



Dear Patient and Family Members:

Welcome to Tampa Ear, Nose & Throat Associates, a division of Select Physicians Alliance. We would like to take this opportunity to welcome you to our practice. This letter contains answers to some of the most commonly asked questions by patients entering our practice. We hope you find this information useful.

Our office hours are Monday through Friday from 9:00AM to 5:00PM. Our office phone number is (813) 972-3353. In the event of an emergency outside of our normal business hours patients may call this number and the call service will contact the doctor on call for you.

We understand that in today's busy world occasionally situations come up that are beyond your control. In those instances, we request you extend us the courtesy of a 24-hour notice. This courtesy allows us to continue to operate efficiently and use the time that was reserved for you to help other patients in need. It is our policy that you call our office at least 24 hours prior to your appointment time. If you fail to contact our office in advance three times over the course of one year, you will be discharged from the practice.

Patients should complete, sign and bring the following items to your first appointment:

- Patient registration form
- Conditions of treatment form
- Health questionnaire
- Medication list
- Allergy patient information (if applicable)
- Allergy questionnaire (if applicable)
- Driver's license or state issued identification card
- Primary and secondary insurance cards

On subsequent visits our front office staff will review your demographic and insurance information with you to ensure we maintain your correct information on file. This allows us to submit claims to your insurance carrier in a timely manner.

We are contracted with several insurance carriers for the benefit of our patients. You will want to check your benefits booklet or with the benefits department of your employer to verify if our physicians are listed as providers within your network.

As part of our contract with the insurance companies we are legally required to collect any co-pays or deductibles from you at the time of service. We ask that you be prepared to pay your co-pay at the time of check-in prior to being seen by our providers. We accept cash, check, American Express, Discover, MasterCard, Visa, and CareCredit.



If your insurance requires a referral from your primary care physician, a written referral or authorization number must be in our office 48 hours prior to your visit or your appointment will be cancelled. Obtaining this authorization is the responsibility of the patient. Please contact your primary care physician as soon as possible to initiate this process.

It is our desire to have a mutually respectful relationship with our patients. As part of this relationship we feel it is important to set patient expectations appropriately:

- Patient telephone messages must first be reviewed by clinical staff prior to a return phone call. In most cases, this process may take 4-6 hours. Please note, for messages left after 12PM, you may not receive a return phone call until the following business day.
- Please allow 2 working days for the clinic to process requests for prescription refills and 3 working days to process authorizations for diagnostic testing.
- Please allow 5-7 working days for the completion of any forms, letters, or records requests. There is a standard fee for any form completion including FMLA. This amount is determined on the type of form and the number of pages per form. It is due at the time the forms are submitted to our office.
- Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing any information without your written permission.
- We expect our patients to maintain a good credit rating with our office. Failure to pay for medical services delivered in good faith will cause your account to be turned over to a third party collection agency and you will be discharged from the practice.
- Our office maintains a zero tolerance policy for disruptive behavior. Any patient who is disrespectful, offensive, or threatening to physicians or staff members will be discharged from the practice.

If you have any questions or need further clarification on any of our policies please contact our office for assistance. Thank you for allowing us to assist you with your healthcare needs.

I have read and agree to the terms specified in this letter.

Patient/Guardian Signature

Date



PATIENT INFORMATION

DATE OF BIRTH: ____/____/____ SEX: _____ DATE OF SERVICE: ____/____/____
FIRST NAME: _____ MI: _____ LAST NAME: _____
LOCAL ADDRESS: _____ EMAIL ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: () _____
SOCIAL SECURITY NO: _____ HOME PHONE: () _____
ETHNICITY: ASIAN ASIAN INDIAN AFRICAN AMERICAN WHITE WORK PHONE: () _____
 OTHER _____ RACE: _____ REFERRING PHYSICIAN: _____
PREFERRED LANGUAGE: _____ PRIMARY CARE PHYSICIAN: _____
MARITAL STATUS (circle): S M D W P SEP PHARMACY: _____
EMPLOYMENT STATUS (circle): EMPLOYED RETIRED STUDENT PHARMACY PHONE: () _____
EMERGENCY CONTACT: _____ CONTACT PHONE: () _____

