Conditions of Care

H. Lee Moffitt Cancer Center and Research Institute Hospital, Inc. ("Hospital")
H. Lee Moffitt Cancer Center and Research Institute, Inc. ("Institute")
H. Lee Moffitt Cancer Center and Research Institute Lifetime Cancer Screening Center, Inc. ("Moffitt Medical Group") (collectively and individually "Moffitt")

Consent to Moffitt Admission/Care and Medical Treatment

I understand and consent to Moffitt admission/care and medical treatment and to my physician(s) providing the diagnostic tests and therapies that they deem appropriate for my care.

I consent to such admissions, diagnostic procedures, care, medical treatment, and other actions related to my care, which in the judgment of my physician(s) or other Moffitt healthcare providers, may be needed while I am a Moffitt Patient. I agree that these conditions of care will apply to my initial admission/care and all later admissions/care. I know that it is the responsibility of my treating physician(s) to obtain my informed consent when required for medical or surgical treatment, special diagnostic or therapeutic procedures, or other services provided to me under the general or special instructions of my treating physician(s). I have the right to consent or refuse to consent to any proposed treatment or procedure, except as otherwise required by law. I understand that the practice of medicine is not an exact science and that diagnosis and treatment involve risk of injury or even death. I know that no guarantees have been made as to the results of my examination or treatment. When my treating physician(s) determine that I no longer require care as an inpatient at the Hospital, I agree to arrange for post-hospital care and agree to be discharged. I further agree that following an admission, I will not leave Moffitt's campus without first advising my assigned healthcare providers of such departure. I also understand that my non-compliance with Moffitt policy, my treatment plan, or with the directions of Moffitt personnel may result in my immediate discharge from Moffitt's care.

Notification of and Consultation with Primary Care Provider

Within 24 hours of my admission and discharge, the Hospital is required to notify my primary care provider, if I have one. The Hospital is also required to provide my primary care provider with my discharge summary within 14 days of its completion. Upon my admission, I understand that I may request that my Moffitt treating physician consult with my primary care provider or specialist provider when developing my plan of care, provided that such consultation does not interfere with my care at Moffitt. I understand that I must provide the hospital with the name of my primary care provider and specialist provider to allow for such notification and consultation.

Consent for Blood/Body Fluid Testing

In the event that a member of Moffitt's Workforce is suspected to have had exposure to my blood and/or body fluids or if it is likely that a member of Moffitt's Workforce is exposed to my blood and/or body fluids, I consent to have the Hospital determine by serological testing whether or not my blood and/or bodily fluids contained the human immunodeficiency virus (HIV) or Hepatitis A, B, or C. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family, as well as the health of those healthcare personnel or emergency response person(s) who may have been or become involved in my treatment.

I understand that Moffitt's Workforce includes health care workers, employees, faculty, volunteers, trainees, and other persons whose conduct, in the performance of work, is under the direct control of the H. Lee Moffitt Cancer Center and Research Institute and its subsidiaries, whether or not they are paid by the H. Lee Moffitt Cancer Center and Research Institute or one of its subsidiaries.

-

Consent for Medically Necessary Genetic Testing/DNA Analysis:

I agree that Moffitt may conduct medically necessary genetic testing/DNA analysis on me to identify and/or treat certain diseases or illnesses as ordered by my physician or other authorized Moffitt health care provider. This testing/analysis is not considered research but is considered to be an appropriate means of evaluation at the time of testing. The purpose of this testing/analysis includes, but is not limited to, providing guidance related to my clinical care based on the characteristics of my tumor/cancer, clarifying my diagnosis, and/or guiding drug dosing to help mitigate drug-induced toxicities. This testing/analysis is complex and utilizes specialized materials so that there is always a very small possibility that the test will not work properly or that an error will occur. The results of the testing/analysis may have clinical or reproductive implications for me and my family members and in certain instances may indicate a higher chance of an inherited risk in myself or my family. I understand and agree that the results of the genetic testing and/or DNA analysis will become a part of my medical record, and will be disclosed to my Moffitt care team, persons authorized by me, for purposes permitted by federal and state law, and in accordance with Moffitt's policies and procedures, including, these Conditions of Care and Moffitt's Notice of Privacy Practices. Should I have any questions regarding this consent or the medically necessary use of genetic testing/DNA analysis at Moffitt, I acknowledge that I should contact my treating physician.

