? _____

WE RECOMMEND A YEARLY TOTAL BODY SKIN EXAM INCLUDING WHEN APPROPRIATE GENITAL AND/OR PERIANAL SKIN IN ORDER TO EVALUATE FOR SKIN CANCERS. WILL YOU BE HAVING A TOTAL BODY SKIN EXAM TODAY?

☐ Yes ☐ No ☐ Next Visit

IN AN EMERGENCY PLEASE CONTACT:_____ **PHONE NUMBER:** _____

SIGNED: _____

Assignment of Benefits, Financial Policy & Consent for Treatment

ASSIGNMENT OF BENEFITS

If you have no insurance:

I agree to pay my medical expenses, in full, when I am seen by the physician/physician assistant. If for any reason there is a balance owed on my account, I agree to pay promptly upon receipt of the monthly statement.

If you have Medicare or Medicaid:

I request that payment of authorized Medicare and/or Medicaid benefits be made on my behalf to the rendering physician for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services. I agree to pay any portion of my charges that my Medicare and/or Medicaid carrier determines to be my responsibility.

If you have HMO, PPO or commercial insurance:

I authorize any holder of medical information about me to release to my insurance company or its agents any information (including HIV, alcohol, and mental health) needed to determine benefits payable for related services. I agree to comply with the terms of my insurance coverage, including payment of my co-payment at the time of service rendered and payment of any portion of charges that my insurance carrier determines to be my responsibility, upon receipt of my monthly statement.

If you have Medigap insurance (Medicare Supplement):

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the rendering physician for any services furnished me by that provider. I authorize any holder of medical information about me to release to my Medigap carrier any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services.

STATEMENT OF FINANCIAL RESPONSIBILITY

In addition to our charge for the visit or procedure, if you have a biopsy, surgical specimen, or culture swab taken at any visit, you (or your insurance) will be billed separately by the pathologist or lab for their analysis of the specimen. We will provide your billing and insurance information to the lab or pathologist.

All insurance forms processed by this office, prior to payment in full, are assigned to this practice. Your cooperation in complying with the terms of this assignment will be appreciated.

I, the UNDERSIGNED, have read the above and realize that all medical and surgical charges incurred by me, or my dependents, for services rendered by are my financial responsibility. All court fees, attorney fees, or other fees necessary to collect this account, should it become delinquent, are payable by me. **I am also aware of this office's no-show fee of $25.00 for an office visit and $100 for a Mohs surgery appointment. This fee is payable by me should I fail to give 24-hour notice for a scheduled appointment.**

CONSENT FOR TREATMENT

I give consent for myself or dependents for treatment and when appropriate examination of genital or perianal skin. I understand that I will be seen by Monica Bedi, MD, Ann Neff, MD, Dahlia Saleh, DO, Brittony Blakey, DO and/or Margarita Givens, PA-C, Laura De Oliveira, PA-C, Anna Heck, PA-C, Sarah Puccinelli, PA-C or Jennifer Crews, PA-C. I understand that at any time I may choose which provider I schedule my appointment with and be seen by.

Name: _____

Signed: _____ Date: _____/_____/_____

Witness (by staff): _____

IMPORTANT SUMMARY OF THE PRIVACY OF YOUR HEALTH INFORMATION

Your privacy is extremely important to us. The information that we record about you and your medical history is to help us provide quality medical care. We are committed to protecting this information. The *Notice of Privacy Practices* describes your rights with regards to your health information and our responsibility to protect that information. This is just a summary, but a detailed description of your rights is posted in the waiting area. We would also be happy to provide you with a detailed copy to take with you.

Your rights include:

- The right to amend your health information
- The right to request restrictions on what information we use or how we disclose your health information
- The right to see an account of certain disclosures we have made of your health information
- The right to obtain access to your health information with limited exceptions (A written or notarized request, an appointment for access, appropriate advance notice, and a cost-based fee for expenses delineated by law)
- The right to receive a paper copy of our *Notice of Privacy Practices*

These rights do have certain restrictions and you may obtain detailed disclosure of these restrictions at any time.

We may use your health information and/or records to:

- Plan for your care and help your health care providers communicate and work together for your overall medical benefit
- Submit bills for reimbursement for the care provided to you
- Help health care payers or medical insurance companies verify that services were provided to you
- Help improve the quality of your health care
- Disclose information to certain officials or organizations as requested by law

Everyone working for Monica K. Bedi, MD PA, who has access to your information, is bound by law to uphold to all privacy standards.

We encourage you to read the *Notice of Privacy Practices* and to please ask if you need further information.

Your signature below confirms that you have read and understand your rights to privacy, and that you have been given access to all information pertaining to those rights.

Signature: _____ Date: _____

Florida Medical Specialists, LLC

MAXHealth
Bradenton Physicians Medical Center
Manatee Family Physicians
Cancer Center
Dermatology Associates
9419299443

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.

If you have any questions about this Notice please contact our Privacy Officer who is Inita Bedi

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

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

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some

circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **[describe how patient may obtain a restriction.]**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Inita Bedi** by phone at (941) 284-5448 or email ibedi@mymaxdoc.com for further information about the complaint process.

This notice was published and becomes effective on **September 23, 2013.**