RESPONSIBLE PARTY (IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? IF **NO**, PLEASE COMPLETE THIS SECTION)

RELATIONSHIP: _____ DAYTIME PHONE: () _____
FIRST NAME: _____ MI: _____ LAST NAME: _____
DATE OF BIRTH: ____/____/____ SEX: _____ SOCIAL SECURITY NO: _____
BILLING ADDRESS: _____ EMPLOYER: _____
CITY: _____ STATE: _____ ZIP: _____ ADDRESS: _____
EMAIL ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST)

INSURANCE COMPANY: _____ INSURED'S DATE OF BIRTH: ____/____/____
INSURANCE/CARD HOLDER'S NAME: _____ RELATIONSHIP: _____
INSURED'S SOCIAL SECURITY NO: _____ INSURANCE PHONE: () _____
INSURANCE ID # _____ INSURANCE GROUP # _____

SECONDARY INSURANCE COMPANY: _____ INSURED'S DATE OF BIRTH: ____/____/____
INSURANCE/CARD HOLDER'S NAME: _____ RELATIONSHIP: _____
INSURED'S SOCIAL SECURITY NO: _____ INSURANCE PHONE: () _____
INSURANCE ID # _____ INSURANCE GROUP # _____

**CONDITIONS OF TREATMENT BY
TAMPA EAR NOSE & THROAT ASSOCIATES**

Patient: _____ DOB: _____

Permission for Treatment: Permission is hereby granted for physicians, residents, employees, or agents of Tampa Ear Nose & Throat Associates (collectively, the "Provider") to render the patient named above such medical and surgical treatment as is deemed necessary.

Authorization for Release of Information: The Provider (through its employees or other contracted agents) may disclose the patient's medical record account to:

1. Any person or corporation which is or may be liable for all or any portion of the patient's charges; including but not limited to insurance companies, health care service plans, and worker's compensation carriers to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.
2. Any referring physician to ensure continuity of medical care.

Financial Agreement: (Please initial as applicable)

_____ **Assignment of Insurance Benefits:** I request my insurance carrier to pay to Tampa Ear Nose & Throat associates all benefits due me related to my pending claim for medical and surgical services. I agree to pay all applicable deductible and coinsurance amounts due and other fees for services rendered for which my insurance plan/HMO is not liable for payment to the Provider, and agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect such amounts.

_____ **Medicare B Authorization:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

_____ **Self-Paying Patient:** I have been informed that Tampa Ear Nose & Throat Associates does not have a contract to participate with my insurance plan or HMO, and the requested services have not been authorized by my insurance plan/HMO, as applicable. I am requesting medical services as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this account.

Patient/Guardian: _____ Date: _____

DR. NOFSINGER'S NEW PATIENT HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

REASON FOR VISIT: _____

LIST OF MEDICATIONS: _____

CURRENT MEDICAL PROBLEMS: _____

ALLERGIES TO MEDICATIONS: _____

PAST SURGERIES OR HOSPITALIZATIONS: _____

FAMILY HISTORY: _____ Alcohol Use: yes/ no, Tobacco Use: yes/no

REVIEW OF MEDICAL HISTORY (CHECK ALL THAT APPLY)

CONSTITUTIONAL

- Fever
- Night sweats/chills
- Fatigue
- Change in weight: yes/no

SKIN

- Skin cancer
- Healing problems
- Rash
- Eczema

EYES

- Glaucoma
- Visual disturbance
- Dry eyes
- Double vision

ENT

- Nose bleeding
- Feel something stuck in throat
- Change in voice
- Neck Mass
- Ringing in ears
- Tonsillitis (# ___ /yr)
- Snoring
- Ear pain
- Throat pain
- Sinus infections (# ___ /yr)
- Ear drainage
- Hearing loss

