Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

PATIENT INFORMATION

Patient Name: _____
(Last) (First) (Middle)

Phone: (_____) _____ - _____

SS#: _____ Date of Birth: _____

Guarantor (If patient is a child): _____

FL. Address _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Secondary Address: _____

Marital Status: _____ Drivers License #: _____

Employer: _____ Occupation: _____

Address: _____ Phone: (_____) _____ - _____

Emergency Contact: _____ Phone: (_____) _____ - _____

Contact's Address: _____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

ASSIGNMENT OF BENEFITS

I authorize the release of any payment and medical information necessary to process this claim and related claims. I request payment of benefits to Midway Primary Care, LLC. who accepts assignment of benefits.

_____ _____
Signature of Patient (or Personal Representative) Date

Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. Treatment includes medications currently authorized or approved by the US FDA for treatment of COVID 19 or other emerging communicable respiratory illnesses. Testing includes, but is not limited to physical, radiological, and laboratory testing. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, taking of photographs of my condition and treatment for the condition which has brought me to seek care at this practice.

I consent to allow my laboratory testing specimens (including, but not limited to blood, urine, or sputum samples) to be processed in-house (by MSCC/lab) or sent out to a reference lab as deemed necessary by of Midway Primary Care, LLC. I also understand that my specimens may be used for validation purposes.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient (or Personal Representative)	Date
_____	_____
Printed Name of Patient (or Personal Representative)	Relationship
_____	_____
Printed Name of Witness	Employee Job Title

PRIVACY POLICY ACKNOWLEDGEMENT

Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

I consent to the use and disclosure of my protected health information by Midway Primary Care, LLC. for the purpose of diagnosing or providing treatment to me, obtaining payments for my healthcare bills or to conduct healthcare operations of Midway Primary Care, LLC.. I understand that diagnosis or treatment of me by Midway Primary Care, LLC. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Midway Primary Care, LLC. is not required to agree to the restrictions that I request. However, if Midway Primary Care, LLC. agrees to a restriction that I request, the restriction is binding on Midway Primary Care, LLC..

I have the right to revoke this consent in writing at any time, except to the extent that Midway Primary Care, LLC. has taken action in reliance on this consent.

My “protected health information” means health information including my demographic information collected from me and created or received by my physician, another healthcare provider and health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify.

I understand that I have the right to review Midway Primary Care, LLC.’s Notice of Privacy Practices prior to signing this document. Midway Primary Care, LLC.’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payments of my bills or in performance of healthcare operations of Midway Primary Care, LLC.. The Notice of Privacy Practices for Midway Primary Care, LLC. is also provided at the front waiting area. The Notice of Privacy Practices also describes my rights and Midway Primary Care, LLC.’s duties with respect to my protected health information.

Midway Primary Care, LLC. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient (or Personal Representative) Date

_____ _____

Printed Name of Patient (or Personal Representative) Relationship

Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your healthcare provider. In order to give you and all our patients the best possible care, we request that you review our policy regarding missed appointments. A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24 hours. Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24 hour notice in order to reschedule your appointment. This will enable us to offer your canceled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office in advance in order to avoid a missed appointment fee. This charge is not covered by insurance. Your phone call is critical in helping us provide continuous care to all of our valued patients.

I have read and understand the policy stated above.

_____ _____

Signature of Patient (or Personal Representative) Date

Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Social Security #: _____

I authorize the release of my medical records specifically to include the following:

_____ Complete Medical Records _____ Consultations _____ Other

_____ Lab Reports _____ Medications

This medical record may contain information about drug abuse, substance abuse, mental health treatment and HIV/AIDS information. Separate consent must be given to release this information.

_____ I DO consent to having this information disclosed.

_____ I DO NOT consent to having this information disclosed.

I authorize Midway Primary Care LLC. to release any information regarding my health to the following persons or entities:

Name	Date of Birth	Relationship	Phone Number

The purpose of this request is for diagnosis and treatment.
This authorization will expire 90 days from the date of signing.

I have the right to revoke this authorization at any time in writing except to the extent of information that has already been released.

