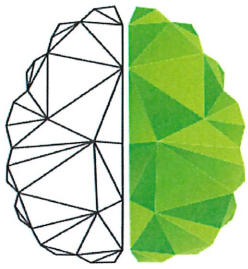


# THOMAS A. DIGERONIMO, M.D., P.A.

## NEUROLOGY

Plant City – 3302 West Baker Street, Plant City, Florida 33563
Riverview – 13117 Elk Mountain Drive, Riverview, Florida 33579
Wesley Chapel – 2106 Ashley Oaks Circle Suite 101, Wesley Chapel, Florida 33544

**Dear**

Welcome to our Neurology office. Enclosed is your appointment card. **Please complete the enclosed forms and bring them to your appointment.** Two days prior to your appointment, you will receive an automated reminder call. **Listen to the entire message and press 1 to confirm your appointment.** Be sure to give us your correct cell phone number and email address so that we can send you appointment reminders.

**ALSO REQUIRED FOR YOUR VISIT: Photo ID, Insurance Cards, Medical Records, Medication List, Referrals, Co-Pays and Deductibles. We accept cash and credit card ONLY.**

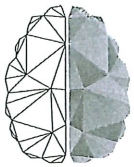
If you are unable to keep your appointment, **we require a 24-hour notice** and if you fail to do so you will be assessed a fee of **$25.00.** This fee must be paid prior to your next visit.

We are affiliated with most major insurance plans; however, there are some that we are unable to accept. **CALL YOUR INSURANCE COMPANY TO BE CERTAIN BEFORE YOU ARRIVE AT OUR OFFICE.**

REFERRALS: Your insurance company requires YOU to get your referrals; **IT IS YOUR RESPONSIBILITY.** Referrals must be received by us 24 hours prior to your appointment. **Without a referral, your appointment will have to be rescheduled. We cannot call your doctor on the day of your visit to request a referral for you.**

Patient Signature: _____

Date: _____



# THOMAS A. DIGERONIMO, M.D., P.A.

NEUROLOGY

3302 West Baker Street – Plant City, FL 33563
Phone - (813) 752-1336 Fax (813) 754-6914

## DEMOGRAPHICS

| | | |
|---|---|---|
| Last Name: | First Name: | Middle Name: |
| Date of Birth: | SSN: | Biological Gender: |
| Home Phone: | Cell Phone: | Work Phone: |
| Street Address: | | City, St, Zip: |
| Emergency Contact: | | Phone: |
| Your email: | | |
| Referring Provider/Family Doctor: | | |

## INSURANCE INFORMATION

| | |
|---|---|
| Primary Policy Holder: | Relationship to Patient: |
| Primary Holder SSN: | Primary Holder DOB: |

## PARENT/GUARDIAN INFORMATION (APPLIES TO PATIENTS UNDER 18)

| | | |
|---|---|---|
| Name: | DOB: | SSN: |
| Street Address: | | City, St, Zip: |
| Home Phone: | Cell Phone: | Work Phone: |

## COMPLETE THIS SECTION IF YOU ARE BEING SEEN FOR A WORKER'S COMPENSATION INJURY, OR FOR A MOTOR VEHICLE ACCIDENT

Circle which you are being seen for: Worker's Compensation or Motor Vehicle Accident

| | | |
|---|---|---|
| Insurance: | Date of Accident: | Claim #: |
| Claim Billing Address: | | City, St, Zip: |
| Adjuster: | | Adjuster Phone: |

## HEALTH HISTORY AND VISIT INFORMATION

What Condition Will You Be Treated For Today? _____

| | |
|---|---|
| What Pharmacy do you use? | Pharmacy Phone: |
| Pharmacy City and Road: | |
| What Lab do you prefer (for instance, Lab Corps, Quest)? | |

What is your religious preference?

What is your marital status?

What is your race?

What is your occupation?

What is your native language?

Do you have an advanced directive or a living will?