CARDIOLOGY

- Chest pain
- Irregular heart rhythm
- Heart murmur
- Leg swelling

ENDOCRINOLOGY

- Sleep problems
- Sleep apnea
- Temperature intolerance
- Excessive thirst

RESPIRATORY

- Asthma
- Shortness of breath
- Cough
- Blood in sputum

MUSCULOSKELETAL

- Osteoporosis treatment
- Pain in jaw with chewing
- Back pain
- TMJ (night guard: yes/no)
- Teeth Clenching

NEUROLOGY

- Headache
- Stroke
- Paralysis/weakness
- Tingling
- Dizziness
- Seizures

ALLERGY

- CIRCLE WORST SEASONS:**
(Jan, Feb, Mar, Apr, May, Jun, Jul, Aug, Sept, Oct, Nov, Dec, All Year)
- CIRCLE TRIGGERS:**
(animals, dust, yard work, air conditioning, cleaning solutions, tobacco, milk, egg, wheat, soy, perfume, food odors, exercise)
- OTHER: _____

ALLERGY TESTING/TREATMENT

- Skin Test
- Blood Test
- Prior allergy shots or drops

LIST ALL FOOD ALLERGIES/SENSITIVITIES: _____

STANDING CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

PLEASE SIGN ONLY AFTER YOU HAVE READ AND UNDERSTAND ALL OF THE FOLLOWING

I, _____, whose signature appears below, authorize Tampa Ear, Nose & Throat Associates, a division of Select Physicians Alliance, PL and its affiliated providers to view external prescription history via the RxHub service for the patient listed below.

Please initial below. By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.

_____ I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions issued back in time for several years.

Patient Name

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT I AUTHORIZE THE ACCESS TO MY PRESCRIPTION HISTORY.

Signature of Patient or Guardian

Date

If Guardian, Relationship to Patient



Patients and Family Members:

Please be advised we are a specialty care practice and some services performed in the office may be charged **in addition** to an office visit.

These charges are separate from your co-payment and may apply to your co-insurance and/or deductible depending on your insurance plan.

These services include **but are not limited to:**

- Any type of scope
- Control of nose bleeds
- Removal of foreign bodies
- Wax removal
- Sinus debridement
- Biopsies
- Excisions
- Audio services
- Somnoplasty
- Tympanostomy
- Videostrobe

We are happy to review your insurance benefit **prior** to any in office procedure to estimate your financial responsibility upon request.

Patient Name: _____ DOB: _____

Parent/Guardian Name: _____

Signature: _____ Date: _____

Otolaryngology
Pediatric Otolaryngology
Allergy
Facial Rejuvenation
Audiology
Hearing Testing
Hearing Aid Dispensing

PERMISSION TO TREAT

Peter F. Agnello, M.D.

Otolaryngology
Head & Neck Surgery
Board Certified
American Board of Otolaryngology

I, _____, authorize Tampa Ear, Nose and Throat
(Print name of patient/legal guardian)
Associates and its personnel to provide medical services such as medical examination
and treatment, as they deem best for the patient's physical or mental welfare.

Yoon C. Nofsinger, M.D.

Otolaryngology
Head & Neck Surgery
Allergy
Board Certified
American Board of Otolaryngology
Fellow
American Academy of Otolaryngic Allergy

(Print Patient's Name) *(Date of Birth)* *(Social Security Number)*

I authorize the following person/people to discuss any necessary treatments, medications and to authorize any tests and/or labs that are necessary up to and including admission to the hospital. I authorize the following person/people to bring my child in for treatment and to discuss any necessary treatments, medications and to authorize any tests and/or labs that are necessary up to and including admission to the hospital.

Nalin J. Patel, M.D.

Pediatric Otolaryngology
Laryngology
Voice & Swallowing Disorders
Board Certified
American Board of Otolaryngology

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Janet L. Seper, M.D.

