Effective Date of this Notice: April 2003

PEDIATRIC WIZARDS

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD (AS A PATIENT OF OUR PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Pediatric Wizards is dedicated to maintaining the privacy of your child's individually identifiable health information (IIHI). In conducting our business, we will create records regarding your child and the treatment and services we provide to him/her. We are required by law to maintain the confidentiality of health information that identifies your child. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your child's IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your child's IIHI
- Your child's privacy rights in their IIHI
- Our obligations concerning the use and disclosure of your child's IIHI

The terms of this notice apply to all records containing your child's IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your child's records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

David Helft M.D., HIPAA Privacy Officer at (321) 255-3434

C. WE MAY USE AND DISCLOSE YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI).

The following categories describe the different ways in which we may use and disclose your child's IIHI:

1. Treatment. Our practice may use your child's IIHI to treat your child. For example, we may disclose your child's IIHI as follows:

- To order laboratory tests (such as blood or urine tests), which we may use the results to help us reach a diagnosis.
- To write a prescription, or we might disclose your child's IIHI to a pharmacy when we order a prescription for you.
- To treat or to assist others in the treatment of your child.
- To inform you of potential treatment options or alternatives or programs, such as our Asthma Program.
- To others who you have given permission to bring your child to the office for treatment. For example, if you ask your babysitter to bring your child to our office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
- To other health care providers for purposes related to their treatment.

2. Payment. Our practice may use and disclose your child's IIHI in order to bill and collect payment for the services and items provided by us for your child. For example, we may disclose your child's IIHI as follows:

- To contact your child's health insurer to certify that your child is eligible for benefits (and for what range of benefits), and we may provide your child's insurer with details regarding your child's treatment to determine if the insurer will cover, or pay for, your child's treatment.
- To obtain payment from other third parties that may be responsible for such costs.
- To bill you directly for services and items.
- To other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your child's IIHI to operate our business. As examples of the ways in which we may use and disclose your child's information for our operations include, but are not limited to the following:

- To evaluate the quality of care your child received from us, or to conduct cost-management and business planning activities for our practice.
- To other health care providers and entities to assist in their health care operations under certain circumstances.
- To contact you and remind you of your child's appointment.
- To inform you of health-related benefits or services that may be of interest to you.
- When we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR CHILD'S IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information to the extent such use or disclosure is required by law:

1. Public Health Risks. Our practice may disclose your child's IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled

2. Health Oversight Activities. Our practice may disclose your child's IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your child's IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your child's IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices

- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Research. Our practice may use and disclose your child's IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your child's IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your child's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the Protected Health Information (PHI) will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

7. Serious Threats to Health or Safety. Our practice may use and disclose your child's IIHI when necessary to reduce or prevent a serious threat to your child's health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Workers' Compensation. Our practice may release your child's IIHI for workers' compensation and similar programs.

9. Compliance. We are required to disclose your child's IIHI to the Secretary of the Department of Health and Human Services or his designee upon request to investigate our compliance with HIPAA or to you upon request pursuant to section E.3. below.

E. YOUR RIGHTS REGARDING YOUR CHILD'S IIHI

You have the following rights regarding the IIHI that we maintain about your child:

1. Confidential Communications. You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For instance, you may ask us not to contact you work. In order to request a type of confidential communication, you must make a written request to the office, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your child's IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your child's IIHI to only certain individuals involved in your child's care or the payment for care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat your child. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the office. Your request must describe in a clear and concise fashion:

- the information you wish restricted;
- whether you are requesting to limit our practice's use, disclosure or both; and
- to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about your child, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Site Manager in order to inspect and/or obtain a copy of your child's IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your child's health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Site Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI

which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your child's IIHI for non-treatment, non-payment or non-operations purposes. Use of your child's IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your child's information to file your insurance claim. We also will not provide an accounting of disclosures made to you about your child, or incident to a use or disclosure we are permitted to make as described above, or pursuant to an authorization. In order to obtain an accounting of disclosures, you must submit your request in writing to David Helft, M.D., HIPAA Privacy Office at 1310 W. Eau Gallie Blvd Suite C Melbourne, FL 32935. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact David Helft, M.D., HIPAA Privacy Officer at (321) 255-3434 or visit our website at www. Pediatricwizards.com

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact David Helft, M.D., HIPAA Privacy Officer at 1310 W. Eau Gallie Blvd, Suite C, Melbourne, FL 32935. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your child's IIHI may be revoked at any time **in writing**. After you revoke your authorization, we will no longer use or disclose your child's IIHI for the reasons described in the authorization. Please note, we are required to retain records of your child's care.
Again, if you have any questions regarding this notice or our health information privacy policies, please contact:

David A. Helft, M.D.
Pediatric Wizards
1310 W. Eau Gallie Blvd
Suite C
Melbourne, FL 32935

Pediatric Wizards

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, ______________________________, have received a copy of the Notice of Privacy Practices
Parent/Guardian Name (please print)

from Pediatric Wizards.

Parent/Guardian Signature: ____

Patient Name: ____

DOB: ______________________________

Witness ____ Date:____________________________

FINANCIAL POLICY

Patient Name: ______________________________________ DOB: _______________

1. Insurance companies require copays and deductibles to be collected at the time of service. We accept Cash, Visa, MasterCard, and Discover. As a courtesy, we also accept personal checks. However, if a check is returned by the bank, the family account will be assessed a $25 check return fee plus the original amount and you will no longer be able to pay by check. We HIGHLY encourage you to contact your insurance company to inquire about your benefits. Know, for example, if your insurance company does not pay for check-ups which are less than 12 months apart. Know which labs, diagnostic centers, and hospitals are covered.