I have reviewed this authorization. I understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

_____ _____

Signature of Patient (or Personal Representative) Date

_____

Printed Name

MIDWAY PRIMARY CARE CENTER

Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

PRESCRIPTION MEDICATION CONSENT FORM

The providers at Midway Primary Care, LLC. use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescribing connection (RxHub) which improves the timely and secure transmission of your medication information.

To optimize the use of this electronic capability, and coordinate your care between us and your specialists, we ask that patients allow us to access their medication history through RxHub.

Please check only one of the following:

_____ I consent to allow my provider to access all of my medication history.

_____ I consent to allow my provider to access only my medication history for medications prescribed in this office.

_____ I DO NOT consent to my provider accessing any of my medication history.

_____ _____
Signature of Patient Date

_____
Printed Name

PHARMACY INFORMATION

Name: _____ Phone: (_____) _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

HEALTHCARE ADVANCE DIRECTIVES
THE PATIENT'S RIGHT TO DECIDE

All adult individuals in health care facilities such as hospitals, nursing homes, hospices, home health agencies and health maintenance organizations have certain rights under Florida law.

You have a right to fill out a paper known as an Advance Directive. The paper says in advance what kind of treatment you want or do not want under special, serious medical conditions – conditions that would stop you from telling your doctor how you want to be treated. For example, if you were taken to a health care facility in a coma, would you want the facility's staff to know your specific wishes about decisions affecting your treatment?

What is an Advance Directive?

An advance directive is a written or oral statement which is made and witnessed in advance of serious illness or injury, about how you want medical decisions made.

Two forms of advance directives are:

- A Living Will and
- A Health Care Surrogate Designation

An advance directive allows you to state your choice about health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. An advance directive can enable you to make decisions about your future medical treatment.

What is a Living Will?

A Living Will generally states the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes affect while you are still living. Florida law provides a suggested form for a living will. You may use it or some other form. You may wish to speak to an attorney or physician to be certain you have completed the living will in a way so that your wishes will be understood.

What is a Health Care Surrogate Designation?

A Health Care Surrogate Designation is a signed, dated and witnessed paper naming another person such as a husband, wife, daughter, son or close friend as your agent to make medical decisions for you, if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid. Florida law provides a suggested form for designation of a health care surrogate. You may use it or some other form. You may wish to name a second person to stand in for you, if your first choice is not available.

Which is better?

You may wish to have both or combine them into a single document that describes treatment choices in a variety of situations and names someone to make decisions for you should you be unable to make decisions for yourself.
(Continued)

Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

Do I have to write an Advance Directive under Florida Law?

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive or designated a health care surrogate, health care decisions may be made for you by a court-appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative, or a close friend in that order. This person would be called a proxy.

Can I change my mind after I write a Living Will or designate a Health Care Surrogate?

Yes, you may change or cancel these documents at any time. Any changes should be written, signed and witnessed. You can also change an advance directive by verbal statement.

What if I have filled out an Advance Directive in another state and need treatment in a health care facility in Florida?

An advance directive completed in another state, in compliance with the other state's law, can be honored in Florida.

What should I do with my Advance Directive if I choose to have one?

Make sure that someone such as your doctor, lawyer or family members know that you have an advance directive and where it is located.

Consider the following:

- If designating a health care surrogate, give a copy of the written designation form or the original to the person.
- Give a copy of your advance directive to your doctor for your medical file.
- Keep a copy of your advance directive in a place where it can be found easily.
- Keep a note in your purse of wallet which states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your doctor, lawyer and/or family member has the latest copy.

For further information, ask those in charge of your care.

_____ I HAVE read and understand the above information.

_____ I HAVE executed an advance directive.

_____ I HAVE NOT executed an advance directive.

_____ I understand that provision of medical care to me will not be based on whether or not I have executed an advance directive.

_____ _____

Signature of Patient Date

_____ _____

Printed Name of Witness Employee Job Title

MIDWAY PRIMARY CARE CENTER

Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

MEDICATION LIST

Patient Name: _____ Date of Birth: _____

Medication Name	Dosage

NOTE: PLEASE BRING ALL MEDICATION BOTTLES ON YOUR FIRST VISIT.

MEDICAL HISTORY

Patient Name: _____ Date of Visit: _____

☐ ANEMIA	☐ DIVERTICULITIS	☐ HEPATITIS / LIVER	☐ SUICIDE ATTEMPT
☐ ASTHMA	☐ EMPHYSEMA / COPD	☐ HIGH CHOLESTEROL	☐ THYROID PROBLEMS
☐ ANXIETY	☐ EPILEPSY / SEIZURES	☐ BLOOD PRESSURE	☐ OTHER_____
☐ CANCER:_____	☐ GERD / PEPTIC ULCERS	☐ KIDNEY PROBLEMS	_____
☐ DIABETES TYPE I/II	☐ GOUT	☐ PNEUMONIA	☐ OTHER_____
☐ DEPRESSION	☐ HEART DISEASES / MI	☐ STROKE / TIA	_____

SURGERIES

☐ CHECK HERE IF NO SURGERY HISTORY

- ☐ APPENDECTOMY
- ☐ C-SECTION #_____
- ☐ GALLBLADDER REMOVAL
- ☐ GASTRIC BYPASS / BANDING
- ☐ HERNIA REPAIR: _____
- ☐ HYSTERECTOMY (PARTIAL / TOTAL)
- ☐ ORTHO SURGERY:_____
- ☐ TONSILLECTOMY
- ☐ OTHER: _____
- ☐ OTHER: _____

HOSPITALIZATIONS

☐ CHECK HERE IF NO HOSPITAL HISTORY

_____

_____

_____

_____

_____

FAMILY HISTORY

☐ CHECK HERE IF UNKNOWN OR ADOPTED

DAUGHTER:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
FATHER:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
SON:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
SPOUSE:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
MOTHER:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
PATERNAL GF:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
PATERNAL GM:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
MATERNAL GF:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
MATERNAL GM:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
OTHER:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
SIBLINGS? NO / YES →	NUMBER OF SIBLINGS: _____ SISTER(S) _____ BROTHER(S)					
CHILDREN? NO / YES →	NUMBER OF CHILDREN: _____ DAUGHTER(S) _____ SON(S)					

SOCIAL HISTORY

MARITAL STATUS:	SINGLE	MARRIED	SEPERATED	DIVORCED	WIDOWED
RELATIONSHIP:	HAPPY	SATISFIED	AVERAGE	NOT HAPPY	UNSTABLE
STRESS LEVEL:	NONE	MILD	MODERATE	HIGH	VERY HIGH
ALCOHOL USE:	NONE	SOCIALLY	WITH DINNER	HABITUALLY	QUIT: _____ YR
TOBACCO USE:	NEVER	QUIT: ___ YR AGO	CURRENT: #_____ PER DAY	FOR # YEARS: _____	
AEROBIC EXERCISE:	NONE	OCCASIONALLY	1-2 TIMES WEEK	3-4 TIMES WEEK	5-6 TIMES WEEK
STRENGTH TRAINING:	NONE	OCCASIONALLY	1-2 TIMES WEEK	3-4 TIMES WEEK	5-6 TIMES WEEK
VEGETABLE INTAKE:	NONE	1 SERVING/DAY	2 SERVINGS/DAY	3 SERVINGS/DAY	4+ SERVINGS/DAY
FRUIT INTAKE:	NONE	1 SERVING/DAY	2 SERVINGS/DAY	3 SERVINGS/DAY	4+ SERVINGS/DAY
MEAT INTAKE:	NONE	1 SERVING/DAY	2 SERVINGS/DAY	3 SERVINGS/DAY	4+ SERVINGS/DAY
FAST FOOD:	NEVER	1-2 PER WEEK	3-4 PER WEEK	1-2 PER MONTH	3-4 PER MONTH

REVIEW OF SYMPTOMS

Patient Name: _____ Date of Visit: _____

Please check any symptoms that you experience. For any checks, please provide a brief description.

CONSTITUTIONAL	GASTROINTESTINAL
☐ WEIGHT LOSS / GAIN - HOW MANY POUNDS?	☐ ABDOMINAL PAIN
☐ WEAKNESS	☐ BLOATING / GAS
☐ LOSS OF APPETITE	☐ BLOOD IN STOOL
☐ FEVER / CHILLS	☐ CONSTIPATION - # OF BOWEL MOVEMENTS:
☐ EXCESS FATIGUE – HOW LONG?	☐ DIARRHEA
☐ INSOMNIA / LIGHT SLEEP	☐ HEARTBURN
ALLERGIES	☐ DIFFICULTIES SWALLOWING
☐ ITCHY EYES	☐ RECTAL BLEEDING
☐ RUNNY NOSE	**HEMATOLOGY / LYMPHATICS**
☐ SINUS CONGESTION – SEASONAL? Y / N	☐ EASY BRUISING
☐ SCRATCHY THROAT	☐ SWOLLEN GLANDS
EYES / EAR / NOSE / THROAT	**DERMATOLOGY**
☐ BLURRY VISION	☐ RASH
☐ EYE DRAINAGE	☐ DRY SKIN
☐ LOSS OF VISION – OPHTHALMOLOGY EVAL? Y / N	☐ ACNE
☐ HEADACHES / MIGRAINES	☐ WRINKLES
☐ COUGH	☐ ITCHING
☐ SORE THROAT / HOARSENESS	☐ PIGMENTATION / SCARRING
☐ GERD	☐ EXCESSIVE / ABNORMAL HAIR GROWTH
☐ RINGING IN EARS	**PSYCHOLOGY**
☐ HEARING LOSS	☐ DEPRESSED
CARDIOVASCULAR	☐ FEELING ON EDGE / STRESSED
☐ CHEST PAIN: HISTORY OF MI OR HEART DISEASE	☐ NERVOUSNESS
☐ PALPITATION	☐ THOUGHTS OF SUICIDE – ATTEMPTED? Y / N
☐ DIZZINESS	☐ ANXIOUS
☐ LEG SWELLING	**ENDOCRINE**
☐ PAIN IN LEGS WHILE WALKING	☐ INTOLERANCE TO COLD / HOT
RESPIRATORY	☐ EXCESSIVE THIRST – # OF GLASSES PER DAY:
☐ SHORTNESS OF BREATH	☐ HAIR LOSS
☐ WHEEZING	☐ SWEATING
☐ COUGHING	☐ CHANGE IN APPETITE
☐ PAINFUL BREATHING	**UROLOGY**
MUSCULOSKELETAL	☐ FREQUENCY – HOW OFTEN PER DAY?
☐ MUSCLE / JOINT PAIN	☐ BLOOD IN URINE
☐ STIFFNESS	☐ DIFFICULTY OR PAINFUL WHEN URINATING
☐ LOSS OF RANGE OF MOTION	☐ INCONTINENCE
☐ MUSCLE CRAMPS	☐ CHANGES IN URINARY STRENGTH
NEUROLOGY	**HORMONAL**
☐ LOSS OF MEMORY	☐ DECREASED LIBIDO
☐ NUMBNESS / TINGLING	☐ DIFFICULTY WITH EJACULATION / ERECTIONS
☐ PARALYSIS	☐ ABNORMAL VAGINAL BLEEDING – MENOPAUSAL? Y / N
☐ GAIT ABNORMALITY	☐ HOT FLASHES
☐ CONCENTRATION	☐ PRE-MENSTRUAL SYMPTOMS
☐ SEIZURES	☐ VAGINAL DRYNESS
☐ DIZZINESS / FAINTING	☐ BREAST PAIN / DISCHARGE / LUMP

PATIENT HEALTH QUESTIONNAIRE-2 (PHQ-2)

Patient Name: _____ Date of Visit: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Patient Name: _____ Date of Visit: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
FOR OFFICE CODING	0 + _____ + _____ + _____			
TOTAL SCORE				

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
☐	☐	☐	☐

Patient Signature: _____

Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain regarding health information we created or received before we make the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with

MIDWAY PRIMARY CARE CENTER

Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such As voicemail messages, postcards, or letters).

PATIENT RIGHTS Access: We have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12- month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Midway Primary Care, L.L.C.
Suzan E. Zimmer, D.O.
Tracy Britcher, ARNP
Suzanne Runge, ARNP

3255 S US Hwy 1
Fort Pierce, FL 34982
Phone: (772) 742-9270
Fax: (855) 531-6012

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information, if in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative mean(s) or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to privacy of your health information. We will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Anand Sukhram

Telephone: (772) 464-9746

Fax: (772) 464-9750

Address: 356 E Midway Road
Fort Pierce, FL 34982