Otolaryngology
Head & Neck Surgery
Facial Rejuvenation
Board Certified
American Board of Otolaryngology

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Amy L. Charrier, Au.D., CCC-A, FAHA

Clinical Audiologist
American Speech, Language & Hearing Association
Fellow American Academy of Audiology
Florida Academy of Audiology

Name: _____ Relationship to Patient: _____

**** All of the above listed will provide identification to be placed in the patient's chart****

Sierra MacDonald, Au.D., CCC-A

Clinical Audiologist
American Speech, Language & Hearing Association

I agree that unless I give specific instructions otherwise, medical information regarding my treatment or my child's treatment may be released to the biological parents, step parents, referring physicians and other practitioners, and my insurance company.

Alyson Hoffman, Sc.D., CCC-A, FAHA

Clinical Audiologist
American Speech, Language & Hearing Association
Fellow American Academy of Audiology

(Signature of Patient/Guardian)

(Date Signed)

Locations

Tampa and Wesley Chapel

Tampa Ear, Nose and Throat Associates
A Division of Select Physicians Alliance, P.L.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Revised as of July 31, 2013

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 or wish to receive additional information about the matters covered by this Notice of Privacy Practices ("Notice"), please contact the Privacy Officer, for Select Physicians Alliance ("SPA") Sheryl A. Watts, COO, at 1149 Nikki View Dr., Brandon, FL 33511 or call: (813) 571-7184.

This Notice is provided to you in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and associated regulations, as may be amended (collectively referred to as "HIPAA") describing SPA's legal duties and privacy practices with respect to your Protected Health Information ("PHI"). SPA is required to abide by the terms of this Notice currently in effect, and may need to revise the Notice from time to time. Any required revisions of this Notice will be effective for all PHI that SPA maintains. A current copy of the Notice will be posted in each office and you may request a paper, or electronic, copy of it.

PHI consists of all individually identifiable information which is created or received by SPA and which relates to your past, present or future physical or mental health condition, the provision of health care to you, or the past, present or future payment for health care provided to you.

USE AND DISCLOSURE OF PHI FOR WHICH YOUR CONSENT OR AUTHORIZATION IS NOT REQUIRED

HIPAA permits SPA to use or disclose your PHI in certain circumstances, which are described below, without your authorization. However, Florida law may not permit the same disclosures. SPA will comply with whichever law is stricter.

