DELTA PEDIATRICS

PATIENT INFORMATION

Date_____/_____/_____ Male ___ Female ____

Patient's Name: _____
Last First MI

Home Address: _____

Home Phone: (_____) _____

Date of Birth: _____/_____/_____ Age: _____ SS# _____-_____-_____
Mo Day Year

PARENT/GUARDIAN INFORMATION

Mother's Name: _____ Date of Birth: _____/_____/_____
Last First MI

Home Address: _____

Home Phone: (____) _____ Cell Phone: (_____)_____

Email _____

SS#: _____-_____-_____ Employer's Name: _____

Marital Status: Married ____ Single ____ Divorced ____ Separated ____

Father's Name: _____ Date of Birth: _____/_____/_____
Last First MI

Home Address: _____

Home Phone: (____) _____ Cell Phone: (_____)_____

Email_____

SS#: _____-_____-_____ Employer's Name: _____

Marital Status: Married ____ Single ____ Divorced ____ Separated ____

NEXT PAGE→

INSURANCE INFORMATION

Primary Insurance:

Name of Insurance Plan: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

I.D. Number (include alpha prefix): _____

Group Name and Number: _____

Effective Date: _____ Copay Amount: $_____

Secondary Insurance:

Name of Insurance Plan: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

I.D. Number (include alpha prefix): _____

Group Name and Number: _____

Effective Date: _____ Copay Amount: $_____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: ( ) _____

I, _____ acknowledge that I am responsible and liable for all charges accessed for professional services rendered. I acknowledge that I am responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Delta Pediatrics. I understand that I am responsible for my deductible, coinsurance and any non-covered services. Should my account become past due, the balance shall become immediately due and payable. I further authorize my insurance company to release any medical information necessary to process pending and or unpaid claims, and hereby assign payment of all medical benefits to Delta Pediatrics.

_____/____/_____
Signature Date

How did you hear about us?_____

DELTA PEDIATRICS

INITIAL PEDIATRIC HEALTH HISTORY

Your child's health is important to us. Please fill out this form as completely and as accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss with you. All information is treated confidentially.

PATIENT INFORMATION

Patient Name: _____,_____,_____ ☐ Male ☐ Female
Last First Middle

Date of Birth: _____-_____-_____ Age:_____ Child's Prior Pediatrician:_____
Month Day Year
Preferred Method of Contact (Choose one) ☐ Phone ☐ Email ☐ Mail

Are there any pets in the home? ☐ No ☐ Yes _____
Can we send lab results to your email? ☐ No ☐ Yes
Does anyone smoke in the home? ☐ No ☐ Yes

GENERAL INFORMATION

Reason for today's visit? _____

Does your child have any serious illness or medical condition? ☐ yes ☐ no Explain:_____
Has your child had any serious accidents? ☐ yes ☐ no Explain:_____
Has your child had any surgery? ☐ yes ☐ no Explain:_____
Has you child ever been hospitalized? ☐ yes ☐ no Explain:_____
Is your child allergic to any medicines or drugs? ☐ yes ☐ no Explain:_____
Is your child currently taking any medications (either prescription or non-prescription)? ☐ yes ☐ no Explain:_____

CHILD'S BIRTH HISTORY

Birth weight: ____ lbs ____ oz.	Did mother have any complications with her pregnancy? ☐ No ☐ Yes, Explain
Child born ☐ Term ☐ Early ☐ Late? If early how many weeks gestation?	Was the delivery ☐ vaginal ☐ cesarean If cesarean, why? _____

MEDICAL HISTORY

Check box ONLY if your child has or has ever had any of the following:

- ☐ Abdominal pain (frequent)
- ☐ Alcohol or drug use
- ☐ Allergies
- ☐ Anemia or a bleeding problem
- ☐ Asthma, bronchitis, bronchiolitis, or pneumonia
- ☐ Bed-wetting (after age 5)
- ☐ Blood transfusion
- ☐ Breathing difficulties
- ☐ Broken bones or sprains
- ☐ Chickenpox
- ☐ Constipation
- ☐ Cough (persistent)
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Earache
- ☐ Ear infections
- ☐ Ear or hearing problem
- ☐ Epilepsy or convulsions
- ☐ Eye or vision problems
- ☐ Headaches (frequent)
- ☐ Heart problem or murmur
- ☐ Hepatitis
- ☐ Measles, rubella, mumps
- ☐ Menstrual periods started (for girls)
- ☐ Menstrual period problems (for girls)
- ☐ Nausea / vomiting
- ☐ Nosebleeds
- ☐ Rectal Bleeding
- ☐ Rheumatic fever
- ☐ RSV
- ☐ Sinus problems
- ☐ Skin conditions (chronic) – i.e. eczema
- ☐ Sore throat, strep throat
- ☐ Stomachache (frequent)
- ☐ Thyroid or endocrine problem
- ☐ Urinary tract infection

☐ Any other significant problem _____

Guarantor Signature:_____ Date:_____

Delta Pediatrics

Overview of Today's Visit

Patient's Name: _____

Patient's Date of Birth: _____/_____/____

Main reason for today's visit: _____

_____

Other concerns I would like to discuss if there is time: _____

_____

Please check all that apply.

_____ I have prescriptions that I need refilled.

_____ I need a doctor's note for school or work.

_____ I need a referral for my insurance company.

_____ I need the attached forms filled out or updated.

_____ I have questions about a child other than the one to be seen.

Please help us keep your information updated.

_____ I have new insurance.

_____ I have a new address, phone or cell phone number, or e-mail address.

_____ I have a new work number.

_____ I need to update my emergency contact list.

Checklist for Parents of Newborns

Before you leave the hospital, obtain the following information to bring to the first visit:

- ☐ Discharge Weight:
- ☐ Results of any lab test performed
- ☐ Results of Bilirubin tests, if done
- ☐ Were Blood types done for Mom and Baby? If so, keep a record for yourself.

The State of Georgia is now requiring a **hearing screen** to be done on all newborns before discharge.

- ☐ Please bring the hearing screen report to the first visit.

PKU Metabolic Screening Test – this is done on all babies for several metabolic diseases which are preventable if treated early. This test will be done in the hospital before discharge. If it is done before the baby is 24 hours old, it will need to be repeated at their first visit in the office.

- ☐ Record date and time test was done:

Please call the office and schedule the following appointments:

- ☐ Newborn visit in approximately 1-3 days (after discharge from hospital) with our Physician.
- ☐ Visit #2 with our Physician at approximately 1 month of age
- ☐ Visit #3 with our Physician at approximately 2 months of age

Call your insurance company or your Human Resource Department to add your baby to the policy.

- ☐ Record date call was made
- ☐ Remember to bring the insurance card to every visit

Complete the following forms and bring them with you to your first visit:

- ☐ New Patient Information
- ☐ Pediatric Health History

DELTA PEDIATRICS

VACCINE ADMINISTRATION CONSENT FORM

I _____ authorize Delta Pediatrics
(Please Print)
to administer any immunizations as recommended by the Academy of Pediatrics and Georgia Department of Health Services Immunization Branch to my child
_____.
(Please Print Child's Name)

Signature of Parent/Legal Guardian:
_____

Date_____/_____/_____

CONSENT FOR MEDICAL SERVICES

I have been informed of the types of services I will receive and I voluntarily consent for my child _____ to be examined and evaluated by Delta Pediatrics. I also agree to any routine test to be administered as deemed necessary. Included in this agreement is permission for treatment as indicated and referral to other appropriate health facilities when necessary.