Notice of Limitation on Liability

I understand that the Hospital is a teaching hospital and that my care may be directed by physicians employed by the Moffitt Medical Group, the University of South Florida, or other third party entities. Medical liability is limited by state law.

I understand that the Hospital and the Moffitt Medical Group are subsidiaries of the Institute. The Institute, the Moffitt Medical Group, the Hospital and the H. Lee Moffitt Cancer Center and Research Institute Foundation, Inc. ("Foundation") are not-for-profit corporations organized under Section 1004.43, Florida Statutes, and acting primarily as an instrumentality of the State of Florida, and any liability that may arise from my care is limited by law.

I understand that some of the physicians on the Hospital's medical staff have been granted the privilege of using the Hospital's facilities but exercise their own independent medical judgment and are not employees or agents of Moffitt, Moffitt Medical Group, or the Hospital, but rather are independent contractors, or employees of the University of South Florida College of Medicine or Board of Trustees (collectively "USF") or other third party physician group or healthcare entity.

I understand and agree that the Institute, Moffitt Medical Group and the Hospital are not liable for any act or failure to act by following the instructions of any of the independent contractors or employees of USF or other third party entity. I further understand that the Institute, Moffitt Medical Group and the Hospital are not liable for the medical care and treatment rendered to me that may be provided by employees, servants or agents of USF or other third party entity. To the extent that employees, servants or agents of USF or other third party entity provide care at the Hospital or a Moffitt facility, such personnel shall not be deemed to be agents of any person other than the USF or other third party entity, respectively. Any liability that may arise from that care may also be limited by law.

Personal Valuables

Moffitt shall not be responsible for my valuables.

I agree that Moffitt is not responsible or liable for the loss or damage of any money or personal property brought or believed to have been brought into the Hospital or any other Moffitt facility by me and/or my agent, whether or not placed in the facility's safe, including, but not limited to, money, jewelry, glasses, dentures, hearing aids, laptops, other electronics, or documents. I understand that if I choose to bring such valuables to Moffitt, that I am doing so at my own risk.

Financial Payments

I agree to pay my bills and agree to have all insurance plans, benefit plans and health care service plans make payment directly to Moffitt and physician(s).

In consideration of all Moffitt services, or future Moffitt services rendered to me, I unconditionally and irrevocably assign to the Hospital, Moffitt Medical Group, USF, and all my physician(s) participating in my treatment and care, all of my rights and interest in any insurance proceeds, benefits (including Medicare, TRICARE/CHAMPUS, and Medicaid benefits), policy provisions, and/or judgments, payable to me or on my behalf.I direct any and all payors (including, but not limited to, all insurance companies, self-insurance benefit plans, whether governed by ERISA or not, personal injury protection benefits, uninsured and under-insured benefits, and health care service plans) to make payment on my behalf directly to the Hospital, Moffitt Medical Group, USF and my physician(s), as applicable.

I have primary responsibility for all my related charges even if the Hospital or Moffitt Medical Group agrees to accept payment directly from another payor, except as otherwise provided under applicable law. I shall remain responsible for the payment of all unpaid amounts and for all services provided to me, which are not covered services by insurance.

I acknowledge that Moffitt has created or acquired certain facilities for providing healthcare services, either on the campus or off the campus of the Hospital. Further, I acknowledge that some of Moffitt's facilities are licensed as a part of the Hospital and are considered provider-based facilities, while others may not be considered provider-based facilities and may be operated by the Moffitt Medical Group. If I obtain healthcare services from a provider-based facility of the Hospital, I understand and agree that I may be responsible for a separate hospital facility charge that would not be charged at a non-provider-based facility. This charge is in addition to the professional charge for the services of the physicians or other healthcare providers and may result in higher out-of-pocket expenses to me. Should I have any questions or concerns related to whether a facility is a provider-based location of the Hospital or the impact on billing of the healthcare services provided at a facility, I acknowledge that I should contact the Billing Department at 813-745- 8422.

I acknowledge that FLORIDA FRAUD STATUTE, Section 817.234, Florida Statutes, provides that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement or claim containing any false, incomplete or misleading information is guilty of a felony of the third degree. I certify that the insurance information given by me in applying for payment under such programs is correct.