1. **Treatment:** SPA may use and disclose your PHI to provide, coordinate or manage your health care and related services, including consulting with other health care providers about your health care or referring you to another health care provider for treatment. For example, SPA may discuss your health information with a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you. Further, SPA may contact you to remind you of a scheduled appointment.
2. **Payment:** SPA may use and disclose your PHI, as needed, to obtain payment for the health care it provides to you. For example, SPA may disclose to a third-party payer the treatment you are going to receive to ensure that the payer will cover that treatment. Additionally, SPA may disclose to a third party payer or grant funding service, as necessary, the type of services you received to reimbursement for your treatment.
3. **Health Care Operations:** SPA may use or disclose your PHI in order to carry out its administrative functions. These activities include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, conducting training programs in which students provide treatment under the supervision of one of SPA's health care professionals, business planning and development, business management and general administrative activities. For example, SPA may disclose your PHI to accreditation agencies reviewing the types of services provided.
4. **Required by Law:** SPA may use or disclose your PHI to the extent that such use or disclosure is required by law.
5. **Public Health:** SPA may disclose your PHI to a public health authority, employer or appropriate governmental authority authorized to receive such information for the purpose of: (a) preventing or controlling disease, injury or disability; reporting disease or injury; conducting public health surveillance, public health investigations and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency in collaboration with a public health authority; or reporting child abuse or neglect; (b) activities related to the quality, safety or effectiveness or activities or products regulated by the Food and Drug Administration; (c) notifying a person who may have been exposed to a communicable disease or may otherwise be at risk of spreading a disease or condition.
6. **Abuse, Neglect or Domestic Violence:** SPA may disclose your PHI to a government authority authorized to receive reports of abuse, neglect or domestic violence if it reasonably believes that you are a victim of abuse, neglect or domestic violence. Any such disclosure will be made: 1) to the extent it is required by law; 2) to the extent that the disclosure is authorized by statute or regulation and SPA believes the disclosure is necessary to prevent serious harm to you or other potential victims; or 3) if you agree to the disclosure.
7. **Health Oversight Activities:** SPA may disclose your PHI to a health oversight agency for any oversight activities authorized by law, including audits; investigations; inspections; licensure or disciplinary actions; civil, criminal or administrative actions or proceedings; or other activities necessary for the oversight of the health care system, government benefit programs, compliance with government regulatory program standards or applicable laws.
8. **Judicial and Administrative Proceedings:** SPA may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process upon receipt of "satisfactory assurance" that you have received notice of the request.
9. **Law Enforcement Purposes:** SPA may disclose limited PHI about you for law enforcement purposes to a law enforcement official: (a) in compliance with a court order, a court-ordered warrant, a subpoena or summons issued by a judicial officer or an administrative request; (b) in response to a request for information for the purposes of identifying or locating a suspect, fugitive, material witness or missing person; (c) in response to a request about an individual that is suspected to be a victim of a crime, if, under limited circumstances, SPA is not able to obtain your consent; (d) if the information relates to a death SPA believes may have resulted from criminal conduct; (e) if the information constitutes evidence of criminal conduct that occurred on the premises of SPA; or (f) in certain emergency circumstances, to alert law enforcement of the commission and nature of a crime, the location and victims of the crime and the identity, or description and location of the perpetrator of the crime.
10. **Coroners, Medical Examiners and Funeral Directors:** SPA may disclose your PHI to a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law. SPA may disclose your PHI to a funeral director, consistent with all applicable laws, in order to allow the funeral director to carry out his or her duties.
11. **Research:** SPA may use or disclose your PHI for research purposes, provided that an institutional review board authorized by law or a privacy board waives the authorization requirement and provided that the researcher makes certain representations regarding the use and protection of the PHI.
12. **Serious Threat to Health or Safety:** SPA may disclose your PHI, in a manner which is consistent with applicable laws and ethical standards, if the disclosure is necessary to prevent or lessen a serious threat to health or safety of a person or the public, or the information is necessary to apprehend an individual.
13. **Specialized Government Functions:** SPA may also disclose your PHI, (a) If you are a member of the United States or foreign Armed Forces, for activities that are deemed necessary by appropriate military command authorities to assure the proper execution of a military mission; (b) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by law; (c) to authorized federal officials for the provision of

protective services to the President, foreign heads of state, or other people authorized by law and to conduct investigations authorized by law; or (d) to a correctional institution or a law enforcement official having lawful custody of you under certain circumstances.

14. **Workers' Compensation:** SPA may disclose your PHI as authorized by, and in compliance with, laws relating to workers' compensation and other similar programs established by law.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

15. If you do not object to the following uses or disclosures of your PHI, SPA may: 1) disclose to a family member, other relative, a close personal friend, or other person identified by you the information relevant to their involvement in your care or payment related to your care; 2) notify others, or assist in the notification, of your location, general condition, or death; or 3) disclose your PHI to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES OF PHI

16. Any use or disclosure of your PHI that is not listed herein will be made only with your written authorization. You have the right to revoke such authorization at any time, provided that the revocation is in writing, except to the extent that: 1) SPA has taken action in reliance on the prior authorization; or 2) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

YOUR RIGHTS REGARDING YOUR PHI

17. **Restriction of Use and Disclosure:** You have the right to request that SPA restrict the PHI it uses and discloses in carrying out treatment, payment and health care operations. You also have the right to request that SPA restrict the PHI it discloses to a family member, other relative or any other person identified by you, which is relevant to such person's involvement in your treatment or payment for your treatment. By law, SPA is not obligated to agree to any restriction that you request. If SPA agrees to a restriction, however, it may only disclose your PHI in accordance with that restriction, unless the information is needed to provide emergency health care to you. If you wish to request a restriction on the use and disclosure of your PHI, please send a written request to the Privacy Officer which specifically sets forth: 1) that you are requesting a restriction on the use or the disclosure of your PHI; 2) what PHI you wish to restrict; and 3) to whom you wish the restrictions to apply (e.g., your spouse). SPA will not ask why you are requesting the restriction. The Privacy Officer will review your request and notify you whether or not SPA will agree to your requested restriction. You also have the right to request to restrict disclosure of your PHI to a health plan, if the disclosure is for payment or health care operations and the disclosure pertains to a health care item or service for which you have paid out of pocket in full.

