FRANK P FILIBERTO MD I 400 E Strawbridge Ave I Melbourne, FL 32901
321-676-3101 | Fax: 321-984-4456

Name: _____
First M Last

DOB: _____

SS# _____

Address _____

City, ST. Zip: _____

Phone: _____ Cell: _____

Email: _____

Qualifying Conditions

Your Qualifying Conditions for the "The Florida Medical Marijuana Program"

- ☐ Cancer
- ☐ Glaucoma
- ☐ AIDS
- ☐ HIV
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Crohn's Disease
- ☐ Parkinson's
- ☐ PTSD
- ☐ ALS
- ☐ or other debilitating conditions of the same kind or class as or comparable to those enumerated, and for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient
- ☐ Chronic Pain Please Explain: _____

How Did You Hear About Us? _____

Frank P Filiberto MD
321-676-3101 FAX: 321-984-4456

I,_____(PRINT PATIENT NAME)

BIRTHDATE ___/___/___, **SOCIAL SECURITY#** XXX-XX-_____

Authorize _____
(Doctor Name) (Doctors Phone or Fax Number)

to release and discuss any and all medical records and medical information that you have for me in your possession regarding my medical condition and my medical treatment, including but not limited to, my medical history, my medical treatment, your findings regarding my medical condition, records of consultations that I have had, records of medication prescribed for me, x-rays taken of me, my radiology reports, and hospital, and medical records to:

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for the sole purpose of medical records review and certification of my medical condition.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV1) and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is intended to be an unlimited, full, and complete Authorization for the release of any and all protected medical information as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Medical Records Access Act, as amended, and under the rules and regulations thereof, and covers all protected information from primary and secondary providers, health plans, health care clearinghouses, emergency services, financial and administrative transactions, and business associates. A covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR 164.508(b) (4) applies. It is understood that the person to whom this Authorization is given has my permission to use and disseminate this information in his or her sole discretion.

1. **Expiration.** This authorization expires 18 months after patient signed this release.

2. **Right to Revoke.** I have the right to revoke this authorization by signing and dating a written statement revoking this authorization, and it shall become effective on delivery to you. If this authorization is revoked, any person or entity acting in good faith in reliance upon it and lacking actual knowledge of its revocation shall be held harmless.

3. **Redisclosure.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by this rule.

4. **Administrative Provisions.** I revoke any prior authorizations I have made to disclose health information that are inconsistent with this authorization. This document shall be governed by Florida law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub L No 104-191, and the Medical Records Access Act, MCL 333.26261 et seq. However, I intend it to be honored in any jurisdiction where it is presented and for other jurisdictions to refer to Florida law and HIPAA to interpret and determine the validity and enforceability of this document. Photocopies or facsimile reproductions of this signed authorization shall be treated as original counterparts. I am providing this authorization voluntarily and have not been required to give it to obtain treatment. I am at least 18 years old and of sound mind.

5. Any Billing for Medical Records is solely the patient's responsibility.

_____

PATIENT OR LEGAL REPRESENTATIVE'S SIGNATURE **DATE**

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial)
Veterans Health Administration Location:	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Frank P Filiberto MD 400 E Strawbridge Ave, Melbourne, FL 32901

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☒ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

Pertinent health information from electronic health records from the last 12 months including information created within 24 months after their signature date of this authorization.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Certification

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

Two years from the date of signature

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA) (Sign in ink)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM JUL 2013 **10-5345** USE EXISTING STOCK OF VA FORM 10-5345, DATED MAY 2005.

400 East Strawbridge Ave
Melbourne, FL 32901
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Cancellation/No Show Payment Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we were unable to schedule you for a visit, due to a full schedule.

Cancellations

It is our policy that all appointments must be cancelled at least 48 hours in advance of the appointment. If an appointment is not cancelled 48 hours in advance, you will be charged the full appointment cost. Your credit or debit card on file will automatically be charged on the day of the cancellation if you are cancelling less than 48 business hours prior to your appointment. All patients will have the opportunity to show proof of an "urgent" reason as to why they were unable to make their scheduled appointment. Upon doing so, the patient will be reimbursed the charges incurred for late cancellations.

No Show

Patients who "No Show" their visit will be charged for that visit, AND will need to prepay future appointments. Your credit or debit card on file will automatically be charged on the day you "No Show" your appointment. All patients will have the opportunity to show proof of an "urgent" reason as to why they were unable to make their scheduled appointment. Upon doing so, the patient will be reimbursed the charges incurred for not showing for their scheduled appointment.

Follow Up Visits

Follow up visits are crucial to maintaining the state mandate of creating and maintaining a bonafide relationship with your provider. Patients who miss the scheduled follow up visits will be charged the $60 for the missed appointment

Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. We request you come 30 minutes early to your appointment to account for traffic and to complete the required paperwork. If you are 15 minutes past your scheduled time, your provider may not be able to complete a full visit or we will do our best to accommodate you and fit you into the schedule later in the day. If you cannot complete your visit you will be charged for the full visit and you will be required to book a new visit.

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Account Balances

We will require that patients pay their account balances to zero (0) prior to receiving further services by our practice. We also require payment be rendered prior to services.

Acknowledgement of Receipt of Cancellation/No Show Policy

I,_____do hereby acknowledge receipt of a copy of the Cancellation and No Show Payment Policy of Frank P Filiberto MD.

Signature:_____Date:_____