2. For all services rendered to minor patients, we will look to the adult accompanying the patient or the parent/guardian for payment (including any past due balances). If the parents are DIVORCED, whoever brings in the child into the office is responsible for copays and for having a current insurance card. We will not get involved in arrangements made between divorced parents or custodial agreements.

3. Pediatric Wizards has agreed to file insurance for patients who participate in these plans. In order to do this as accurately as possible, we MUST see your child's insurance card at each visit and if you participate with a managed care program, our physician's name must appear on the card. If another physician is listed as the PCP, we will ask that you reschedule your appointment, until the change has been made.

4. Any services that are deemed to be the family's responsibility (additional co-pays, co-insurance, deductible, etc.) or that are considered non-covered by your insurance will be put to patient balance and are due immediately. **Account must be paid in full before any medical records are released or there will be a fee assessed in addition to the monies owed.**

5. Additional issues addressed at well check appointments may be billed separately. Therefore, an additional copayment may be required. If your child is sick when they come in for their well-visit, we may ask you to reschedule as some insurance companies will not cover two office services on the same date.

6. A statement will be sent to you detailing unpaid charges by our office. If you have questions regarding items which have not been paid by your insurance, we ask that you contact your insurance company or employer as benefit packages vary by employer. If you have trouble paying a bill, please contact our billing department and we be able to set up a payment arrangement.

7. If we do not participate with your insurance plan, we ask that you pay in full at the time services are rendered. We do provide our patients without health insurance, a self pay discount.

8. For our new babies, we must have your child's insurance card or written verification from your insurance company that your child is currently eligible for benefits by the **2 month check-up**. If you do not have this available, the visit will be need to be paid in full and suitable payment arrangements must be made regarding the previous balance. Any applicable credit amounts will be refunded to you once contracted insurance information is received and dates of services are paid by the insurance company.

Non-compliance with this financial policy may result in dismissal from the practice.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended at will by the practice.

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Printed Name of Patient or Parent/Guardian

______________________________ ____________________

Printed Name of Patient or *Date*

<u>Health Information Privacy</u>

At Pediatric Wizards, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of Pediatric Wizards, kept in a secure location, and are accessed for only purposes outlined by the Notice of Privacy Practices. Records may be released or shared with other health care providers for treatment of your child.

- I have received a copy of the Notice of Privacy Practices from Pediatric Wizards.
- I understand that Pediatric Wizards may call my home and place of employment for health care reasons, appointment reminders and to resolve billing issues.
- I understand that Pediatric Wizards may use letters to notify me of appointments or other pertinent information.
- I understand that Pediatric Wizards may fax immunization certificates, school excuses, physical/sports forms and/or medication instructions to my personal or work fax, or may mail to my home. Pediatric Wizards cannot fax or send these documents to third parties (schools, daycares, etc.) without a separate, signed authorization form.
- I understand that Pediatric Wizards may leave messages on my answering machine and/or voicemail regarding appointments and limited lab information.
- I understand that Pediatric Wizards may discuss patient information with adults or minors present during the visit.

<u>I understand and agree to all of the above unless I strike through one of the statements.</u>

____ _____________________________

Printed Name of Patient ***DOB***

____ _____________________________

Signature of Patient or Parent / Legal Guardian ***Date***

Medical Image Consent

Patient Name: ____ DOB: _______________

Parent or Legal Guardian: ____

I consent to have my child's, or individual to whom I provide guardianship's image to be taken by the staff at Pediatric Wizards as described below.

I understand that my child's, or individual to whom I provide guardianship's image will be recorded to document and assist with his/her care. I understand that Pediatric Wizards will own these images, but that I will be allowed access to view them. Other than for treatment and identification purposes, images that identify my child, or individual to whom I provide guardianship, will NOT be released and/or used outside the office, without written authorization from me.

I may revoke or withdraw this consent at any time. Withdrawal of this consent must be made in writing. Unless revoked earlier, this consent will be kept for the same time period as any other part of the medical record. We will update the image from time to time. When this occurs, the outdated image will be destroyed.

By signing below, I am indicating that I have read and understand the "Medical Image Consent" form. My questions regarding this consent have been answered.

____ _______________________

Parent/Legal Guardian Signature *Date*

Designee Authorization Form

I, the parent/legal guardian of the below named child:

______________________________________ ________________

Print Child's Name *DOB*

authorize and consent to the examination and/or treatment of my child during office and facility visits by the physicians and clinical staff of Pediatric Wizards. In addition, I give permission for the following person(s) to bring my child to Pediatric Wizards in my absence and to act in my behalf in authorizing medical care and treatment. In the event of emergency or other illness, I understand that the physicians and staff of Pediatric Wizards will deliver any medical care deemed necessary regardless of the accompanying adult. **Unless we are notified in writing,** Pediatric Wizards will assume that a child's biological and/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

I designate the following people to bring my child in on my behalf, to obtain treatment, and to discuss my child's health care with Pediatric Wizards:

Name: ______________________________ Relationship: ________________

Name: ______________________________ Relationship: ________________

This authorization shall be in effect from __________ to _________ or ☐ until further notice

______________________________________ ________________

Parent/Guardian Printed Name *Date*

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Parent/Guardian Signature