## Surgical History

Please list all of the surgeries you have had, and the year if you know it:

## Personal Health History

Please circle any condition you have been diagnosed with.

| | | | |
|---|---|---|---|
| Allergies | Congestive Heart Failure | Hepatitis A B C | Spinal Cord Injury |
| Alzheimer's | COPD | High Cholesterol | Osteoarthritis |
| Anemia | Cancer: _____ | High Blood Pressure | Osteopenia/Osteoporosis |
| Aneurysm | Cerebral Palsy | High Thyroid (Hyper) | PTSD |
| Anxiety | Depression | Low Thyroid (Hypo) | Parkinson's Disease |
| Arthritis | Developmental Delays | Joint Pain | Peripheral Neuropathy |
| Asthma | Diabetes | Kidney Problems | Restless Leg Syndrome |
| Atrial Fibrillation | Epilepsy/Seizures | Liver Problems | Rheumatoid Arthritis |
| Auto-Immune Disease | Fibromyalgia | Lung Problems | Stroke |
| Back Problems | Fractures: _____ | Lupus | TIA (Mini-Stroke) |
| Bipolar | Acid Reflux/Heartburn | MRSA | Tuberculosis |
| Bleeding Disorders | Stomach Problems | Migraine Headaches | Ulcers |
| Blood Transfusions | Head Injury | Multiple Sclerosis | Vertigo |
| Brain Tumor | Heart Attack (MI) | Myasthenia Gravis | |

Other: _____

Please list the Medications you take for all conditions, from all providers, including vitamins and supplements:

| Medication | Mg/Strength | Times per day | Medication | Mg/Strength | Times per day |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Please list any Medication Allergies and the Reaction you had to it:

| Medication | Reaction |
|---|---|
| | |
| | |
| | |

## Family Medical History

### Parents, Grandparents, Aunts, Uncles, Siblings, and Your Children

Please circle any condition that **someone in your family possesses.** If you are not sure, it is okay to circle it to be on the safe side. Please put the relative next to the diagnosis. If you are adopted, circle, 'I am adopted,' below.

| | | |
|---|---|---|
| I am adopted | Congestive Heart Failure | Cancer (Type_____) |
| Alzheimer's Disease | Depression | Multiple Sclerosis |
| Anemia | Diabetes | Myasthenia Gravis |
| Anxiety | Thyroid Disease | Heart Attack (MI) |
| Asthma | Epilepsy/Seizures | Obesity |
| Atrial Fibrillation | GERD/Reflux Disease | Arthritis (Osteoarthritis) |
| Auto-Immune Disease | Headches/Migraines | Parkinson's Disease |
| Brain Aneurysm | Heart Disease/CAD | Fibromyalgia |
| Stroke/CVA | High Cholesterol | Rheumatoid Arthritis |
| Cerebral Palsy | Hypertension | Sleep Apnea |
| COPD | Neuropathy | Substance Abuse |

## Social History

| Do you Smoke? | (circle below and answer relevant questions) |
|---|---|
| Yes | How much do you smoke per day? |
| | How many years have you smoked for? |
| No | |
| | What year did you quit? |
| Former | How many years did you smoke for? |
| | How many packs per day did you smoke? |

Do you use other forms of tobacco? Yes No

Do you consume alcohol? No Occasional Social Moderate Heavy

Do you consume caffeine? None Less than Daily #/Day _____

Do you use illegal drugs? No Yes Type: _____ How Often? _____

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# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize T. A. DIGERONIMO MD to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

# Financial Responsibility

**Statement of Financial Responsibility**
I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.
**Notice of "Non-Covered" Services**
I am aware that some services performed by the Practice may be considered "non-covered" by my insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.
**Waiver of "Usual, Customary and Reasonable" Clauses** (For patients with "out-of-network coverage)
I acknowledge that the fee charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable" due to specialized services and staff. However, I agree to pat the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.
**Bill To/Payment Instructions**

_____ Commercial Insurance/Third Party Payor _____ Medicare

I hereby authorize the Practice to bill my insurance company and/or Medicare (indicated or initialed above) for services provided to me and request that payments for such services to be made to the practice on my behalf.

