NOTICE OF PRIVACY POLICY AND 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.

Purpose of this Notice: Our office respects the privacy of personal information and understands the importance of keeping this information confidential and secure. This Notice describes our privacy practices with respect to your health information. Our privacy practices apply to current and former patients.

Types of Personal and Health Information We Collect: We collect a variety of personal health information when delivering health care. You provide some of this information, when you initially come into the office (such as address, Social Security number, and health history). We also receive additional personal and health information (such as eligibility) through our transaction with employers, insurance companies, and other health care providers. We limit the collection of personal information to that which is necessary to administer our business, provide quality service, and meeting regulatory requirements.

How We Protect Personal and Health Information: We treat personal and health information securely and confidentially. We limit access to personal information to only those personal who need to know that information to provide services to patients (for example, or billing clerks and medical assistants). These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable law. We meet physical, electronic and procedural security standards to protect personal and health information and maintain internal procedures to promote the integrity and accuracy of that information.

Disclosure of Personal and Health Information: We may share any of the personal and health information we collect (as described above) with our associates as permitted by law. We may also disclose this information to non-associated entities or individuals as permitted or required by law. Non-associates with whom we may disclose information as permitted by law include our attorneys, accountants, and auditors, a patient's authorized representative, other health care providers, public health authorities, coroners, medical examiners, and funeral directors, organ donation organizations, Institutional Review Boards for research purposes, third party administrators, insurers and law enforcement or regulatory authorities. We may also disclose any of the personal and health information we collect (as described above) in order to provide appointment reminders or to give you information about other treatments or health related benefits and services that may be of interest to you. In addition, in the event that this office is sold or merged with another office, your personal and health information will become the property of the new owner. We do not disclose personal or health information to any other third parties without a patient's request or authorization.**HIPAA'S PRIVACY STANDARDS:** Privacy Standards are designed to protect an individual's health information. This was signed into law in 1996.Healthcare legislation called the Health Insurance Portability & Accountability Act (HIPAA) also known as Public Act 104-191 or the Kennedy – Kassebaum Bill.

Individual Rights to Access & Correct Personal & Health Information: We have procedures for a patient to access the personal and health information we collect, and other than information we collect in connection with, or in anticipation of, a lawsuit or legal claim, we will make this information available to the patient upon written request.

Our goal is to keep our patient information up-to-date and to correct inaccurate information. We have procedures in place to ensure the integrity of our information and for the timely correction of incorrect information. If you believe that any personal or health information we have about you is not accurate, please let us know by contacting our Office Manager.

Further Information: The practice reserves the right to amend this Notice to Privacy & Practices at any time in the future. Until such amendment is made the practice is required by law to comply with the Notice.

720 W. Oak Street, Suite 309, Kissimmee, FL 34741 * 339 Cypress Pkwy, Suite 240, Poinciana FL 34759
106 Park Place, Suite B, Davenport FL 33837

DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us if you wish to designate the named person as your personal representative

Designation Section

I hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

_____

(Print Name of Personal Rep)

This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.

I understand that I may revoke this designation as any time by signing the revocation section of my copy of this form and returning it to 720 West Oak St., Suite 380, Kissimmee, FL 34741. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

Revocation Section

____I hereby revoke this designation of a personal representative.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or me dependent(s), have insurance coverage and assign directly to Dr. Scott Hannum all insurance benefits, if any otherwise payable services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-mentioned insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

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FINANCIAL POLICY

AGREEMENT BETWEEN DR. /CREDITOR AND THE PATIENT/DEBTOR
In this agreement the words "You", "Your" and "yours" mean the Patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited.

The words "we", "us", and "our" refer to **Dr. Scott R. Hannum.**

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, and new charged to the account, and any payment or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statements is due and payable when the statement is issued.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at time of service rendered.

Required Payments: Any co-payments required by an insurance company* **MUST** be paid at time of service. Because this is an insurance requirement, we CANNOT bill you for these.
Payment Options if you have no Insurance:
A. You may choose to pay by Cash, Check or Credit Card on the same day that services are rendered.

***Benefits provided for our office and follow-up visits, ultrasound and procedures are only an estimate given to us by your insurance company. Once claims are submitted and processed, and depending on your plan's design, your responsibility may change. It is your responsibility to know your benefits.**

Medicare Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Scott R. Hannum D.O. for services furnished by Scott R. Hannum D.O. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on the other approved claims forms, my signature authorizes releasing the information to the insurer or agency shown.Scott R. Hannum D.O. accepts the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____
Medicare Patients
Please Initial

Credit: We have option to report your account status to any credit reporting agency as a Credit Bureau.

Financial Charge: A finance charge of 1% interest per month will be computed and imposed on your account of which has not been paid within 30 days of the time the charges were added to the account.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court or if you past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all lawyer fees which we incur plus all court cost.

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Transferring of Records: You will need to request, in writing, and pay a reasonable copying fee (currently $7 for the first 25 pages and $1 for each page thereafter) if you want to have copies of your records sent to another provider as a professional courtesy. You authorize to include all relevant information, including your payment history. If you are requesting your records to be transferred from another provider to us, you authorize us to receive all relevant information, including payment history.

Effective Date: Once you have signed this agreement you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Late Cancellation / Missed Appointment Policy

For any appointment that is missed or canceled with less than the required **24-hour notice**, patients will be charged **a cancelation fee of $25.**

Patient Signature: _____

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REQUEST FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

I hereby authorize you to release medical information when needed to:

Scott R. Hannum, D.O.
720 W. Oak Street, Suite 309, Kissimmee, FL 34741 * 339 Cypress Pkwy, Suite 240, Poinciana FL 34759
106 Park Place, Suite B, Davenport FL 33837
Office Phone #:407-518-4982 Fax#: 407-518-1748

Requested Report: _____

_____

_____

Signature of Patient: _____

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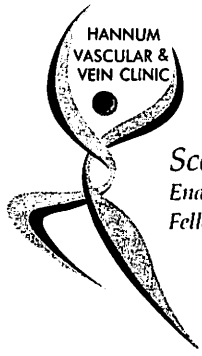

Scott R. Hannum, D.O.
Endovascular
Fellowship Trained • Board Certified

Please provide the office with the following information. Thank you!

In case of an emergency who to call: Name _____

Phone number: _____

Current Address: _____

Email: _____

Primary Care Physician: _____

Which pharmacy do you use? _____

Pharmacy Address or Phone Number _____

Insurance Subscriber Name & DOB: _____

How did you hear about the office: _____