PATIENT CONTRACT

The purpose of this Patient Contract is to inform you the patient of some of the risks of using controlled substances and to advise you of our procedures to reduce the risk that any abuse of prescriptions for controlled substances will occur. This Patient Contract is also being used to obtain your informed consent to your medical treatment by our medical professionals, as well as advise you concerning out privacy and financial policies.
I agree to be treated in the best way possible by Sun Lake Medical Associates physicians in order to improve my medical condition.

Chronic Pain Provisions

Controlled substances include narcotics, opioids, tranquilizers, barbiturates and some sleep medications. When used properly, these medications can be very effective in alleviating not only pain, but also the mood changes and sleep disturbances associated with pain. There is, however, a high potential for addiction and abuse, and for that reason, controlled substances are closely controlled by governmental agencies. In addition, certain adverse side effects may occur with their use. These include, but are not limited to, nausea, vomiting, constipation, lethargy and impaired judgment. With excessive use, respiration and blood pressure may be depressed and liver damage and even death may occur. Patients on narcotics must not drink alcohol, use illicit drugs or be or become pregnant. Patients on narcotics must exercise special care when operating automobiles or other mechanical equipment.

Because these drugs can be abused by the patients who receive them, or by others, it is necessary to observe strict rules when they are prescribed over the long term. For this reason we require each patient receiving long-term treatment with these medications to read and agree to the rules, policies and procedures in this Patient Contract. Any violation of these rules, policies and procedures by you that is discovered by us is likely to lead to your immediate discharge as a patient from our practice and, in the case of criminal conduct or other misconduct by you, potential reporting to your primary care physician, your state's prescription drug monitoring program and/or law enforcement officials.

As a condition of the physician whose signature appears below (**"Your Prescribing Doctor"**) to consider prescribing or to continue prescribing controlled substances to treat your medical condition, you consent to and agree to strictly observe the following rules and procedures:

1. All controlled substances used by you must come from Your Prescribing Doctor, or during his or her absence, by the covering physician, unless specific authorization is obtained from Your Prescribing Doctor or the covering physician for an exception.

2. You will promptly inform Your Prescribing Doctor of any current or past substance abuse, or any past substance abuse of any immediate member of your immediate family.

3. You will inform Your Prescribing Doctor of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4. You will not allow anyone else to have, use, sell or otherwise have access to these medications.

5. You understand that these medications may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that you must keep them out of reach of such people for their own safety.

6. You understand that tampering with a written prescription is a felony, and you will not change or tamper with Your Prescribing Doctor's written prescription.

7. You will take your medication as prescribed and will not exceed the maximum prescribed dose.

8. You are aware that attempting to obtain a controlled substance under false pretenses is illegal. If the responsible legal authorities have questions concerning your treatment, as may occur, for example if you obtain medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to your full records of controlled substances administration.

9. You agree that Your Prescribing Doctor has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

10. You understand that these drugs should not be stopped abruptly, as withdrawal symptoms may develop.

11. You understand that medications may not be replaced if they are lost, damaged or stolen. If any of these situations arise that may cause you to request an early refill of your medication, you will be required to complete a statement explaining the circumstances. At that time a determination will be made as to whether you may receive an early refill.

12. You understand that a prescription may be given early if Your Prescribing Doctor or you will be out of town when the refill is due.

13. You will keep your scheduled appointments in order to receive medication renewals.

14. You understand that any medical treatment is initially a trial and that continued prescription is contingent on whether Your Prescribing Doctor believes that the medication usage benefits you.

15. You acknowledge that you have been explained the risks and potential benefits of these therapies, including psychological addiction, physical dependence, withdrawal and over dosage.

16. You and Your Prescribing Doctor acknowledge and agree that your treatment by Your Prescribing Doctor creates a valid and legally recognized physician-patient relationship and that you and Your Prescribing Doctor consider the medical treatment rendered by Your Prescribing Doctor to at all times be rendered in the State of Florida, the State in which Your Prescribing Doctor maintains his or her medical office.

17. You will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacy; you will inform Your Prescribing Doctor. The pharmacy you have selected is the filling pharmacy of your choice made by you):

Print Name, Address & Phone Number of Pharmacy:

_____

18. You affirm that you have full right and power to sign and be bound by this Patient Contract, and that you have read, understand and accepts all of its terms.

Date:_____, 2011

Patient Signature: _____ Patient's Printed Name:_____

Physician Acknowledgement:

Physician Signature: _____ Physician Name (Printed): _____

Informed Consent to Treatment/Privacy Notice

You understand that:

1. You have the right to withhold or withdraw consent to medical treatment from our medical practice at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you are entitled.

2. You may benefit from our medical treatment, but that results cannot be guaranteed or assured.

You hereby authorize any referring physician to release all medical information necessary to complete your medical care to our medical practice.