_____ _____

Signature of Parent/Legal Guardian Date

*** IF PATIENT IS UNDER 18 YEARS OF AGE, A PARENT OR LEGAL GUARDIAN MUST SIGN***

CONSENT FOR MESSAGE AUTHORIZATION

I authorize Delta Pediatrics, its representatives, physicians and staff to leave messages related to my child's healthcare on a recorder such as voicemail or answering machine at the following phone number (s):

1. _____

2. _____

3. _____

_____ _____

Signature of Parent/Legal Guardian Date

*** IF PATIENT IS UNDER 18 YEARS OF AGE, A PARENT OR LEGAL GUARDIAN MUST SIGN***

OFICINA MEDICA
AUTORIZACION DE MENSAJE

Yo,_____ autorizo a **Delta Pediatrics**, sus representantes, medicos, y personal, para dejar un mensaje relacionado con mi cuidado medico en un registrador en los numeros de telefono siguientes:
Yo entiendo que esta autorizacion es voluntaria y que puedo rechazar firmar. Yo entiendo que puedo revocar esta autorizacion a cualquier momento no firmando en el espacio señalado. Revoco por este medio esta autorizacion.

Casa:_____

Empleo:_____Ext._____ Celular:_____

Autorizado:

_____
Firma de Padre/Guarda

*** Si el paciente es menor de 18 años de edad, el padre o el guarda legal debe firmar***

Delta Pediatrics, LLC

Appointment Policy

It is our intention to provide your children the best care possible at all times and to accommodate as many requests as is realistic and feasible. It is within this context that we ask you to take a few moments to review policies that affect the way services are provided.

In the Office

- **Arrive early.** Please remember that all insurance requires that your insurance data be updated prior to each encounter. This usually takes a few minutes. If this is not done, your insurance may deny your claim. We do not want time spent on administrative requirements to limit your time with the doctor.

- **Schedule an appointment by calling 678-765-6749.** Walk-in patients are offered the first available appointment.

- **Schedule same-day appointments for sick visits.** Appointments are used on a first-available appointment basis.

- **Patients who arrive on time are seen at their appointment time.** Patients who have arrived on time will be seen ahead of those who arrive late. If you arrive late, we may need to abbreviate or reschedule your child's visit.

- **Call ahead if you are late or unable to make your appointment time.** We will do all that we can to accommodate your child's appointment and to minimize the need to reschedule your appointment.

- **Late arrivals (>15 minutes after scheduled appointment) will be offered the next available appointment.** In these cases, a no-show charge of $35 for the lost appointment will apply. While we will do all that is possible to accommodate requests, the first-available appointment may *or may not* be on the day the appointment was missed.

- **The no-show charge will be waived if you contact the office before your appointment.** Remember that appointments canceled more than 24 business hours prior to when they were scheduled do *not* incur a no-show fee.

- **Appointments for additional children should be made by phone prior to coming to the office.** If you would like another child to be seen, please schedule appointments for *both* children *by phone* prior to coming to the office.

- **Turn off cell phones in the office and examination rooms.**

After-hours Call Service

- **Please limit after-hour calls to urgent issues. For medical emergencies, call 911.** Please refer to our patient center and useful links for answers to common illness questions (Web site). For refills, appointment requests, and other nonurgent matters, you may leave a message or call the office during regular hours. Please also do the following when using this service:
    - When leaving a message, please speak slowly.
    - Be sure to leave a callback number.
    - Disable your call block feature.
    - Follow the doctor's instructions.
- **Nurse Advice Line -** Your insurance Nurse Advise Line is a health information line. The Nurse Advice Line is ready to answer your health questions 24 hours a day, every day of the year. The Nurse Advice Line is staffed with Registered Nurses. These nurses have spent lots of time caring for people. Now they are ready and eager to help you.

How can the Nurse Advice Line help me? When you • Have questions about your health • Are worried about a sick child • Do not know how much medicine to give your child • Not sure if you need to go to the emergency room • Have questions about pregnancy and more

Sometimes you may not be sure if you need to go to the Emergency Room. Call your insurance's Nurse Advice Line. They can help you decide if you have a real emergency. If you have a real emergency, go directly to the nearest hospital emergency room!