Venue for any action arising hereunder shall be proper only in the state courts of Hillsborough County, Florida.

Consent for Use and/or Disclosure of My Health Information

I give my consent for the Cancer Center to use and/or disclose my Health Information as permitted by federal and Florida law and as represented in the Cancer Center's Notice of Privacy Practices.

I recognize that in this Consent for Use and/or Disclosure of My Health Information section, the term "Cancer Center" means the Hospital, Institute, Moffitt Medical Group and all other participants in the organized health care arrangement identified in the Cancer Center's Notice of Privacy Practices.

I recognize that in these Conditions of Care, the term "Health Information" means my identifying and non-identifying information including, but not limited to, my medical records, my demographic, diagnostic, and therapeutic treatment information, prescription medication history and information, billing and other business information, information related to sexually transmissible diseases, communicable diseases, HIV/AIDS, mental health, or substance abuse, and genetic information.

As permitted by federal and Florida law, I consent to the Cancer Center's use and/or disclosure of my Health Information:

- For my care and treatment, including sharing my Health Information with another provider to determine how to diagnose or treat me, or to provide continuity of my health care.
- For obtaining payment for my health care services, including providing Health Information to any of my guarantor(s) to show treatment and necessity of services, and obtaining pre-approval from my insurance company for my treatment and determining benefit entitlement.
- For the Cancer Center's health care related business operations.

- For product monitoring, repair and recall, as discussed in the Cancer Center's Notice of Privacy Practices.
- For my inclusion in the Cancer Center's Patient Directory. (I may choose to be excluded when I am admitted.)
- When the Cancer Center removes some or all of the information that may identify me.
- For other purposes permitted by federal or state law as discussed in the Cancer Center's Notice of Privacy Practices.

I agree that the Cancer Center may contact me, including via text messaging, e-mail, automatic telephone dialing device, artificial or prerecorded voice, or any other form of electronic communication at any phone number or e-mail address that I provide to the Cancer Center, to provide me with information to help me manage my health, remind me about my scheduled appointments and recommended tests, facilitate account billing and collection and payment posting and/or processing for services obtained at the Cancer Center, and provide surveys, quality assurance reviews, newsletters, or other information including, but not limited to, invitations to participate in research, studies, or focus groups, and other educational or supportive information or how I may donate. This electronic communication may come from the Cancer Center or from the Cancer Center's partners, who assist the Cancer Center with such messages. By agreeing, I understand that the information transmitted by and to me by e-mail and text messages is unencrypted and that, as a result, it may be possible for others to intercept the information sent and received. I also understand that standard text messaging and data rates may apply. I agree to keep the Cancer Center informed of my up to date mobile number and email address at all times, and notify the Cancer Center if the telephone number I have provided is no longer in my possession. I understand that I can revoke my consent to receive text messages and e-mails from the Cancer Center at any time by notifying the Cancer Center, as represented in the Cancer Center's Notice of Privacy Practices. I understand that I should not contact the Cancer Center via text messaging or e-mail regarding urgent or time-sensitive matters.

I give permission to the Cancer Center to disclose my name and other demographic information, including information about my age and gender, where I live or work, and the dates that I received treatment, to its related charitable foundation for the purpose of contacting me, including via text messaging, e-mail, automatic telephone dialing devices, or any other form of electronic communication, about fundraising and attendance at events and providing me with informational materials or for other purposes related to the mission of the Cancer Center and its related charitable foundation. I recognize that I do not have to participate if I am contacted and may elect to "opt-out" of certain future communications, as represented in the Cancer Center's Notice of Privacy Practices.

I recognize that research will not be conducted on me unless I voluntarily give my informed consent, or as otherwise permitted by laws governing research. I consent, however, for my Health Information to be used consistent with federal law in reviews preparatory to research, in research studies if I should become deceased, or in research where the Institutional Review Board and Privacy Board have approved the use of my Health Information for research.

In the event my care and treatment involves the removal of blood, plasma, tissues, organs or devices that would otherwise be discarded, I agree to donate to the Hospital, Moffitt Medical Group and/or Institute these items and give my permission to the Hospital, Moffitt Medical Group and/or Institute to retain, preserve, use or dispose of any such material for the coordination and continuity of my care and treatment, for education of physicians, nurses, and other health care personnel, and for research as permitted by law.

