VIP PEDIATRICS, PA

WRITTEN ACKNOWLEDGEMENT OF RECIEPT OF VIP PEDIATRICS NOTICE OF PRIVACY PRACTICES, CONSENT TO TREAT, & ADVANCED DIRECTIVES

General Consent to Treat

I am the parent/guardian of _____ (name of patient). I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that Dr. Wolens and his designated associates or assistants believe are necessary for this child. Additionally, I understand that services may be rendered by an advanced practice nurse. An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I understand that by signing this form, I am giving permission to the doctors, physician assistants, advanced practice nurses, nurses, and other health care providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent. I understand that at any time I can refuse to see the advanced practice nurse or physician assistant and request to see a physician.

I voluntarily authorize and consent to the exchange of medical data including medications, consults, vaccinations, diagnostic tests, and hospital records.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Advanced Directives

In Texas, there are three types of Advanced Directives. Please check all boxes for forms that you have already completed and provide copies of these forms for VIP PEDIATRICS to place in child=s medical record. Please leave area blank if this does not pertain to the patient.

1. _____ Directive to Physicians 2. _____ Medical Power of Attorney
3. _____ Out-of-Hospital Do Not Resuscitate Order (DNR).

Authorization for Specific Communication (Please check the appropriate boxes)

_____ I authorize VIP PEDIATRICS to leave general medical information messages for this patient on telephone voice mail systems for numbers I have provided.

_____ I authorize VIP PEDIATRICS to communicate (non-urgent issues only) via email.

Notice of Privacy Practices

By signing below, you acknowledge receiving the VIP PEDIATRICS Notice of Privacy Practices (Notice). The Notice explains how VIP PEDIATRICS may use and disclose your protected health information for treatment, payment, and health care operations purposes.

Protected health information means your personal health information found in your medical and billing records.

Your signature below acknowledges that your consent of treatment for the patient by a doctor or nurse practitioner, authorization to the above checked communications, and receipt of the Notice.

If you have questions about the Notice, please contact VIP PEDIATRICS. Contact information is located in the Notice.

Name of Patient: _____

Print Name of Patient=s Representative _____

Relationship of Patient=s Representative to Patient: _____

Signature of Patient or Patient=s Representative: _____

Date: _____

PATIENT REGISTRATION

VIP Pediatrics Today's Date: _____

CHILD

_____ _____
Full Name Date of Birth

_____
Address where child lives (Street and Apt #, City, State, and Zip)

_____ Sex : ☐ Male ☐ Female
Telephone Number where child lives

_____ _____
Who referred patient? Pharmacy Phone Number

PARENT #1

_____ _____
Full Name Date of Birth

Sex : ☐ Male ☐ Female SS#_____ Driver's License # _____

_____
Address (if different from where child lives) (Street and Apt #, City, State, and Zip)

_____ _____
Home Telephone Number Cellular Telephone Number

_____ _____
Work / Day Telephone Number Occupation / Employer

PARENT #2

_____ _____
Full Name Date of Birth

Sex : ☐ Male ☐ Female SS#_____ Driver's License # _____

_____
Address (if different from where child lives) (Street and Apt #, City, State, and Zip)

_____ _____
Home Telephone Number Cellular Telephone Number

_____ _____
Work / Day Telephone Number Occupation / Employer

Check in the box next to any of the above telephone numbers if you would like to have messages with specific medical information (labs, etc.) on this patient recorded on Voice Mail associated with the number.
☐ Check here if we have your permission to leave messages with specific medical information at this E-Mail address _____

Updated 2012

PATIENT REGISTRATION

SIBLINGS

Full Name	Date of Birth	
_____	_____	Male Female
_____	_____	Male Female
_____	_____	Male Female
_____	_____	Male Female
_____	_____	Male Female

EMERGENCY

_____
Full Name of Adult #1 NOT living with child to contact in case of Emergency

_____
Address of Emergency Contact #1 (Street and Apt #, City, State, and Zip)

_____ _____
Telephone # of Emergency Contact #1 Relationship to Patient

_____
Full Name of Adult #2 NOT living with child to contact in case of Emergency

_____
Address of Emergency Contact #2 (Street and Apt #, City, State, and Zip)

_____ _____
Telephone # of Emergency Contact #2 Relationship to Patient

PAYMENTS

_____ _____
Full Name of person legally responsible for Payments Relationship to Patient

SS#_____ Driver's License # _____

_____
Address (if not where child lives) (Street and Apt #, City, State, and Zip)

_____ _____
Home Telephone Number Day or Alternate Telephone Number

Updated 2012

VIP PEDIATRICS FINANCIAL POLICY

VIP PEDIATRICS is committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

TO assist us in establishing your VIP PEDIATRICS financial account, please:

- Supply all necessary information for the accurate billing of your claims, including your insurance card, employer information, and demographic information. Please update any changes to this information promptly.
- Satisfy all insurance co-payments, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and VIP PEDIATRICS with any additional information requested to complete the processing of claims filed on your behalf.
- Authorize release of information necessary for insurance filing and pre-certification (sign on this sheet below).

UNACCOMPANIED MINORS
Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE:
VIP PEDIATRICS does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING INSURANCE
Indemnity/Fee for schedule for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement when asked by you so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing.

Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or reasonable and customary charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.

I do ___ do not ___ currently have Medicaid insurance (please check one)

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)
Each time you make an appointment with VIP PEDIATRICS it is your responsibility to make sure that Dr. Wolens is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. *Please plan to show your current card at each visit.*

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to keep track of the expiration dates and for giving your doctor's office a minimum of 48-hours notice before being seen by a specialist. Retro referrals may not be allowed on all managed care plans. Therefore, if a referral is not obtained, you may be held responsible for payment in full by the Specialist.

- **I have read and understand that I am personally responsible for payment on this account.**
- **Assignment: I hereby authorize payment directly to VIP PEDIATRICS or Dr. Jeoffrey K. Wolens. Any changes in this authorization must be received in writing within thirty days of the effective date.**
- **I understand that this practice has a No-show Appointment fee of $20.00 for first no-show., increasing by $20 for every no show in the family I am responsible for paying this fee if I do not cancel an appointment with 24-hours notice. If 3 no-shows occur for a family, no further appointments will be made and all your children will be discharged from the practice.**
- **A Returned Check fee of $30 will be charged for any check returned for insufficient funds.**
- **Basic School, Camp and Sports and other forms will be assessed $10 per form to complete (fee waived if completed at time of well visit or sports exam).**
- **Complex Forms requiring detailed explanations or calculations with be assessed $25 per form to complete. We require 24 hours to complete these forms.**
- **Requests for "Rush", ie. same day or required in less than 24 hours, form completion not done at time of well visit will be assessed the form charge plus an extra $25 per form.**
- **In the event my insurance company deems a service to be non-covered, I understand that I am personally responsible for payment.**
- **I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of the effective date.**
- **Phone calls, portal messages and email questions may be assessed charges as allowed by insurance coding.**

Print Name: _____ Date: _____

Guarantor Signature: _____ Relationship to Patient: _____

PATIENT(S) NAME: _____

Jeoffrey K. Wolens, MD, FAAP
2727 Gramercy St., Suite #225
Houston, Texas 77025
(713) 665-4567 (telephone)
(713) 665-8962 (fax)
www.vippediatrics.com

PAYMENT POLICIES

Thank you for choosing VIP Pediatrics for your child's medical care. We are providing you with the following information to help you understand our insurance and billing policies.

Your Responsibilities

- You must **show your current insurance card at every visit**. This is to protect you from receiving a bill because we did not have correct insurance information. We will attempt to validate your insurance benefits at time of service and alert you to any problems. If we cannot validate your coverage, we may assign your account to self-paid status and request full payment at the end of your visit.
- You must **pay your co-payment at the time of the office visit**. Our contracts with insurance companies require us to collect your co-pay at the time of service. We accept cash, credit cards (VISA, MasterCard, Discover, American Express), and checks as forms of payment. In the event a personal **check is returned unpaid** from your bank, your account will be charged with a returned check fee of $30, and your account may be placed on a "cash only" basis for up to one year.
- Your insurance plan is subject **to copays**, **routine deductibles and co-insurance**. We require that you allow us to keep a credit card on file at our Credit Card Merchant Service provider so we can collect those charges as soon as your insurance carrier assigns the appropriate amount of patient responsibility. During the time you leave a credit card on file, if it expires or otherwise becomes uncollectable, we will expect you to promptly provide a new means of payment.
- You must **cancel any appointment you cannot keep** at least 24 hours prior to your scheduled start time. Otherwise you may be assessed a $20 missed appointment fee. **No-show Appointment** fee of $20 for first no-show, increasing by $20 for every no-show in the family. If 3 no-shows occur for a family, no further appointments will be made and all of your children will be discharged from the practice.
- **Know your insurance benefits**. Your insurance policy is a contract between you and your insurance company, even if your employer provides it. There are many subtle differences in insurance policies, and employers frequently change coverage and co-payments. You are responsible for knowing what services are covered (and how often, in the case of well visits), and how much of the cost is your responsibility. You will be responsible for any portion of services that your insurance doesn't cover, or for which you have a deductible that has not yet been met. You should also be aware of where your insurance wants you to go for any lab or radiology procedures, so that in an urgent situation, you are seen at the appropriate facility and will not receive a bill.
- If your insurance plan requires you to **choose a primary care provider**, you must contact your carrier and select our office as soon as your medical records are transferred. In

accordance with carrier guidelines, we cannot schedule any appointments or write any referrals until we receive notice that you have been added to our roster.

- If you have a **newborn or newly adopted child**, congratulations! Most plans typically cover newborns for the first 30 days by the mother's policy, regardless of which parent will provide ongoing insurance coverage. You should contact your carrier as soon as feasible to add the new child to your policy. Permanent coverage must be in place before the automatic newborn coverage expires. Contact your carrier for coverage details.
- If your child is **covered by more than one insurance policy**, be sure you know which is considered primary. We must submit claims to the appropriate carrier(s) in the right order.
- **Carefully read all Explanation of Benefits (EOB) statements** you receive from your insurance carrier. We receive the same statements, and any charges which your insurance carrier designates as "patient responsibility" will be charged directly to the credit card on file.

Our Collection Procedures

- If your account is **self-pay**, all services must be paid for at the time of your visit. This may include situations where we cannot validate active coverage with your insurance carrier. In such cases, we will collect payment at time of service and refund any amounts subsequently collected from your carrier.
- If you have valid coverage with a **participating insurance carrier**, we will file an insurance claim within five business days of your date of service. If there are any problems with this submission, we will notify you immediately and request your prompt assistance with any conditions under your control that are causing a delay in processing. If your insurance carrier does not respond within 30 days, we will submit a second claim. If your insurance carrier does not respond to our secondary submission within 60 days from the original date of service you will be notified, payment will become your responsibility and the credit card on file will be charged
- If your participating insurance policy is subject to **routine copay, deductibles and/or co-insurance** that cannot be collected on the date of service, we will charge your credit card on file as soon as your carrier provides an EOB designating your financial responsibility for the claim. You will be notified, via specified billing preference, 10 days prior to charging your card on file.
- If you are **uninsured** or insured by a **non-participating insurance carrier** we will expect payment from you at time of service, and it will be your responsibility to submit any claims to your insurance company for direct reimbursement to you. We will provide you with the appropriate information to assist you in this process.
- We will no longer mail out patient statements. You will be notified, via your specified billing preference, 10 business days prior to charging your card on file. If you choose to pay by alternate payment method or need to set up payment arrangements, you will need to contact our office within this 10 day notification period. If your credit card on file is declined, our office will notify you. You will have 10 business days to update the information. If you do not provide the updated information in the specified time, your account will be considered delinquent. Routine (non-urgent) office appointments and routine paperwork/forms may be declined to delinquent accounts. If charges remain unpaid after 60 days, a final statement will be rendered with a letter informing you that our relationship is subject to cancellation after 30 days of urgent and emergent care.

