Individual rights You have certain rights under the Federal privacy standards. They include but are not limited to the right to request restrictions on the use and disclosure of her protected health information, the right to receive confidential communication regarding her medical condition and treatment, the right to inspect copies of your protected health information if it is not deemed potentially harmful to you, the right to receive an accounting of how and to whom year protective health information has been disclosed, the right to receive a print to copy of this notice.**Our Duties:** We are required by law to maintain the privacy of your protected health information and to post and offer you this notice of privacy practices. In addition, we also are required to abide by the privacy and practices outlined in this notice. Implicit consent from you to discuss information related to you is assumed, if your appointment has been scheduled by somebody else, with that person and if someone has accompanied you to this appointment also with that person and last he revoked this consent at the time of the appointment.

PF-100 Notice of privacy Protection-THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION PLEASE REVIEW. Uses and Disclosures: **Treatment:** Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted or contacted by staff members, such as your PCP. We may contact you regarding treatment by phone or text. Signing this form means that you consent to text communication as well as phone calls. **Payment:** Your health information may be used to seek payment from your health plan and from other sources of coverage such as an automobile insurer, or from financial institutions that you may use to pay for services. For example, your insurer, pharmacist, case manager ,etc may request and receive information on dates of service, the services provided, and the medical condition being treated. Any services in between appointments will be performed solely at the practitioner's discretion. You and your guarantor and/or any person who presents any form a payment for you (and thereby makes themselves your guarantor) are responsible for any and all outstanding balance is not paid by another party such as insurance. Also, we may charge for ancillary services such as paper work, phone calls in between appointments, prior authorizations, refills other than at the time of an appointment and also for missed appointments. If any patient or any associated guarantor has an outstanding unpaid balance more than 90 days after services were rendered there is an automatic de facto termination 30 days later of the practitioner patient relationship established here and with all patients in any way associated with that guarantor. Any deviation from this policy will be solely at the practitioners discretion.**Health Care Operations:** Your health information may be used as necessary to support the day to day activities in management of our office. For example information on the services you receive maybe used in budgeting and accounting data or activities that promote quality. Law enforcement: If demanded, your health information maybe disclose to law enforcement agencies such as DHHS without your permission to support Medicare or other government auto it's inspections to facilitate law enforcement investigations, and to comply with any government mandated reporting. **Public Health Reporting:** Your health information maybe disclose to public health agencies if required by law. For example some infectious diseases must be reported to Florida is Public Health Department. **Other Uses and disclosures require your authorization**. Disclosure of your health information or its use for any purpose other than those listed above requires year specific written authorization. If you change her mind after authorizing a use or disclosure of your information, he may submit a written revocation of the authorization. However, your decision to revoked authorization will not effect or undo any use of disclosure of information that occurred before you notified us of your decision. He may have a copy of this form if you ask for copy to keep. The office of several rights may be contacted with questions or concerns at 800-368-1018.

CONSENT FOR TREATMENT Having voluntarily presented myself (or my dependent[s]) to,Anton Dragonetti A.R.N.P I acknowledge recognition of the fact that the evaluation and treatment received from Anton Dragonetti A.R.N.P, is advised and deemed necessary and the judgment of the practitioner.

PRINT NAME: SIGNATURE: DATE: