

PATIENT INFORMATION				
Last Name:		First Name:		Middle Initial:
Preferred Name:		Date of Birth:		Social Security Number:
Address:		City:	State:	ZIP Code: County:
Home Phone:		Cell Phone:		E-mail Address:
Sex at Birth (Check One) ☐ Male ☐ Female		Gender (Check One) ☐ Male ☐ Female ☐ Other ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Choose Not to Answer		
Race (Check One) ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ American Indian/Alaska Native			Ethnicity (Check One) ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	
			Primary Language Spoken:	
Are you or a family member a migrant worker? ☐ Yes ☐ No			Do you need an interpreter? ☐ Yes ☐ No	
Marital Status (Check One) ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Unknown			U.S. Military Service (Check One) ☐ None ☐ Currently Serving ☐ Discharged	
Current Living Arrangements (Check One) ☐ Own Home ☐ Rent ☐ Live with Family/Friends ☐ Homeless ☐ Other Housing Arrangements ☐ Unstable/Unsure				
Advance Directives I understand that I have the right to have an advance directive. ☐ I currently have an advance directive: (If check, select all that apply below) ☐ Living Will ☐ Health Care Surrogate ☐ Durable Power of Attorney for Health Care ☐ I do not have or want an advance directive. ☐ I would like more information regarding advance directives. We encourage all patients to complete an advance directive, which allows you to state your preferences for medical treatments and to select an agent or person to make your health care decisions in case you are unable to do so or if you want someone else to make decisions for you. <i>If you already have an advance directive, please bring a copy with you at your next visit.</i> Your advance directive will be placed in your medical record. Further information on advance directives is available on our website: http://walton.floridahealth.gov				

DOH-Walton and the Walton Community Health Center does not deny anyone services because of race, national origin, skin color, religion, sexual orientation, physical handicap, disability, source of payment, or the inability to pay and uses recent Federal Poverty Guidelines to establish a sliding fee scale for eligible low-income patients. If you would like to apply for our Sliding Fee, please make sure to complete the other side of this form.

Signature of Client or Parent/Guardian

Employee Signature

Date

PATIENT ACCOUNT INFORMATION <i>Person Responsible for Payment</i>				
Last Name:	First Name:		Middle Initial:	
Preferred Name:	Date of Birth:		Social Security Number:	
Address:	City:	State:	ZIP Code:	County:
Home Phone:	Cell Phone:		E-mail Address:	
INSURANCE INFORMATION				
Name of Insurance Company:	Policy Number:		Group Number:	
Name of the Card Holder (Insured):				
Do you have insurance that covers your health or dental condition? ☐ Yes ☐ No				

I understand that I will be assigned to the full fee category and that I am responsible for any charges denied or not paid by my insurance. I also authorize the payment of medical benefits to the Florida Department of Health in Walton County. Payment is due at the time services are rendered, unless prior arrangements have been made. Past due accounts may be referred to a collection agency.

Signature of Client or Parent/Guardian		Employee Signature		Date
EMPLOYMENT				
Employment Status ☐ Employed ☐ Not Employed		Employer:		
		Start Date:		
SLIDING FEE DISCOUNT PROGRAM				
☐ DECLINED AT THIS TIME. For required Federal Reporting on our patient demographics provide the below information: Family size consists of _____ members and our estimated annual income before taxes is \$ _____.				
☐ APPLYING for Sliding Fee Discount Program by completing the below section. Enter income for your complete household or family unit. List each family member in household and include ALL types of income. Documentation will have to be provided in order to complete sliding fee determination.				
Name	Date of Birth	Relationship	Place of Employment or Other Source of Income	Income Before Taxes or Deductions
1.				\$ WK BW MO
2.				\$ WK BW MO
3.				\$ WK BW MO
4.				\$ WK BW MO
5.				\$ WK BW MO
6.				\$ WK BW MO
Do you pay child support? ☐ No ☐ Yes – If “yes”, how much a month? \$ _____				
Do you pay for childcare? ☐ No ☐ Yes – If “yes”, how much a month? \$ _____				
I was provided a copy of the Primary Care/Family Planning Services Information Sheet on _____.				
Patient Initials _____		Interview Clerk Initials _____		



INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: Walton County Health Dept

Agency Address: _____

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

By initialing this line, I acknowledge that I have been provided with a Telehealth Informed Consent Informational Sheet and that I consent to the provision of some services to be provided by means of telehealth. I may withdraw my consent at any time by discontinuing the use of telehealth services without affecting my right to future care or treatment.

PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations. Additionally, I consent to my health information being shared in the Health Information Exchange (HIE), allowing access by participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. If you choose not to share your information in the HIE, you may opt out by requesting and signing an HIE Opt-Out form.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

Client/Representative Signature

Self or Representative's Relationship to Client

Date

Witness (optional)

Date

PART VII WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____
Client/Representative Signature Date

Mission:

To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.



Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the Healthiest State in the Nation

BROKEN APPOINTMENT & NO-SHOW POLICY

The Florida Department of Health (FDOH) in Walton County and Walton Community Health Center (WCHC) aim to deliver high quality, patient-centered care to our clients. When clients arrive late or miss appointments this negatively impacts our ability to accomplish this goal for all our clients. Due to an increasing number of broken appointments and no shows, we have established a new "Broken Appointment & No-Show Policy", to be effective immediately, for all medical and dental clinics.

It is the responsibility of the client or legal guardian, in the case of a minor child, to notify the FDOH or WCHC at least 24 hours prior to a scheduled appointment if the client is unable to arrive on time for an appointment. Appointments cancelled at least 3 hours before the scheduled appointment time will not be considered a no-show. If a client has two or more no-shows or broken appointments without proper notice, the client will no longer be offered pre-booked appointments for up to one year and will be only offered to come in as a walk-in patient. We cannot guarantee that there will be a walk-in appointment available on a given day, as priority will be given to clients with on-time and scheduled appointments.

All clients are required to arrive on time for their scheduled appointment. Every effort will be made when time permits to contact clients to remind them of their appointment. It is the responsibility of the client to notify FDOH or WCHC staff of current contact information for this purpose.

A grace period of up to 10 minutes will be issued for each scheduled appointment. Once the 10-minute grace period has expired, the client will be asked to reschedule or will be offered to wait as a walk-in client. We cannot guarantee that there will be a walk-in appointment available on a given day, as priority will be given to clients with on-time and scheduled appointments.

By signing below, you acknowledge that you have read and understand the above statement and that every effort will be made to contact the FDOH or WCHC Medical or Dental clinic staff when you are unable to keep your appointment.

Signature: _____

Date: _____

Witness: _____

Date: _____

Updated 10/16/2023



Mission:

To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.



Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the Healthiest State in the Nation

POLÍTICA DE CITAS CANCELADAS Y FALTAS

El Departamento de Salud de Florida (FDOH) en el condado de Walton y Walton Community Health Center (WCHC) tienen como objetivo dar a nuestros clientes una atención de alta calidad centrada en el paciente. Cuando los clientes llegan tarde o faltan a sus citas, esto afecta negativamente nuestra capacidad de lograr este objetivo para todos nuestros clientes. Debido al aumento del número de citas canceladas y faltas, establecimos una nueva "Política de citas canceladas y faltas", que entrará en vigor inmediatamente, para todas las clínicas médicas y dentales.

Es responsabilidad del cliente o del tutor legal, en el caso de un menor de edad, avisar al FDOH o a WCHC al menos 24 horas antes de una cita programada si el cliente no puede llegar a tiempo. Las citas canceladas al menos 3 horas antes de la hora programada no se considerarán como una falta. Si un cliente tiene dos o más faltas o citas canceladas sin el debido aviso, ya no se le darán citas previas hasta después de un año y solo podrá ir como paciente sin cita previa. No podemos garantizar que haya una consulta sin cita disponible en un día determinado, ya que se dará prioridad a los clientes con citas a tiempo y programadas.

Todos los clientes deben llegar a tiempo a su cita programada. Se hará todo lo posible para contactar con los clientes para recordarles su cita, cuando el tiempo lo permita. Es responsabilidad del cliente avisar al personal del FDOH o de WCHC la información de contacto actual para esto.

Se dará un período de gracia de hasta 10 minutos para cada cita programada. Una vez que el período de gracia de 10 minutos termine, se le pedirá al cliente que cambie la cita o se le dará la opción de esperar como cliente sin cita previa. No podemos garantizar que haya una consulta sin cita disponible en un día determinado, ya que se dará prioridad a los clientes con citas a tiempo y programadas.

Firmando abajo, usted reconoce que ha leído y entendido la declaración de arriba y que se hará todo lo posible para contactar al personal de la clínica médica o dental del FDOH o de WCHC cuando no pueda ir a su cita.

Firma: _____

Fecha: _____

Testigo: _____

Fecha: _____

Updated 10/16/2023



Thank you for selecting us as your medical home. We strive to provide all our patients with safe, caring, and comprehensive health care on a personal level to meet your and your family's health goals. This Patient-Centered Medical Home (PCMH) approach, along with evidence-based clinical practice, guide us to coordinate your health care needs in a way that will inspire you to achieve a longer and more fulfilling life. The information that follows are facts about our programs and services you may need to know.

HOURS OF OPERATION - *May vary on the last Wednesday of the month and according to nationally recognized holidays*

- DeFuniak Springs clinic hours are from 7 a.m. to 5 p.m., Monday through Friday.
- Coastal Branch clinic hours are from 7 a.m. to 5 p.m., Monday through Thursday. Closed from noon to 12:30 p.m. for lunch.
- Paxton Branch clinic hours are from 7 a.m. to 5 p.m., Tuesday through Friday. Closed from noon to 12:30 p.m. for lunch.
- Please arrive at the time you are given or you may be asked to reschedule for another day.
- Appointments must be cancelled 24-hours prior to scheduled appointment time. If a patient has two or more no-shows or unkept appointments, they will no longer be offered pre-booked appointments for up to one year and will only be able to come in as a walk-in patient (See Broken Appointment and No-Show Policy).
- After-hours coverage is available. Call 850-892-8015 and follow the automatic assist prompts.

MEDICATIONS

Please know your health care provider **does not prescribe chronic narcotics** and have a limited ability to prescribe other controlled substances.

The Drug Assistance Program (DAP) is available to help eligible patients pay for some medications. Ask your provider about DAP and a referral, if needed.

NON-DISCRIMINATION POLICY

We do not deny anyone services because of race, national origin, skin color, religion, sexual orientation, physical handicap, disability, source of payment, or the inability to pay. Federal Poverty Guidelines are used to establish a sliding fee scale for eligible low-income patients.

WELCOME!