- We reserve the right to place your account with our collection agency after all internal efforts to obtain payment have been exhausted. You are then responsible for any collection costs in addition to your outstanding bill. If you are presently in collection, the practice will use its discretion as to providing you with further treatment or asking you to find another physician.

Patient Consent for Use of Email Communications

V.I.P. Pediatrics, P.A.
2727 Gramercy Street, Suite 225
Houston, TX 77025

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at info@vippediatrics.com. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 24 hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, patient name and return phone number in the body of your message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications related to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communication from work, you should be aware that some companies consider email corporate property and your message may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that although addressed to me, my staff and/or colleagues would have access to this information.

Our office does offer secure communication for medical questions, prescription refills, or appointment requests through our patient portal at www.vippediatrics.com. Note this is not for emergent questions and the turn-around time is 1 business day.

I understand that this office will not be responsible for information loss or delay or breached in confidentially that are due to technical factors beyond this office's control.
I understand and agree to the above email policy.
By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

_____	_____	_____
Patient Name	Parent/Guardian Signature	Date

Updated 1/2012

VIP Pediatrics, 2727 Gramercy STE 225, Houston, TX 77025 Phone: 713-665-4567 Fax: 713-665-8962

Authorization to Use/Release/Disclose Health Information

PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORDS REQUESTS.

Section A: (Must be completed for all authorizations)

I, _____, understand that VIP Pediatrics is authorized by me to use, release, and/or disclose the Protected Health Information (PHI) as described below. I understand the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy regulations.

- **If this request is for any patient 18 years or older, the form must be signed by the patient.**
- **If the patient is in the custody of the county, a representative of the county (Ex: social worker) must complete this release form. (Not the foster parent)**
- **If the request is for records to be sent to VIP Pediatrics, this form may be mailed or faxed by the parent and not from VIP Pediatrics.**

Patient's Full Name: _____ **Date of Birth:** _____ **Best Contact #:** _____

Release From:

Name: _____

Address: _____

_____

Release To:

Name: _____

Address: _____

_____

I authorize the following information to be sent to the above address (Check all that apply):

____ Copy of Complete Medical Records (specify dates) Date: ____ / ____ / _____ to ____ / ____ / ____

____ Copy of Information described below Date: ____ / ____ / _____ to ____ / ____ / _____

- ____ History & Physical Exams
- ____ Reports from other Physicians (Specialist)
- ____ Labs, X-rays, etc. reports
- ____ Other (Explain): _____

___ The following information should **NOT** be released (Explain): _____

Purpose of use or disclosure:

____ Transferring to another provider ____ Physician/Staff Request

____ Patient/Parent Request ____ Moving

Other (Please explain): _____

Section B: (Must be completed for ALL Authorizations)

I understand that:

- I may revoke this authorization at any time by notifying VIP Pediatrics in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. I may request or copy the protected health information to be used or disclosed.
- This authorization will expire ten years from today's date unless otherwise specified.
- VIP Pediatric assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization.

Patient/Parent/Guardian Signature: _____ **Relationship:** _____ **Date** _____

Office Use Only: Initials: _____

Patient Chart #: _____ Date Information Disclosed: _____ Date reviewed: _____

Revised: 11/30/2017

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac2)
MINOR CONSENT FORM

(Please print clearly)

ImmTrac 2
Texas Immunization Registry

For Clinic/Office Use

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth ___ / ___ / ___ ***Children under 18 years only.***

Child's Gender: ☐ **Male** ☐ **Female**

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized 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 state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, 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;
- 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 to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

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

Date

Signature

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.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider. Questions?

(800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 05/18/2012

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac2 *– Please enter client information in ImmTrac2 and* ***affirm*** *that consent has been granted.* ***DO NOT fax to ImmTrac2. Retain this form in your client's record.***

VIP PEDIATRICS, P.A.
Jeoffrey K. Wolens MD, FAAP

Notice of How VIP PEDIATRICS Protects the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

VIP PEDIATRICS may *use* or *disclose your protected health information (PHI) for treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in any health care records VIP PEDIATRICS maintains regarding you that could identify you.

