



Dear Family,

Welcome to our practice! Thank you for allowing us to serve your pediatric needs. The following information is provided to ensure a smooth transition into our practice.

Please complete the following forms and either bring them to the office or email them to registration@midlandpediatrics.com and allow 48hrs for data entry. Please also include a copy of the front and back of your insurance card.

Our goal is to provide the best medical care for your children. To do this successfully, we must be able to review all of your children's medical records from all providers that your children have seen or vaccine record at the minimum. It is our policy to receive your children's vaccine/medical records before we can assume care of your children and schedule an appointment.

Please be aware that under federal (HIPAA) and state laws, your previous medical provider may charge a "reasonable, cost-based fee" to copy your children's medical records. This cost is your responsibility. This fee may possibly be waived if records are sent directly to our office.

It is crucial when choosing a pediatric practice for your children that you have given serious consideration to the fit between the practice philosophies and your own.

Excellent care happens when the physicians and office staff are aligned with your family priorities and philosophies regarding medical care. Only then can shared decision-making be based on mutual respect.

We look forward to meeting you and forming a mutually rewarding relationship.

MPA Partners and Staff

MPA POLICY-FAMILY ADMINISTRATIVE FEE

As of 11-01-2022:

Unlike virtually every other private Pediatric practice in our community, Midland Pediatric Associates (MPA) has never charged an administrative fee for children to be admitted to our practice. Unfortunately, we are now compelled to begin charging such a fee. This administrative fee covers expenses incidental to running our practice, which medical insurance companies do not reimburse. Such expenses include refilling prescriptions, completing forms, writing school notes, making referrals, maintaining our laboratory, and meeting accreditation requirements.

You have undoubtedly noticed that medical insurance premiums have been increasing annually, which, in turn, has caused the reimbursement to our practice from insurers to decrease each year and the costs of running the practice to increase each year substantially.

The administrative fee schedule will be:

Family with *one* child: \$100/year

Family with *two* children: \$125/year

Family with *three* (or more) children: \$150/year

The yearly fee for the upcoming year is due by December 31. This must be paid to have your children continue as patients of MPA. Please be advised that payment of the administrative fee does NOT relieve you of your responsibility for payment of co-payments, deductibles, co-insurance, or other charges determined to be non-covered by your insurance plan and is NON-refundable.

Please understand that we are not making this decision without careful thought. We value each of our families and their children and appreciate being entrusted with their care. We believe this charge will allow us to continue delivering the same high level of care as we have for the last 35 years.

Sincerely,
Wayne L. Sager, MD

MPA Policy Statement: Immunizations and Immunization Schedules

For the last decade, MPA has had a policy in place that requires all our patients to be fully immunized per the schedule published by the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control. The only variations we have allowed have been to delay or exclude the live virus vaccines (MMR and chickenpox) when either the patient's or a family member's medical condition made administering those vaccines dangerous to the affected person. We have also postponed immunizations when a patient was undergoing chemotherapy or any other therapy, which would have made receiving such immunization dangerous.

Recently, we have received several requests from parents to allow different immunization schedules from the one that we use. We have not granted and will continue to disallow such requests unless we receive valid medical justification for the request.

Many of the requests are for an 'alternative' schedule, as proposed by some authors. Others are for 'delayed' administration of the immunizations. We support the AAP/ ACIP schedule because it has been developed with many years of research and validation by sound scientific methods, and we know from our experience that it is a safe and effective schedule. None of the alternative or delayed schedules have been validated, and we, therefore choose to continue with our policy.

We invite questions from our patients and parents and will do our best to answer them fully, thereby alleviating any concerns or fears you may have. We will not authorize an 'alternative' schedule that is not medically justified.

By signing below, I acknowledge that I understand this policy:

Printed Name

Signature

Date



Midland Pediatric Associates

PATIENT REGISTRATION FORM

WE ASK THAT THIS REGISTRATION FORM BE FILLED OUT IN COMPLETION. IT IS VITAL FOR MPA TO HAVE ALL OF THE REQUESTED INFORMATION. THIS FORM MUST BE FILLED OUT BY A BIOLOGICAL PARENT, ADOPTIVE PARENT, OR A LEGAL GUARDIAN, STEP-PARENTS CANNOT SIGN FOR HIS/HER STEP-CHILD(REN).