I release the Cancer Center from any liability that may arise from the use and disclosure of my Health Information for purposes authorized by these Conditions of Care or by law. I acknowledge that the consents for use and/or disclosure of my Health Information given in this section are critical components of my care and treatment and I understand that I may not revoke this consent.

Photography and Video and Audio Recordings

I acknowledge that photography, video, and audio recordings by patients and visitors are generally prohibited on Moffitt's main campus and all Moffitt off-site areas unless I receive written permission from the appropriate Workforce member to make such a recording in accordance with Cancer Center Policy.

I understand that to assist Moffitt with validating my identity, Moffitt may ask to take my picture at the time of registration and store it in my Electronic Health Record (EHR). I also understand that this is not mandatory, and I may decline at any time.

Tobacco Free Campus

Moffitt's main campus and all Moffitt off-site areas are 100-percent tobacco free.

I understand and agree that smoking or tobacco use is not allowed anywhere on these properties and that any person found using tobacco products will be asked to immediately extinguish such products. For more information on Moffitt's tobacco-free initiative, please call 1-888-MOFFITT (1-888-663-3488).

Conditions of Care

I have read, understood, and received a copy of these Conditions of Care. I am satisfied that I understand what it means and accept these terms as the patient or an authorized representative of the patient.

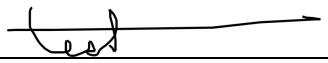
The undersigned certifies that he/she has read and has had the foregoing information explained, has been offered a copy of this document and is able to access this document online, is satisfied that he/she understands fully its contents and significance and is the patient or a representative duly authorized by the patient to execute these Conditions of Care for and on behalf of the patient and to accept its terms for and on behalf of the patient who shall be bound thereby.

I understand that this document covers the topics listed below in readable, layman's terms:

- Consent to Moffitt Admission/Care and Medical Treatment
- Notification of and Consultation with Primary Care Provider
- Consent for Blood/Body Fluid Testing
- Consent for Medically Necessary Genetic testing
- Notice of Limitation on Liability
- Personal Valuables
- Financial Payments
- Consent for Use and/or Disclosure of My Health Information
- Photography and Video and Audio Recordings
- Tobacco Free Campus

I understand that Moffitt may amend, update, or otherwise change, the conditions and/or the provisions included in this document to conform with rules, laws, and or regulations. Please check the contents of these Conditions of Care via your Patient Portal periodically for changes. Each such amendment shall become automatically valid and enforceable at the time when first displayed by Moffitt via the Patient Portal.

***** These Conditions of Care must be signed by the Patient unless the Patient is unable to sign due to mental or physical incapacity or is under the age of eighteen (18) years old *****

Print name of patient: PATIENTPORTALONLY XTEST
Patient's date of birth: 10/10/1956
Signature:  Date: 12/17/2021
(Patient/Patient's representative if patient is unable to sign)
Representative's relationship to patient: Self
Name of patient representative:

TO OUR PATIENTS

It is Moffitt Cancer Center's goal to provide high quality service. Should you have any problems or concerns while a patient at Moffitt Cancer Center, we hope that you will advise us. Our Patient Relations office is located on the first floor near the main lobby. Please feel free to contact Patient Relations at 813-745-3808. The following is a summary of your rights and responsibilities.