- *"Treatment, Payment and Health Care Operations"*

    - *Treatment* is when VIP PEDIATRICS provides, coordinate or manage your health care and other services related to your health care. An example of treatment would be when VIP PEDIATRICS consults with another health care provider.
    - *Payment* is when VIP PEDIATRICS obtains reimbursement for your health care. Examples of payment are when VIP PEDIATRICS discloses your PHI to any third party payor to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- *"Use"* applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- *"Disclosure"* applies to activities outside my practice such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

VIP PEDIATRICS may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*"is written permission permitting specific disclosures above and beyond those permitted by the general consent. In those instances when VIP PEDIATRICS is asked for information for purposes outside of treatment, payment and health care operations, VIP PEDIATRICS will obtain an authorization from you before releasing this information. VIP PEDIATRICS will also need to obtain an authorization before releasing your medical records. You may revoke all such authorizations (regarding PHI) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) VIP PEDIATRICS has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest

the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

VIP PEDIATRICS may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If VIP PEDIATRIC has cause to believe that a child has been, or may be, abused, neglected, or sexually abused, VIP PEDIATRICS must make a report of this belief within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or any local or state law enforcement agency.

- **Adult and Domestic Abuse**: If VIP PEDIATRICS has cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, VIP PEDIATRICS must immediately report this belief to the Department of Protective and Regulatory Services.

- **Health Oversight**: If a complaint is filed against me with the Texas State Board of Medical Examiners they have the authority to subpoena confidential medical information from me relevant to that complaint.

- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law. VIP PEDIATRICS will not release such information unless VIP PEDIATRICS has either written authorization from you or your personal or legally appointed representative or else a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety**: If VIP PEDIATRICS determines that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, VIP PEDIATRICS may disclose relevant confidential medical information to medical or law enforcement personnel.

- **Worker's Compensation**: If you file a worker's compensation claim, VIP PEDIATRICS may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Your Rights and My Duties Your Rights:

- *Right to Request Restrictions*. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, VIP PEDIATRICS is not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, VIP PEDIATRICS will send any mail to you at another address that you provide me.)

- *Right to Inspect and Copy*. You have the right to inspect or obtain a copy (or both inspect and obtain a copy) of PHI and billing records used to make decisions about you for as long as the PHI is maintained in the record. VIP PEDIATRICS may charge a reasonable fee for copying expenses.

- *Right to Amend*. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. VIP PEDIATRICS is not required to accept your request for amendment.

- *Right to Request Restriction or Accounting*. You may request restrictions on how VIP PEDIATRICS uses and/or discloses your PHI. You generally have the right to receive an accounting of disclosures of PHI for which you have provided neither consent nor authorization (as described in Section III of this Notice).

- *Right to Request Confidential Communications.* You may request communications from VIP PEDIATRICS concerning your PHI be made in certain ways or at a certain location. You must specify any preferences regarding confidential communications in writing.

- *Right to a Paper Copy*. You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

My Duties:

- VIP PEDIATRICS is required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- VIP PEDIATRICS reserves the right to change the privacy policies and practices described in this notice. Unless VIP PEDIATRICS notifies you of such changes, however, VIP PEDIATRICS is required to abide by the terms currently in effect.

- VIP PEDIATRICS may revise the terms of this notice. If VIP PEDIATRICS revises this notice, VIP PEDIATRICS will follow the terms of the revised notice from date of revision.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision VIP PEDIATRICS makes about access to your records, or have other concerns about your privacy rights, you may contact me.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at the address provided on my letterhead.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. VIP PEDIATRICS can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. VIP PEDIATRICS will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on March 6, 2006.

VIP PEDIATRICS reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHIs that VIP PEDIATRICS maintains. A copy of the current notice will be posted at our office for your review at each office visit. Additionally, a copy will be available at www.vippediatrics.com with the effective date at the bottom of the notice.

Updated 1/2013