PLEASE NOTE: IF ANY OF THIS INFORMATION CHANGES IT IS THE RESPONSIBILITY OF THE PARENT(S) / GUARDIAN(S) TO ALERT MPA OF THOSE CHANGES. THIS INCLUDES CHANGES TO INSURANCE ELIGIBILITY, STATUS, OR COVERAGE OPTIONS.

Please **CIRCLE** which Provider you are requesting. We will notify you if your selected provider is unavailable and offer alternatives:

Dr. Sager

Marlena Flores
MSN, RN, CPNP

Tokkie Orogbemi
MSN, RN, CPNP

Referred by _____ Today's Date _____

FOR NEWBORNS: OB/GYN _____ Expected Due Date _____

SECTION A: PATIENT'S INFORMATION

Patient's Legal Name: First _____ M.I. _____ Last _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Sex _____ Patient's Social Security # _____

Race: (Circle One) White / Black or African American / Asian / American Indian or Alaskan Native /
Hawaiian or Pacific Islander / Other Race / Decline to Specify

Ethnicity: (Circle One) Unknown / Hispanic or Latino / Non-Hispanic or Latino / Declined to Specify

Languages Spoken in the Home _____

FOR OFFICE USE ONLY

PATNO: _____

SCANNED BY: _____ DATE: _____

ENTERED BY: _____ DATE: _____

SECTION B: PARENT'S/GUARDIAN'S INFORMATION

If any information is the same as above, please indicate by writing "same" in the appropriate section. In the case of blended families with multiple guardians, the biological parents, should be listed, if known. Who so ever is listed as Primary Guardian will be noted as financially responsible "the guarantor" of the patient's billing account.

Primary Guardian's Name: First _____ M.I. _____ Last _____

Legal Relationship to Patient: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Sex _____ Social Security # _____

Email Address _____

Authority Over the Patient: (Circle One) Exclusive / Joint / Emergency Only / Financial Only

Race: (Circle One) White / Black or African American / Asian / American Indian or Alaskan Native /
Hawaiian or Pacific Islander / Other Race / Decline to Specify

Ethnicity: (Circle One) Unknown / Hispanic or Latino / Non-Hispanic or Latino / Declined to Specify

Employer Information: Employer's Name _____

Address _____ City _____ State _____ Zip _____

Employer's Telephone _____ Email _____

Secondary Guardian's Name: First _____ M.I. _____ Last _____

Legal Relationship to Patient: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Sex _____ Social Security # _____

Email Address _____

Authority Over the Patient: (Circle One) Exclusive / Joint / Emergency Only / Financial Only

Race: (Circle One) White / Black or African American / Asian / American Indian or Alaskan Native /
Hawaiian or Pacific Islander / Other Race / Decline to Specify

Ethnicity: (Circle One) Unknown / Hispanic or Latino / Non-Hispanic or Latino / Declined to Specify

Employer Information: Employer's Name _____

Address _____ City _____ State _____ Zip _____

Employer's Telephone _____ Email _____

PATNO: _____

SECTION D: OTHER CONTACTS AND CARE TAKERS

In case of an emergency and you are not available at the above number, please list who you want as the primary emergency contact.

Emergency Contact:

Name _____ Cell Phone _____

Relationship to Patient _____

There may be times when you ask a friend or relative to bring your child to the doctor. Please list those people who you authorize to bring your child to our office and, therefore, authorize him/her to have access to the patient's pertinent medical information.

Additional Contacts:

Name _____ Cell Phone _____

Relationship to Patient _____

Name _____ Cell Phone _____

Relationship to Patient _____

Name _____ Cell Phone _____

Relationship to Patient _____

Name _____ Cell Phone _____

Relationship to Patient _____

I authorize that I am biological parent or legal guardian of this patient and I have the authority to give this authorization. I understand that it will be my responsibility to ensure that this document is up to date and on file any time an individual(s) need to be added or removed.

Sign _____

Date _____

SECTION E: INSURANCE INFORMATION

We must have a copy of your current insurance card at each visit. Please notify us if you have a tertiary insurance so that we can provide you with another form. If any information is the same as above, please indicate by writing "same" in the appropriate section.

Primary Insurance:

Name of Insurance Company _____

Address _____ City _____ State _____ Zip _____

Policy Number _____ Group Number _____

Subscriber's Information: Patient's Relationship to Subscriber: (circle one) Self Spouse Child Other

Subscriber's Name: First _____ M.I. _____ Last _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Policy Holder's D.O.B. _____

Policy Holder's Social Security Number _____

Employer Information:

Employer Name _____

Address _____ City _____ State _____ Zip _____

Employer's Telephone _____ Email _____

Secondary Insurance: (if applicable)

Name of Insurance Company _____

Address _____ City _____ State _____ Zip _____

Policy Number _____ Group Number _____

Subscriber's Information: Patient's Relationship to Subscriber: (circle one) Self Spouse Child Other

Subscribers Name: First _____ M.I. _____ Last _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Policy Holders D.O.B. _____

Policy Holder's Social Security _____

Number **Employer Information:**

Employer Name _____

Address _____ City _____ State _____ Zip _____

Employer's Telephone _____ Email _____

NOTICE: IF MORE THAN 1 POLICY, BOTH INSURANCE COMPANIES MUST BE AWARE OF THE OTHER POLICY COVERING THE PATIENT. THE INSURANCE COMPANY'S GUIDANCE ON PRIMARY/SECONDARY SEQUENCING MUST BE FOLLOWED. THIS IS CALLED COORDINATION OF BENEFITS (COB) AND CAN ONLY BE ESTABLISHED OR CORRECTED BY THE SUBSCRIBER; THEREFORE, A LACK OF CORRECTING COB DENIALS IN A TIMELY MANNER WILL RESULT IN THE FAMILY BEING BILLED FOR THE TOTAL BALANCE OF SERVICES RENDERED.

SECTION F: ASSIGNMENT OF BENEFITS/ RELEASE OF MEDICAL INFORMATION:

I request that payment of my insurance benefits be made on my behalf to Midland Pediatric Associates for any services furnished to me by these physicians.

Sign _____ Date _____

I authorize the release of medical information for processing my medical claim. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Sign _____ Date _____

Names of Siblings at Midland Pediatrics:

Name : _____ Date of Birth _____

Name : _____ Date of Birth _____

Name : _____ Date of Birth _____

Name : _____ Date of Birth _____



Patient Name: _____

Date of Birth: _____

NOTICE OF MOBILE CHECK-IN, RESPONSIBLE PARTY FOR DATA ACCURACY, & DIGITAL POLICY ACKNOWLEDGEMENTS

- MIDLAND PEDIATRICS NOW USES PHREESIA AS A VENDOR PARTNER THAT ALLOWS US TO OFFER ONLINE & MOBILE PRE-REGISTRATION PRIOR TO EACH VISIT SCHEDULED AT OUR CLINIC. USING THE PHREESIA PRE-REGISTRATION PROCESS TO CHECK-IN, FOR ANY TYPE OF APPOINTMENT, IS REQUIRED.
- THE FIRST TIME THIS PRE-REGISTRATION IS COMPLETED, FOR EACH PATIENT, IT IS PRUDENT TO REVIEW THE DATA THAT HAS BEEN ENTERED INTO THE PATIENT'S CHART FOR ACCURACY AS WELL AS TO READ AND ACKNOWLEDGE ALL OF OUR PRACTICE POLICIES.
 - AFTER ACKNOWLEDGING THE PRACTICE POLICIES YOU WILL NOT BE PRESENTED WITH THEM AGAIN FOR ACKNOWLEDGEMENT UNTIL 1 YEAR HAS PASSED - OR A POLICY HAS CHANGED SINCE YOUR LAST ACKNOWLEDGEMENT.
 - A PRINT OUT OF OUR PATIENT POLICIES CAN BE PRINTED OUT FOR YOU UPON REQUEST. ALTHOUGH IN A DIFFERENT FORMAT - ALL INFO PERTAINING TO OUR PATIENT POLICIES IS CONTAINED IN THE CONTENT OF OUR WEBSITE THAT CAN BE REVIEWED AT ANY TIME.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, parent or legal guardian of the patient named above, acknowledge that MPA provided me with a written copy of its Notice of Privacy Practices and informed me that this notice is available on MPA's website and is also available in Spanish, upon request.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ ANY AND ALL NOTICES IN THIS DOCUMENT AND AGREE TO ABIDE BY THE CONTENTS HEREIN.

Signature

Date

Printed Name

Relationship to Patient

**The next 5 pages are your copy of the Notice of Privacy Practices.
This is for you to keep and does not need to be returned with the rest of the
registration documents.**

PATNO: _____



Texas Immunization Registry (ImmTrac2) Minor Consent Form



A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____
_____/_____/_____ Child's Gender: ☐ Male _____ - _____ - _____
Child's Date of Birth (mm/dd/yyyy) ☐ Female Telephone _____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)			Ethnicity (select only one)
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). <https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007>.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, the child's immunization information may by law be accessed by a public health district or local health department, for public health purposes within their areas of jurisdiction, a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient, a state agency having legal custody of the child, a Texas school or child-care facility in which the child is enrolled, and a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. <https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705>.

Please mark the box below to indicate whether your child is an **Immediate Family Member of a First Responder**.

☐ I am an IMMEDIATE FAMILY MEMBER of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas Immunization Registry.

Parent, legal guardian, or managing conservator:

Printed Name _____ Signature _____ Date _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.texas.gov> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Provider Statement

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Contact Information

Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com

Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347



Midland Pediatric Associates

4214 Mamies Cr

Midland, TX 79707

Phone: 432-620-8687 Fax: 432-682-1831

MEDICAL RELEASE FORM

PLEASE NOTE: MPA should have complete records prior to being seen as a patient. Policy **requires** that MPA has the patient's current vaccination record, at a bare minimum, before being seen as a patient.

For transferring patients only.

Leave blank or discard for newborn registration.

This authorizes you to provide a copy of medical records (as indicated by the checkmark(s) below) or otherwise release confidential information for:

Name: _____ D.O.B.: _____

- ☒ Completed Record
- ☐ Records of care from _____ to _____
- ☐ Records concerning the following conditions: _____
- ☐ Other, please specify: _____
- ☐ Confer with person(s) listed below orally about my medical information

Release of records **FROM** the following person(s)/clinic:

Release of records **TO** the following person(s)/ clinic:

Name: _____

Name: Midland Pediatric Associates

Address: _____

Address: 4214 Mamies Cir., Midland, TX 79707

Phone: _____

Phone: 432-620-8687

Fax: _____

Fax/Email: 432-682-1831

The purpose for this release of information is as follows: Transferring care to Midland Pediatric Associates

This authorization shall be in force and effect until: **6 months from the date below**, at which time this authorization to disclose this protected health information expires.

HIV/AIDS: I consent to the release of any positive or negative test results for HIV or AIDS infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

INITIAL: _____ DATE: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to MPA at 4214 Mamies Cr Midland, TX 79707. I understand that a revocation is not effective to the extent that MPA has relied on the disclosure of the protected health information. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

MPA will not condition my treatment, payment, and enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the request disclosure.

Parent/Legal Guardian

Date

Relationship to Patient

Witness

I understand that you will provide this information within 14 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

DO NOT WRITE BELOW THIS LINE, FOR OFFICE USE ONLY

COMPLETED BY: _____

Date: _____



Midland Pediatric Associates

Welcome to Midland Pediatric Associates

Thank you for choosing MPA as your child's medical home. We are proud to partner with you in the care of your child by offering a comprehensive practice that meets the varying needs of our clinic families.

*The clinic Lactation Consultants are available to help you get comfortable with breastfeeding, help you prepare for pumping and returning to work and answer any breastfeeding related questions you might have.

*Free "before baby comes" breastfeeding education offered in our clinic.

*Breastfeeding help offered in person or virtual for the convenience of our patients and their families

Thank you, again, for choosing MPA and we look forward to being part of your family.



**Your Information.
Your Rights.
Our Responsibilities.**

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

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
- File a complaint if you believe your privacy rights have been violated

➤ **See page 2** for more information on these rights and how to exercise them

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

➤ **See page 3** for more information on these choices and how to exercise them

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
- Respond to lawsuits and legal actions

➤ **See pages 3 and 4** for more information on these uses and disclosures

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities 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 correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We 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 shared 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 shared 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, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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 make sure the person has this authority and can act for you 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 1.
- 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/hipaa/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 others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your 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 the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

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

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

continued on next page

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/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- 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.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes 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

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
-

Instruction C: Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."

Instruction D: The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.

Instruction E: If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.

To leave this section blank, add a word space to delete the instructions.

Our Responsibilities

- We are required 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 in this notice and give you a copy of it.
- We will not use or share your information other than as 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/hipaa/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.

2018-05-10

This Notice of Privacy Practices applies to the following organizations.

MIDLAND PEDIATRIC ASSOCIATES, PLLC