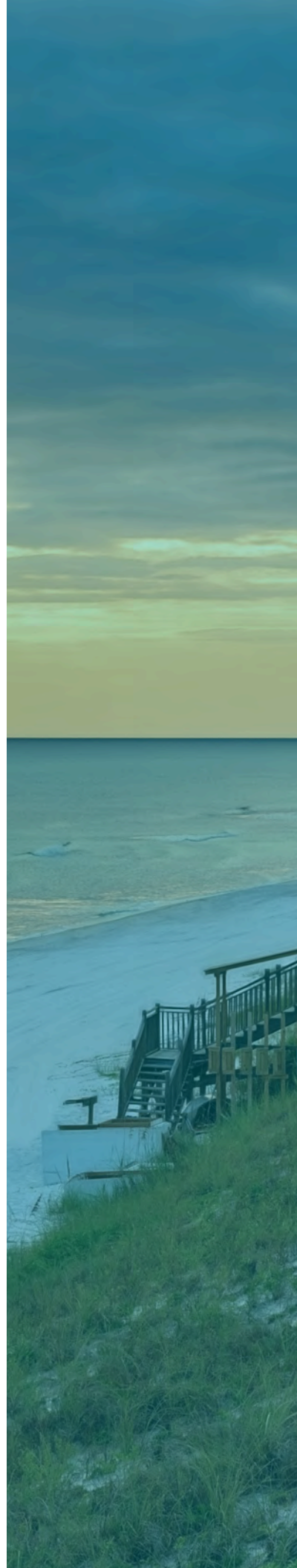
PAYMENT FOR SERVICES PROVIDED

- The Primary Care, Behavioral Health, and Dental services that we provide are contingent on the continuation of federal funding.
- We do not refuse treatment to anyone because of their inability to pay at time of service. We do ask that you have your account in good standing. This helps us continue to provide services to the community. If you are unable to make payment, you must set up a payment plan with us. If you wish to set up a plan, please call 850-892-8015.
- Our Sliding Fee Discount Program is available to eligible patients based on their ability to pay. Proof of income is required to determine eligibility. Ability to pay is determined by the household size and annual income relative to a discount schedule based on federal poverty income guidelines. Copies of the Sliding Fee Discount Schedule are available upon request.
- Patients will be billed according to their sliding scale fee for in-house labs.
- If you have insurance coverage for labs, your insurance information will be sent to Quest labs and billed to you by Quest labs. If your insurance prefers your labs be done by another provider (i.e., LabCorp), please remember it is your responsibility to inform us of your alternate network lab at the time of lab collection.
- Self-pay patients for Primary Care Services are responsible for a nominal fee of \$15.00 for each visit. There is a nominal fee of \$10.00 per visit for Behavioral Health Services.
- Co-pays assigned by commercial insurance companies are billed after your clinic visit. We will gladly file your insurance for you and attempt to obtain payment; however, you may be responsible for a portion of the bill. Claims (bills) not paid by the insurance company after 180 days (6 months) may become your responsibility.
- If you are referred to another medical facility, you are responsible for arranging payment for the services you receive from them. Some facilities have discount programs that you may be eligible for. You are encouraged to contact the facility prior to your first appointment to inquire about options available to you.

Thanks for letting our family take care of yours!

**Florida
HEALTH**

WALT  **N**
COMMUNITY HEALTH CENTER
Caring for the Entire Family





NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic, social and behavioral determinants of health (SBDOH), and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, Social Security number and any other means of identifying you as a specific person. SBDOH may include, but not be limited to, income, food insecurity, socioeconomic status, education level, homeless. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health (Department) can act as each of the above business types. This medical information is used by the Department in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department may use or disclose your health information for case management and services. The Department clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you.

Your information may be used by certain Department personnel to improve the Department's health care operations. The Department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the Department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the Florida Legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals*.
- District medical examiner investigations*.
- Research approved by the Department.
- Court orders, warrants, or subpoenas.*
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings*.

*A disclosure of reproductive health records by the Department to law enforcement, a judicial or administrative tribunal, medical examiner, or health oversight entity will require an attestation by

the requesting individual or entity before such records are released by the Department. The attestation requires acknowledgment of one of the following provisions:

- The purpose of the use or disclosure of protected health information is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes; or alternatively,
- The purpose of the use or disclosure of protected health information is to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was not lawful under the circumstances in which it was provided.

Other uses and disclosures of your protected health information by the Department will require your written authorization. These uses and disclosures may be for marketing or research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in compensation to the Department,

This authorization will have an expiration date that can be revoked by you in writing.

INDIVIDUAL RIGHTS

You have the right to request that the Department restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The Department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where the Department may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by the Department within 30 days of the Department's receipt of your request to obtain a copy of your protected health information. You must complete the Department's Authorization to Disclose Confidential Information form and submit the request to the local county health department or Children's Medical Services office. If there are delays in the Department's ability to provide the information to you within 30 days, you will be told the reason for the delay and the anticipated date your request can be fulfilled.

Your inspection of the information will be supervised at an appointed time and place. You may be denied access to some records as specified by federal or state law.

If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If the Department cannot produce it in that form or format, you will be given the information in a readable hard copy form or another form or format that you and the Department agree to.

The Department cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time, the Department is not required to keep the record and the information may no longer be available.

If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the Department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the Department.
- Is not protected health information.
- Is, by law, not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the Department will make the correction and inform you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The Department may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled persons.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail, text, or call you with health care appointment reminders.

PARTICIPATION IN THE HEALTH INFORMATION EXCHANGE NETWORK

Access to information about your health history, societal and behavioral factors, and medical care is critical to help ensure that you receive high-quality care and gives your health care provider a more complete picture of your overall health. This can help your provider make informed decisions about your care. The information may also prevent you from having repeat tests, saving you time, money, and worry. Recent advancements in technology now support the safe and secure electronic exchange of important clinical information from one health care provider to another through Health Information Exchange (HIE) networks. The Department and its county health departments participate in an HIE network and also participate in several HIE

networks with trusted outside health care providers to quickly and securely share your health information electronically among a network of health care providers, including physicians, hospitals, laboratories and pharmacies. Your health information is transmitted securely and only authorized health care providers with a valid reason may access your information. By sharing information electronically through a secure system, the risk that your paper or faxed records may be misused or misplaced is reduced.

Participation in HIE is completely your choice.

Choice 1. YES to HIE participation. If you agree to have your medical information shared through HIE and you have a current Initiation of Services form on file, you need not do anything. By signing that form, you have granted the Department permission to share your health information through the HIE.