**Financial Agreement**
The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection and attorney fees for collection expenses.

## Patient Consent

**Request for care and Consent for Treatment**
The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Thomas A. DiGeronimo M.D., P.A. has the right to refuse to treat you if you refuse to sign this consent or at any time you choose to revoke this consent.
**Assignment of Insurance Benefits**
I authorize payment directly to Thomas A. DiGeronimo M.D., P.A. of any insurance benefits otherwise payable to me for services, at a rate not to exceed Thomas A. DiGeronimo M.D., P.A. regular charges for such services.
Authorization to Release Information
I authorize the release of medical records and related information from Thomas A. DiGeronimo M.D., P.A. to authorized representatives of my third party payor or physician related to my care. I authorize review of records for any necessary agency audit and the release of the physician plan of care and discharge summary from my medical record upon my transfer to or from another health care facility.

(Please initial the below statement)

_____**I have read and reviewed the Patient Responsibilities form and have been provided a copy.**

The Undersigned certifies that he/she has read the forgoing, received a copy there of and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

Patient (print name) _____ Date: _____

Signature of patient or authorized person: _____

If the patient did not sign, please state reason: _____

# Thomas A. DiGeronimo M.D., P.A.

Patient's Name: _____ Date: _____

## INFORMED CONSENT AND CONTROLLED SUBSTANCE AGREEMENT

Controlled substance medications (i.e. narcotics, opiates, tranquilizers, barbiturates) are very useful, but they have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain to improve function and/or ability to work, not to simply feel good. As a patient, you have the right to be informed about your condition and the recommended therapy to be used, so that you may make an informed decision whether or not to take the drug after knowing the risks and hazards involved.

**MEDICATION:** I have been prescribed the following medications as of the date of this Agreement.

Medication:_____Dosage: _____Quantity: _____
As of the date of this Agreement, you will be permitted ___0___ refills.

Medication:_____Dosage: _____Quantity: _____
As of the date of this Agreement, you will be permitted ___0___ refills.

Medication:_____Dosage: _____Quantity: _____
As of the date of this Agreement, you will be permitted ___0___ refills.

Medication:_____Dosage: _____Quantity: _____
As of the date of this Agreement, you will be permitted ___0___ refills..

***Providers: Mark through each section not needed above.**

I understand that should my prescription(s) change during treatment with this facility, a list of my active prescription(s) will be updated through Addenda to this agreement if/as necessary. I further understand that I will be required to sign such updated prescription lists to accept changes in my prescriptions and to continue treatment with this facility.

**CONSENT TO TREATMENT AND/OR DRUG THERAPY:** I voluntarily request Dr. DiGeronimo, as my physician, and/or Glenn Turner, A.R.N.P/Tina Theobald, A.R.N.P./Sheri Mehl, A.R.N.P. (hereinafter "Associates"), technical assistants, nurses and healthcare providers as deemed necessary or advisable, to treat my condition which has been explained to me as: chronic pain. I hereby authorize and give my consent to administer or follow prescribed prescription(s), controlled substance(s), or narcotic medication(s) as an element on the treatment of my chronic pain.

It has been explained to me that these medication(s) include narcotic drug(s), which can be harmful. I further understand that these medication(s) are addictive and may produce adverse effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result of taking these medication(s).

I understand that I will undergo medical tests and examinations before and during my treatment by Dr. DiGeronimo and his Associates. Those tests include initial and subsequent random, unannounced urine and/or blood tests for drugs, and I hereby give permission to perform the tests or, my refusal will lead to my immediate discharge from treatment with Dr. DiGeronimo and his Associates. Presence of unauthorized substances may result in my discharge from treatment with Dr. DiGeronimo and his Associates.

**For female patients only:** To the best of my knowledge,

_____ I am pregnant. _____ I am NOT pregnant.

I understand that I must tell Dr. DiGeronimo and/or his Associates immediately if I am pregnant, as the medication(s) prescribed could have an adverse effect upon me and/or my unborn child.