When you have questions, call the Nurse Advice Line • It's free • It's simple • It's fast

- **AETNA 1-800-556-1555**
- **Amerigroup 1-800-600-4441**
- **Blue Cross/Blue Shield of GA 1-888-724-2583**
- **Cigna or Great West 1-800-564-8982**
- **Coventry 1-888-936-2298**
- **Humana 1-800-622-9529**
- **Peachstate Health Plan 1-800-704-1484 and press option 7**
- **Tricare 1-888-475-9233**
- **United Healthcare 1-800-237-4936**
- **Wellcare 1-800-919-8807**

La Enfermera de Guardia/Después de Horas

Por favor, llame a su seguro de Línea de Consejos si la clínica está cerrada. Si es una emergencia, llame al 911. La línea de Asesoramiento de Enfermeras es una línea de información de salud. La Línea de Enfermeras está lista para responder a sus preguntas de salud las 24 horas del día, todos los días del año. La Línea de Enfermeras es personal con enfermeras registradas. Estos enfermeros han pasado mucho tiempo cuidando a la gente. Ahora están listos y dispuestos a ayudarte.

¿Cómo puede la Línea de Enfermeras ayudarme? Cuando usted • ¿Tiene preguntas sobre su salud • Están preocupados por un niño enfermo • No sabe cuánto medicamento debe darle a su hijo • ¿No está seguro si necesita ir a la sala de emergencias • ¿Tiene preguntas sobre el embarazo Y más • A veces no se puede estar seguro de si necesita ir a la sala de emergencias. Llame a su aseguradora Línea de Enfermeras. Ellos pueden ayudarle a decidir si usted tiene una emergencia real. Si usted tiene una verdadera emergencia, vaya directamente a la sala de emergencias más cercana!

Cuando usted tiene preguntas, llame a Enfermera línea de asesoramiento • Es gratis • Es simple • Es rápido

El personal Línea de Asesoramiento de Enfermera habla Inglés y Español. Si usted no habla Inglés o español, por favor, solicite un traductor.

Llame al número anterior.

We are here to provide the *best* care we can to your children should the need arise. As always, we welcome the opportunity to care for your children and appreciate your trust in the services we provide.

Medical Ear Piercing

Delta Pediatrics provides medical ear piercing services using Blomdahl Advanced Medical Ear Piercing Technology for children ages two months and above. This service is **not** restricted to Delta Pediatrics patients only but open to everyone who desires the service.

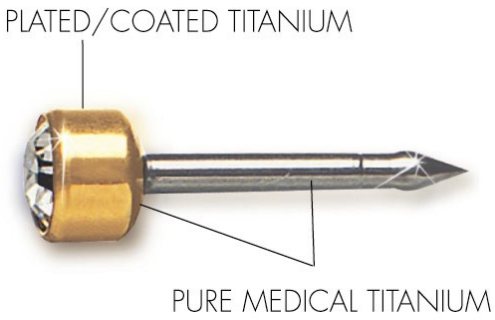
Ear piercing is a medical procedure, so there is every reason to make sure that it is done properly. Blomdahl Medical Ear Piercing has been developed from a medical standpoint, using modern technology, safe, sterile and hypoallergenic materials.

We use medical grade earrings which include medical plastic which contains 0% nickel or titanium coated earrings. This makes the risk of an allergic reaction almost negligible.

The cost of this service is from $60 cash only depending on the type of earring.

Here are some earring designs -

Medical Grade Titanium:



Titanium – the skin friendly metal for ear piercing! We use pure, homogeneous titanium of a medical grade quality because of it superior non-allergenic characteristics. Silver Titanium is coated with the exclusive precious metal rhodium. Golden Titanium is plated with 18K gold. This rhodium / gold covers only the visible part of the earring, that is to say the part that does not come into contact direct with the skin. It is only the skin friendly, pure, homogeneous titanium that comes into direct contact with the skin.

Medical Plastic Daisy - kids new favorites!