Choice 2. NO to HIE participation. You can choose to not have your information shared electronically through the HIE network (opt out) at any time, by completing the Health Information Exchange Opt-Out Form available at the county health department. If you decide to opt out of HIE, health care providers will not be able to access your health information through HIE. You should understand that if you opt out, the health care providers treating you are still permitted to contact the Department to ask that your health information be shared with them as stated in this Notice of Privacy Practices. Opting out does not prevent information from being shared between members of your care team. Please note, opting out does not affect health information that was disclosed through HIE prior to the time you opted out.

Choice 3. You may change your mind at any time.

You may consent today to the sharing of your information via HIE and change your mind later by following the instructions on the opt out form described under Choice 2.

Alternatively, you may opt out of HIE today and change your mind later by submitting the Department's Revocation of HIE Opt Out Request Form.

PERSONAL HEALTH RECORDS (PHR) MOBILE APPLICATION SYNCHRONIZATION WITH USER DATA

As part of the services provided by the Department, you can download the companion PHR mobile application to access your personal health records. This application is the mobile version of the Florida Health Connect portal.

The purpose of the PHR mobile application is to provide you with access to your health information through your mobile device. You can synchronize your Florida Health Connect account through the mobile application with your personal health information captured on your mobile device (Google Fit or Apple Health) to provide you with a 360 degree view of your health history and current health status.

Your Google Fit or Apple Health information will not be disclosed to any third parties without your express written permission.

.

DEPARTMENT OF HEALTH DUTIES

The Department is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the Department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The Department has

the responsibility to notify you following a breach of your unsecured protected health information.

As part of the Department's legal duties, this Notice of Privacy Practices must be given to you. The Department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department may change the terms of its notice. The change, if made, will be effective for all protected health information maintained by the Department. New or revised Notices of Privacy Practices and all forms referenced in this Notice of Privacy Practices may be accessed on the Department's website at <https://www.floridahealth.gov/about/patient-rights-and-safety/hipaa/index.html> and will be available by email and at all Department of Health locations. Also available are additional documents that further explain your rights to inspect, copy, or amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning February 25, 2025, and shall remain in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002).

HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).

45 CFR Parts 160 and 164 RIN 0945-AA20, April 26, 2024.

No Surprises: What's a good faith estimate?

If you don't have health insurance or you plan to pay for health care bills yourself, generally, health care providers and facilities must give you an estimate of expected charges when you schedule an appointment for a health care item or service, or if you ask for an estimate. This is called a "good faith estimate."

A good faith estimate isn't a bill

The good faith estimate shows the list of expected charges for items or services from your provider or facility. Because the good faith estimate is based on information known at the time your provider or facility creates the estimate, it won't include any unknown or unexpected costs that may be added during your treatment. Generally, the good faith estimate must include expected charges for:

- The primary item or service
- Any other items or services you're reasonably expected to get as part of the primary item or service for that period of care.

The estimate might not include every item or service you get from another provider or facility, even if some items or services may seem connected to the same service. For example, if you're getting surgery, the good faith estimate could include the cost of the surgery, anesthesia, any lab services, or tests.

In some cases, items or services related to the surgery **that are scheduled separately**, like certain pre-surgery appointments or physical therapy in the weeks after the surgery, might not be included in the good faith estimate. You'll get a separate good faith estimate when you schedule those items or services with the provider or facility, or if you ask for it.

Your right to a good faith estimate

Providers and facilities must give you the good faith estimate:

- After you schedule a health care item or service. If you schedule an item or service at least 3 business days before the date you'll get the item or service, the provider must give you a good faith estimate no later than 1 business day after scheduling. If you schedule the item or service OR ask for cost information about it at least 10 business days before the date you get the item or service, the provider or facility must give you a good faith estimate no later than 3 business days after you schedule or ask for the estimate.
- That includes a list of each item or service (with the provider or facility), and specific details, like the health care service code.
- In a way that's accessible to you, like in large print, Braille, audio files, or other forms of communication.

Providers and facilities must also explain the good faith estimate to you over the phone or in person if you ask, then follow up with a written (paper or electronic) estimate, per your preferred form of communication.

Keep the estimate in a safe place so you can compare it to any bills you get later. After you get a bill for the items or services, if the billed amount is \$400 or more above the good faith estimate, you may be eligible to [dispute the bill](#).

For more information, review an [example of what a good faith estimate may include \(PDF\)](#) and [examples of good faith estimates that do and don't qualify for the dispute process \(PDF\)](#).

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.