**MOST COMMON SIDE EFFECTS:** constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment or reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional/psychological dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications, and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive controlled substance medication(s) for the treatment of my condition. I understand that I may withdraw from this treatment and discontinue the use of the medication(s) at any time. I understand that no warranty or guarantee has been made to me as to result of any drug therapy or cure of any condition. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, and I believe that I have sufficient information to give this informed consent.

I am aware that certain other medicines may reverse the action of the medicine I am using for pain control.

**CONTROLLED SUBSTANCES:** This informed consent also contains the following important requirements that I must fulfill in order to be and remain a patient of Dr. DiGeronimo and/or his Associates and to receive prescriptions for any controlled substance(s). Please initial each item on the line provided.

**Initial**

_____ I am responsible for my controlled substance medications. If the prescription is lost, misplaced, or even stolen, or if I use it sooner than prescribed, I understand it **WILL NOT** be replaced.

_____ I will use the medication(s) exactly as directed by Dr. DiGeronimo and/or his Associates.

_____ Some persons may develop a tolerance to controlled substances, which is the need to increase the dose of medication to achieve the same effect of pain control. It is possible I may become physically dependent upon the medication. If this occurs, when I stop the medication, I must do so slowly and under medical supervision, or I may have withdrawals.

_____ I **WILL NOT** request nor accept any controlled substance medications (i.e. narcotics, opiates, tranquilizers, barbiturates, medical marijuana) from any other physician or individual while I am receiving medication from Dr. DiGeronimo and/or his Associates. Besides being illegal to do so in some cases, it may endanger my health. The only exceptions are medications I am already taking and about which I have already informed Dr. DiGeronimo and/or his Associates; or medications prescribed while I am admitted to a hospital or being seen by one of Dr. DiGeronimo's Associates in the clinic under his direct supervision.

_____ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

_____ Refills of controlled substance medication:

a. Will be made only during Dr. DiGeronimo and/or his Associates during regular **office hours,** in person, or once a month during a scheduled office visit.
   Refills will not be made at night, on holidays, on the weekends, or without an office visit.
b. **WILL NOT** be made if "I run out early." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
c. **WILL NOT** be made in an "emergency", such as, Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least 24 hours ahead if I need assistance with a controlled substance medication prescription.

_____ All controlled substances must be obtained at the same pharmacy, where possible.

_____ I **WILL NOT** give or sell the medications prescribed to me under any circumstance. Besides being illegal to do so, it may endanger the health of those who take *my* prescribed medication.

_____ **I WILL TAKE** the medication as prescribed. Improper use can cause death. It is my responsibility to inform Dr. DiGeronimo and/or his Associates about the success or failure of treatment so appropriate adjustments in my medication may be made. I should not have pills left at the end of the month, nor should I run out early.

_____ I understand the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits: exercise if as recommended by my doctor, weight loss if/as recommended by my doctor, and the non-use of alcohol and tobacco. I will also participate in physical therapy as prescribed by my doctor. I understand a healthier lifestyle is an imperative element for the successful outcome of my treatment.

_____ In order for Dr. DiGeronimo and/or his Associates to monitor my compliance with medication use, **I agree to random urine and/or blood drug testing** and, I waive certain privacy rights and give permission to Dr.DiGeronimo and/or his Associates to communicate with my healthcare providers outside of Dr. DiGeronimo's practice, including but not limited to my referring physicians, my primary care physicians, and my pharmacists regarding my use of controlled substance(s).

**Refusal of random or scheduled drug testing will result in immediate dismissal from the practice.**

_____ I agree and consent to complete the ordered urine drug screen immediately on the day it was ordered at the office of Dr. Thomas A. DiGeronimo. I further agree and consent that I will be immediately dismissed from the practice of Dr. Thomas A. DiGeronimo if I leave the office premises prior to completing the urine drug screen.