YOUR RIGHTS*

- You have the right to receive kind and respectful care, while also considering your dignity. To be made comfortable, and have health care providers respect your cultural, social, emotional, spiritual, and personal values, beliefs and preferences.
- You have the right to upon request, have a family member or other person of your choice and your own doctor notified if you are admitted to the Hospital.
- You have the right to receive reasonable and fair treatment or services without regard to your age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, or source of payment.
- You have the right to know what patient support services are available to you; including whether an interpreter is available as well as the availability of pastoral and other spiritual services.
- You have the right to receive information from all health care providers, including medical information, in your preferred language or form of communication at no cost to you. If you have vision, speech, hearing, or cognitive impairments, a method of communication that meets your needs will be provided.
- You have the right to know the names of the doctors performing medical services and the name of the person who is primarily responsible for your care.
- You have the right to receive prompt and reasonable responses to reasonable questions and requests. You may consult with a specialist, at your own request and expense.
- You have the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.
- You have the right to know, upon request and prior to treatment, whether the health care provider or facility accepts the Medicare assignment rate, if you are eligible for Medicare.
- You have the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- You have the right to receive information about your health; including diagnosis, planned course of treatment, alternatives, risks, expected and unexpected outcomes, and prognosis, in terms you can understand.
- You have the right to take part in developing and implementing your plan of care.
- You have the right to participate in resolving questions that arise during your care, including issues of conflict resolution, withholding resuscitation, and end of life care.
- You have the right to make decisions regarding your medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, other courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
- You have the right to be told if proposed medical treatment is for purposes of experimental research and either consent or refuse to participate.
- You have the right to give or refuse consent for the Hospital to use recordings, films, or other images of you for purposes other than your care.
- You have the right to receive treatment for any emergency medical condition that will get worse if treatment is not provided.
- You have the right to request or refuse treatment, to the extent permitted by law. You do not have the right to demand inappropriate or medically unnecessary treatment. You have the right to leave the Hospital, even against the advice of physicians, to the extent permitted by law.
- You have the right to confidentiality of your medical record and the right to access information from it when the medical record is complete.
- You have the right to appropriate assessment and management of your pain. You may request or reject the use of any or all treatment to relieve pain, including opiate medication.
- You have the right to create advance directives, whether inpatient or outpatient. Advanced directives allow you to make your preferences known about your health care, and often include designation of a healthcare surrogate, a living will, and organ donation preferences. Assistance in preparing advance directives is available by contacting the Social Work Office at 813-745-8407.
- You have the right to have your personal privacy respected. Discussion about your case, consultation, examination, and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed.
- You have the right to keep and use personal clothing or possessions as space permits, unless it affects the right of another patient or is not recommended for documented medical, safety, or programmatic reasons.
- You have the right to confidential treatment of all communications and records about your care and stay in the Hospital. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.
- You have the right to receive care in a safe setting, free from mental, physical, sexual, or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services, including notifying government agencies of neglect or abuse.
- You have the right to be free from restraints and seclusion used as a means of coercion, discipline, convenience, or retaliation by staff.
- You have the right to reasonable continuity of care and to know in advance the time and location of appointments, as well as the identity of the persons providing the care.

- You have the right to be informed by the doctor, or a delegate of the doctor, of continuing health care requirements following discharge from the Hospital. Upon your request, a friend or family member may also be provided this information.
- You have the right to receive a complete explanation of needs and alternatives before being transferred to another health care facility.
- You have the right to know hospital rules and policies, including those rules which apply to your conduct.
- You have the right to have a family member, friend or other individual present with you for emotional support during your hospitalization or outpatient visit. You may designate visitors of your choosing, if you have decision-making capacity, unless:
  1. No visitors are allowed.
  2. The facility reasonably determines the presence of a particular visitor would endanger the health or safety of a patient, a member of the staff or other visitor to the facility or would significantly disrupt the operations of the facility.
  3. You have told the health facility staff that you no longer want a particular person to visit.

  However, a health facility may establish reasonable restrictions upon visitation, including limitations upon the hours of visitation and the number of visitors.
- You have the right to have the person(s) of your choosing involved in your care, treatment, and services decisions to the extent permitted by you or your chosen decision-maker if you're unable to make decisions.
- You have the right to receive a reasonably clear and understandable itemized bill and, upon request, to have the charges explained
- You have the right to request a copy of the full text of the Florida Patient's Bill of Rights and Responsibilities.
- You have the right to be informed of the Cancer Center's procedures for expressing grievances (complaints) and to express grievances regarding any violation of your rights as set forth in Florida law, through the grievance procedure and the appropriate state licensing agency.
- You have the right to file a grievance. If you want to file a grievance with this Hospital, you may do so by writing or calling Moffitt Cancer Center, Mailstop MCC-PTREL, 12902 Magnolia Drive, Tampa, 33612, Phone 813-745-3808. The grievance committee will review each grievance and provide you with a written response. The written response will contain the name of a person to contact at the Hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO).
- You have the right to file a complaint against our hospital regardless of whether you use the Hospital's grievance process. Such complaints may be filed by writing or calling the Agency for Healthcare Administration, 2727 Mahan Drive, Tallahassee, FL, 32308-5407. Phone 888-419-3456. Another option is to contact the Joint Commission (formerly known as the Joint Commission of Accreditation of Healthcare Organizations) at 1-800-994-6610 or visit www.jointcommission.org.