Golden Medical Plastic – 0% Nickel

Silver Medical Plastic – 0% Nickel

The finished earring

After care instructions will be provided after the procedure. The three key words to a problem free healing are CLEAN, DRY & AIRY and of course not to touch your newly pierced ears with your own hands.

Here are some frequently asked questions and answers on medical ear piercing:

1. What type of ear piercings do you offer?

We only do earlobe piercings. This is the safest place to pierce with the lowest incidence of complications. We do not pierce any other part of the ear or any other part of the body.

2. Should I get my child's ears pierced?

Ear piercing is not a medical necessity. The decision to get your child's ears pierced is based on personal and cultural preferences.

3. How early can I get my child's ears pierced?

We recommend you wait until your child has received her first set of immunizations by the age of two months.

4. Do you use a piercing gun?

No. Our instrument is a medical grade piercer. EVERY part of the instrument that comes in contact with the ears is disposable. The earrings are packaged singly and are completely encapsulated so there is no cross contamination whatsoever.

5. Do you use gold earrings?

No. It is documented that 10% of the population is allergic to gold. We use medical grade earrings which include medical plastic which contains 0% nickel or titanium coated earrings. This makes the risk of an allergic reaction almost negligible.

6. How long should I keep the ear piercing earrings on for?

6 weeks. This is how long it will take an ear lobe piercing to heal. You should wear earrings in your newly pierced ears for the first year as this will prevent the diameter of the hole from shrinking.

7. Do I have to be a part of the practice in order to get my ears pierced?

No. This service is open to everyone.

8. What are the age limits?

We offer ear piercing in babies from 2 months (after first immnunization), teens and adults.

9. What is the cost for this service?

Starting from $60 (depending on type of earring), cash only. This includes the earrings.

For more information, please call the office at 678-765-6749.

Our Physicians and Staff Want You to Know How We Will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil & criminal penalties; and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients with the attached Notice of Privacy Practices at their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of the attached Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer.

Thank you for your cooperation.

I acknowledge that I have received a copy of the practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name:_____

(Please Print)

Signature of Patient or Personal Representative:

_____ **Date:** _____

If Personal Representative, give relationship to patient:

_____

DELTA PEDIATRICS NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: December 1ST, 2011

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. 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 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 IIHI

Your privacy rights in your IIHI

Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your 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 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 offices 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:

The Office Manager at 678-765-6749 for further information

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI 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 IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

OPTIONAL:

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

OPTIONAL:

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL:

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking

care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

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

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your 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

notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information

notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your 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 IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your 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

In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL:

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.

OPTIONAL:

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL:

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your 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 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 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.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your 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.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

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

E. YOUR RIGHTS REGARDING YOUR IIHI

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

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **[the office manager, Delta Pediatrics 3966-B South Bogan Rd, Buford, GA 30519 Ph: 678-765-6749]** 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 IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your 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 you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **[the office manager, Delta Pediatrics 3966-B South Bogan Rd, Buford, GA 30519 Ph: 678-765-6749].** Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;

(b) whether you are requesting to limit our practice's use, disclosure or both; and

(c) 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 you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **[the office manager, Delta Pediatrics 3966-B South Bogan Rd, Buford, GA 30519 Ph: 678-765-6749]** in order to inspect and/or obtain a copy of your 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 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 office manager, Delta Pediatrics 3966-B South Bogan Rd, Buford, GA 30519 Ph: 678-765-6749].** 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 IIHI for non-treatment, non-payment or non-operations purposes. Use of your 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 information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **[the office manager, Delta Pediatrics 3966-B South Bogan Rd, Buford, GA 30519 Ph: 678-765-6749].** 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 **[the office manager, Delta Pediatrics 3966-B South Bogan Rd, Buford, GA 30519 Ph: 678-765-6749].**

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 **[the office manager, Delta Pediatrics 3966-B South Bogan Rd, Buford, GA 30519 Ph: 678-765-6749].** 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 IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose yo ur IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **the office manager, Delta Pediatrics 3966-B South Bogan Rd, Buford, GA 30519 Ph: 678-765-6749.**