18. **Marketing and Sale of PHI:** Most uses and disclosures of PHI for marketing and the sale of PHI require your authorization.

19. **Fundraising:** SPA may contact you for purposes of fundraising to support its programs. You have the option to opt-out of this type of communication.

20. **Confidential Communications:** You have the right to receive confidential communications of your PHI. You may request that you receive communications of your PHI from SPA in alternative means or at alternative locations. SPA will accommodate all reasonable requests, but certain conditions may be imposed.

To request that SPA make communications of your PHI by alternative means or at alternative locations, please send a written request to the Privacy Officer setting forth the alternative means by which you wish to receive communications or the alternative location at which you wish to receive such communications. SPA will not ask why you are making such a request.

21. **Access to PHI:** You have the right to inspect and obtain a copy of your PHI maintained by SPA. Under HIPAA, you do not have the right to inspect or copy information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or information that SPA is otherwise prohibited by law from disclosing.

If you wish to inspect or obtain a copy of your PHI, please send a written request to the Privacy Officer. If you request a copy of your PHI, SPA may charge a fee for the cost of copying and mailing the information. You may also request that a copy of your PHI be transmitted to you electronically.

HIPAA permits SPA to deny your request to inspect or obtain a copy of your PHI for certain limited reasons. If access is denied, you may be entitled to a review of that denial. If you receive an access denial and want a review, please contact the Privacy Officer. The Privacy Officer will designate a licensed health care professional to review your request. This reviewing health care professional will not have participated in the original decision to deny your request. SPA will comply with the decision of the reviewing health care professional.

22. **Amending PHI:** You have the right to request that SPA amend your PHI. To request that an amendment be made to your PHI, please send a written request to the Privacy Officer. Your written request must provide a reason that supports the request amendment. SPA may deny your request if it does not contain a reason that supports the requested amendment. Additionally, SPA may deny your request to have your PHI amended if it determines that: 1) the information was not created by SPA and amendment may be made elsewhere; 2) the information is not part of a medical or billing record; 3) the information is not available for your inspection; or 4) the information is accurate and complete.

23. **Notification of Breach:** SPA will notify you following a breach of your PHI as required by law.

24. **Accounting of Disclosure of Your PHI:** You have the right to request a listing of certain disclosure of your PHI made by SPA during the period of up to six (6) years prior to the date on which you make your request. Any accounting you request will not include: 1) disclosures made to carry out treatment, payment or health care operations; 2) disclosures made to you; 3) disclosures made pursuant to an authorization given by you; 4) disclosures made to other people involved in your care or made for notification purposes; 5) disclosures made for national security or intelligence purposes; 6) disclosure made to correctional institutions or law enforcement officials; or 7) disclosures made prior to April 14, 2003. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations set forth in applicable statutes and regulations.

To request an accounting of the disclosures of your PHI, please send a written request to the Privacy Officer. Your written request must set forth the period for which you wish to receive an accounting. SPA will provide one free accounting during each twelve (12) month period. If you request additional accountings during the same twelve (12) month period, you may be charged for all costs incurred in preparing and providing that accounting. SPA will inform you of the fee for each accounting in advance and will allow you to modify or withdraw your request in order to reduce or avoid the fee.

25. **Obtaining a Copy of this Notice:** You have the right to request and receive a paper or electronic copy of this Notice at any time.