* These rights extend to a parent, guardian or surrogate who is authorized to make decisions on behalf of the patient.

PATIENT RESPONSIBILITIES

- You are responsible for providing complete and correct information, to the best of your knowledge, about your present illness, past illnesses, hospitalizations, medications, and other matters relating to your health.
- You are responsible for reporting changes in your condition and any concerns you may have about your care or safety. Asking questions will help your care team provide you with the best possible care.
- You are responsible for following the instructions of your doctor and care team. If you cannot follow your care instructions or do not understand them, you are responsible for telling a member of your care team that you cannot follow or do not understand their instructions.
- You are responsible for keeping your appointments and notifying the Cancer Center when you are unable to keep an appointment.
- You are responsible for assuring that the financial obligations to the Cancer center are fulfilled as promptly as possible.
- You are responsible for interacting with the Hospital staff in a courteous and respectful manner. Please respect the rights and property of Hospital staff and other patients. You are also expected to follow hospital rules such as those regarding noise, smoking, and visitation.
- You are responsible for your actions if you refuse treatment or do not follow your doctor's or care team's instructions.
- You are responsible for telling the Hospital if you have an advanced directive. You or your representative should tell the Hospital if you have an advance directive. If you have one, please bring a copy to the Admitting Office or outpatient registration. At the time of admission or registration, we will need to know the name of the person you designate to make your health care decisions and the general nature of your preferences for your care. A clinical social worker can help you prepare an advance directive if you have not done so. The Social Work office can be reached by calling (813) 745-8407.

A representative from the Patient Relations Department is here to answer your questions and listen and respond to your concerns and questions.

Patient Relations Representative A Patient Relations Representative will:
Serve as an advocate for patients to ensure the best possible health care is provided while upholding their rights and responsibilities.
Interpret the institution's philosophy, policies, procedures and services to patients, their families and visitors.
Help to expedite services on behalf of patients.
Provide a place where patients, family members or visitors can come to offer a question, compliment, concern or suggestion and be assured that their concerns will be acknowledged and responded to.
Patient Relations Department - The Patient Relations Office is located on the first floor just off the main lobby. Services are provided from 8 a.m. - 5 p.m., Monday through Friday. A Patient Relations Representative can be reached internally at extension 3808, or externally at 813-745-3808 or toll-free at 800-456-3434, extension 3808. Appointments are not needed but are encouraged.

Questions and Concerns We welcome your questions, compliments and concerns. It is Moffitt Cancer Center's goal to provide high quality service. Should you have any problems or concerns while a patient at Moffitt Cancer Center, we hope that you will advise us.

For Additional Assistance Should you feel your concerns were not addressed appropriately, we are providing the following for your information:

If you have a complaint against our hospital, please contact:
Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5407, phone: 888-419-3456, website: http://www.fdhc.state.fl.us

If you have a complaint against a health care professional and want to receive a complaint form, please contact:
Department of Health, Consumer Services Unit, 4052 Bald Cypress Way, Bin C75, Tallahassee, FL 32399-3275, phone: 888-419-3456, website: http://www.flhealthsource.com

Questions and Concerns We welcome your questions, compliments and concerns. It is Moffitt Cancer Center's goal to provide high quality service. Should you have any problems or concerns while a patient at Moffitt Cancer Center, we hope that you will advise us.

For Additional Assistance Should you feel your concerns were not addressed appropriately, we are providing the following for your information:

If you have a complaint against our hospital, please contact:
Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5407, phone: 888-419-3456, website: http://www.fdhc.state.fl.us

If you have a complaint against a health care professional and want to receive a complaint form, please contact:
Department of Health, Consumer Services Unit, 4052 Bald Cypress Way, Bin C75, Tallahassee, FL 32399-3275, phone: 888-419-3456, website: http://www.flhealthsource.com