_____ I understand that **if I violate any of the above conditions, my controlled substance prescriptions and treatment with Dr. DiGeronimo and/or his Associates may be immediately terminated.** In addition to dismissal from the practice, if the violation involves obtaining controlled substances from another individual, as prescribed above, I may be reported to my primary physician and other authorities.

I have read this contract and it has been explained to me by Dr. DiGeronimo and/or his Associates. In addition, I understand the consequences of violating the contract.

Patient's Name_____ Date of Birth_____

Patient's Signature_____ Date_____

Parent/Guardian's Name_____

Parent/Guardian's Signature_____ Date_____

Provider Signature _____ Date_____

__ Thomas A. DiGeronimo, MD

__ Glenn Turner, ARNP

__ Tina Theobald, ARNP

__ Sheri Mehl, ARNP

# Thomas A. DiGeronimo M.D., P.A. & Associates, Neurology

## Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information.**

### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you

### Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

### Our uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests

**When it comes to your health information, you have certain rights. This section explains your rights and some of our responsible to help you.**

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to amend your medical record**

- You can ask us to amend health information about you that you think incorrect or incomplete. Ask us how to do this.
- You may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've share information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we share it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice-You can ask for a paper copy of this notice at any time.**

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 2.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/.
- We will not retaliate against you for filing a complaint.

**Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or other involved in your care
- Share information in a disaster relief situation.

If you are not able to tell us your preference we may go ahead and share you information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

**In these cases we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In cases of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

**Our Uses and Disclosures**

**We typically use or share your health information in the following ways:**

- We can use your health information and share it with other professionals who are treating you.
- We can use and share your health information to run our practice, improve your care and contact you when necessary.
- We can use and share your health information to bill and get payment from health plans or other entities.

**Electronic exchange: Your information may be shared with other providers, labs and radiology groups though out HER system as listed:**

1. Lab Corp
2. Quest Diagnostics

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see www.hhs.gov/ocr/privacy/hippa/understanding/consumers/index.html.

**Health with public health and safety issues**

We can share information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Preventing or reducing a serious threat to anyone's health or safety
- Reporting suspected abuse, neglect or domestic violence

Do Research

Comply with the law

Respond to organ and tissue donation requests

Work with a medical examiner or funeral director

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**We can use of share health information about you:**

- For Worker's Compensation claims
- For law enforcement or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security and presidential protective services
- Respond to lawsuits and legal actions

**Our Responsibilities**

- We are requires by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.\We must follow the duties and privacy practices described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
  For more information see www.hhs.gov/ocr/privacy/hippa/understanding/consumers/noticepp.html

**Changes to the Terms of this Notice**

We can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our web site.

In accordance with the ethical standards of the medical profession, Thomas D Digeronimo, M.D. & Associates complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our practice also does not exclude people or treat them differently due to race, color, national origin, age, disability, or sex. We offer the following:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please let our practice know.

If you believe that our practice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing with:

Amy Wyatt
Civil Rights Coordinator

Thomas Digeronimo, M.D & Associates
3302 West Baker Street
Plant City, Florida 33563

You may also contact the Civil Rights Coordinator by phone at (813) 752-1336. Ext. 102, or by email at Amy@drtomd.com or you may file a grievance in person. If you need help filing a grievance, Amy Wyatt is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf , or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

(800) 368-1019, or 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.htm

Tagline Informing Individuals with Limited English Proficiency of Language Assistance Services

State of Florida

Spanish:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-813-752-1336

French Creole:
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-813-752-1336

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-813-752-1336

Portuguese:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-813-752-1336

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-813-752-1336

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-813-752-1336

Tagalong:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-813-752-1336.

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-813-752-1336

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 هاتف الصم والبكم:-1 813-752-1336

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-813-752-1336

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-813-752-1336

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-813-752-1336번으로 전화해 주십시오.

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-813-752-1336

Gujarati:
ચુના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છ. ફોન કરો 1-813-752-1336

Thai:
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-813-752-1336