The Health Insurance Portability and Accountability Act of 1996 (**"HIPAA"**), established a "Privacy Rule" to help ensure that personal health care information is protected as private. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you choose to give consent by signing this Patient Contract, at some future time you may request to refuse the disclosure of all or part of your personal health information. Any such revocation or limitation of your consent should be in writing and sent to us at the following address:

_____
_____
_____
Attn:_____

You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to our privacy policies described in this section of the Patient Contract, please ask to speak with our HIPAA Compliance Officer. You also may review our separate Privacy Notice, a copy of which is posted in the reception area of our clinic.

Financial Policies

By signing below you authorize our medical practice to furnish information to insurance carriers concerning this illness/accident, and you hereby irrevocably assign to Your Prescribing Doctor and/or our medical practice all payments for medical services rendered. You understand that you are financially responsible for all charges whether or not covered by insurance.

We are committed to providing the best medical care. We also want to help you receive your maximum allowable benefits if you have medical insurance. In order to do so, we need your partnership and your clear **understanding of our financial policies**. Therefore, we ask that you read and understand the following:

1. Your insurance is a unique contract between you, your employer and your insurance company. **Not all services are covered by all insurance plans** (for example, a routine physical exam is not covered under Medicare or some PPO plans.) This is not to be confused with the physician's determination of which services are medically necessary or appropriate.

2. Our staff cannot possibly know all the details of your policy. It is in your best interest to know and understand your benefits, deductible, co-payments, etc. **before** you seek services. If you have questions as to what is covered by your insurance, call the insurance company directly. We recommend that you record the name of the person with whom you speak, the date, and the phone number called; this provides important documentation if your claim is later denied, or if services are not covered as represented to you. When reviewing your written policy, be sure to review the "Exclusions" page, as services which appear to be covered in the body of the policy may be excluded there.

3. Our physicians have a **medical care relationship with you**, separate from any contractual agreements with insurance companies. Because you are the recipient of services, all charges are your responsibility from the date the services are provided. **We cannot legally bill your insurance for services without your permission and cooperation. You are responsible for charges not covered by your insurance, and payment must be made as soon as responsibility is determined.**

4. If you have coverage through a plan in which we participate, we will collect your co-payment, if any, at the time of service. We will bill your insurance for services only if you have supplied us with current, complete, and verifiable information. Our policy is to have patients bring their current insurance card to every appointment. We also request that you send us a copy of any new card you receive for new or continuing insurance.

5. Co-payments and payments toward your deductible must be paid at the time of service.

6. The balance remaining after the insurance portion is paid or denied is due within 30 days. If you disagree with the insurance determined benefit, you must contact your insurance directly.

7. If your coverage is not verifiable at the time of your visit, **we will require your full payment for care at that time**. In this case, we will provide you with a detailed receipt that you may submit to your insurance for reimbursement.

8. **If you do not have insurance, or have insurance with which we are not contracted, payment must be made when you arrive for your appointment.**

9. Returned checks will be subject to an additional $25 fee.

10. We will gladly discuss your estimated medical care costs; however, your provider determines actual costs at the time services are provided.

11. We realize that temporary financial problems may affect timely payment of your account. If such problems occur, contact our billing staff promptly to make arrangements.

12. You understand that in the event that legal action should become necessary to collect an unpaid balance due for medical services rendered, you agree to pay for reasonable attorneys' fees and other costs of collection and litigation. You agree that the exclusive venue and jurisdiction for any such proceeding shall be in Hillsborough County, Florida and submit yourself to such jurisdiction.

We set aside valuable equipment, professional staff time and physician time when scheduling patient visits. Too often, an appointment is not kept, or is cancelled with too little notice to schedule the time allotted with another patient. Therefore, our policy requires $100 payment for any patient appointment that is not kept, or cancelled or rescheduled with less than 24 hours' notice (only business days included).

We fully support your access to your personal medical records. A nominal fee must also be charged to you to cover our costs when we send a copy of your records to you, to another provider (unless we are referring you), or for disability or other legal claims. This fee is $25.

By signing below, you understand and accept that, regardless of your insurance status, you are responsible for prompt payment of all charges for medical care and other services provided by Sun Lake Medical Assoc.

By your signature below, you direct assignment of payments as defined in the rights and benefits of your insurance policy, to Sun Lake Medical Associates, or to an individual physician member, the professional or medical expense benefits allowable and otherwise payable to you under your current insurance policy as payment toward the total charges of the professional medical care provided to you. The payment will not exceed your indebtedness to the above-mentioned assignee, and you have agreed to pay, in a current manner, any balance of said professional charges over and above insurance payment, as due. A photocopy of this assignment shall be considered as effective and valid as the original. By your signature below, you authorize release of any information required of your insurance to process a specific claim.

Dated: _____, 20__

_____
Patient Signature

_____
Patient Name (printed)

PHYSICIAN ACKNOWLEDGEMENT:

_____
Physician Signature

_____
Physician Name (printed)