COMPLAINTS

26. If you believe that your privacy rights have been violated, you may file a complaint with SPA or with the Secretary of Health and Human Services. To file a complaint with SPA, please contact the Privacy Officer at the address listed on page 1 of this notice. All complaints must be submitted in writing. SPA WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

**Tampa Ear, Nose and Throat Associates
A Division of Select Physicians Alliance, P.L.**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Revised as of July 31, 2013

By law, we are required to make available to you a copy of our Notice of Privacy Practices (“Notice”). By signing below you acknowledge that you received, or been offered and declined, a copy the Notice.

A current copy of the Notice is also posted in the office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time.

You may decline to sign this acknowledgement.

I have received, or declined, a copy of the Notice of Privacy Practices.

Patient Name (Print): _____

Signature of Patient or Legal Representative: _____

If Legal Representative, list Relationship to Patient: _____

Date: _____

For Office Use Only

We were unable to obtain this written acknowledgement because:

Initials: _____

Date: _____

Otolaryngology
 Pediatric Otolaryngology
 Allergy
 Facial Rejuvenation
 Audiology
 Hearing Testing
 Hearing Aid Dispensing

Peter F. Agnello, M.D.
 Otolaryngology
 Head & Neck Surgery
 Board Certified
 American Board of Otolaryngology

Yoon C. Nofsinger, M.D.
 Otolaryngology
 Head & Neck Surgery
 Allergy
 Board Certified
 American Board of Otolaryngology
 Fellow
 American Academy of Otolaryngic Allergy

Nalin J. Patel, M.D.
 Pediatric Otolaryngology
 Laryngology
 Voice & Swallowing Disorders
 Board Certified
 American Board of Otolaryngology

Janet L. Seper, M.D.
 Otolaryngology
 Head & Neck Surgery
 Facial Rejuvenation
 Board Certified
 American Board of Otolaryngology

Amy L. Charrier, Au.D., CCC-A, FAAA
 Clinical Audiologist
 American Speech, Language & Hearing Association
 Fellow American Academy of Audiology
 Florida Academy of Audiology

Sierra MacDonald, Au.D., CCC-A
 Clinical Audiologist
 American Speech, Language & Hearing Association

Alyson Hoffman, Sc.D., CCC-A, FAAA
 Clinical Audiologist
 American Speech, Language & Hearing Association
 Fellow American Academy of Audiology

Locations
 Tampa and Wesley Chapel

DIRECTIONS - TAMPA

Our Tampa office is located at **3000 Medical Park Drive**, Suite 200. From I-275 take exit **52-Fletcher Avenue**, head East. Turn left onto **Bruce B. Downs Blvd.** Take the **second right** onto **Medical Park Drive**. We are located in the **Life Hope Building** facing **Bruce B. Downs Blvd** which is in front of the **Women’s Center** at **Florida Hospital Tampa**.

From I-75 take exit **266-Fletcher Avenue**, head West. Take a right onto **Bruce B. Downs Blvd.** Take the **second right** onto **Medical Park Drive**.

PARKING

Parking is limited around the building; however, there is overflow parking behind the **Life Hope building** next to **Florida Hospital Tampa**. Free parking is also available in the parking garage.

Overflow Parking -

Take **Medical Park Drive** to the stop sign, turn left in front of the new construction for the **Women’s Center**, then take the first right and immediately turn left into the overflow parking area for the **LifeHope Medical Offices** patients.

Take **E 138th Ave**, turn right onto **31st St.** and take the first left and immediately turn left into the overflow parking area for the **LifeHope Medical Offices** patients.

Parking Garage -

Take **Medical Park Drive** to the stop sign, turn right in front of the **Florida Hospital Pepin Heart Institute** and continue until you reach the entrance to the “**Visitor Parking**” garage. The parking is free.

DIRECTIONS - WESLEY CHAPEL

Our Wesley Chapel office is located at **26853 Foggy Creek Road**, Building 21, Suite 101. From I-75 exit onto **State Road 56**, turn left onto **Cypress Ridge Boulevard**, turn right at **Ridge Brook Drive**, and turn right at **Crestover Lane**. The building is around the corner to the left. There is ample parking in the complex.