Patient Information

Last Name: _____ **First:** _____ **Middle:** _____

DOB: ____/____/_____ **SSN:** ____-____-_____ **Gender:** ◯ **M** ◯ **F**

Email Address: _____ **Preferred Language:** _____

RACE: ☐ **African American/Black** ☐ **Native Hawaiian or Pacific Islander** **Ethnicity:** ☐ **Hispanic**
☐ **American Indian or Alaskan Native** ☐ **White** ☐ **Non-Hispanic**
☐ **Asian** ☐ **Declined**

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Primary Phone: (____) ____-_____ **Secondary Phone:** (____) ____-_____

Primary Care Physician: _____ **Physician Phone:** (____) ____-_____

Pharmacy: _____ **Pharmacy Phone:** (____) ____-_____

Additional providers to receive reports:

Physician: _____ **Physician Phone:** (____) ____-_____

Physician: _____ **Physician Phone:** (____) ____-_____

Who has legal custody/guardianship of the patient?

☐ **Parents** ☐ **Grandparent/Other Relative (specify):** _____

☐ **Mother Only** ☐ **Foster Parent:** _____

☐ **Father Only** ☐ **State Custody/Other (specify):** _____

Mother's Information

Last Name: _____ **First:** _____ **Middle:** _____

DOB: ____/____/_____ **SSN:** ____-____-_____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____
(if different from child)

Primary Phone: (____) ____-_____ **Secondary Phone:** (____) ____-_____

Place of Employment: _____ **Occupation:** _____ **Work Phone:** (____) ____-_____

Father's Information

Last Name: _____ **First:** _____ **Middle:** _____

DOB: ____/____/_____ **SSN:** ____-____-_____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____
(if different from child)

Primary Phone: (____) ____-_____ **Secondary Phone:** (____) ____-_____

Place of Employment: _____ **Occupation:** _____ **Work Phone:** (____) ____-_____

Emergency Contacts (please provide 2)

Name: _____ **Phone:** (____) ____-_____ **Relationship:** _____

Name: _____ **Phone:** (____) ____-_____ **Relationship:** _____

Patient History

Last Name: _____ **First:** _____ **Middle:** _____ **DOB:** ____/____/_____
Reason for Visit:

_____

_____

_____

Birth History:
How many weeks was your child at birth? _____weeks
Where was your child born? _____
Please list any complications with pregnancy or delivery:

_____

_____

Did your child stay in the NICU? ◯Yes ◯No
If yes, how long was the NICU stay? _____
Did your child pass the newborn hearing screening? ◯Yes ◯No
If no, which ear(s)? ☐Right ☐Left ☐Both

Medical History
Additional space is provided at the end of the document for any information that does not fit below.
Please list past medical problems or diagnoses. Check here if NONE ☐
Problem/Diagnosis: _____ Date Diagnosed: ____/____/_____
Problem/Diagnosis: _____ Date Diagnosed: ____/____/_____
Problem/Diagnosis: _____ Date Diagnosed: ____/____/_____
Please list any specialist physicians caring for your child. Check here if NONE ☐
Physician Name: _____ Specialty: _____ Reason:_____
Physician Name: _____ Specialty: _____ Reason:_____
Physician Name: _____ Specialty: _____ Reason:_____
Please list any hospitalizations. Check here if NONE ☐
Date of Hospitalization____/____/_____ Reason for Hospitalization:_____
Date of Hospitalization____/____/_____ Reason for Hospitalization:_____
Date of Hospitalization____/____/_____ Reason for Hospitalization:_____

Surgical History
Please list all surgical procedures your child has had. Check here if NONE ☐
Date of Procedure____/____/_____ Procedure: _____
Date of Procedure____/____/_____ Procedure: _____
Date of Procedure____/____/_____ Procedure: _____
Any complications with anesthesia? ◯Yes ◯No
Complications: _____
Any other surgical complications? ◯Yes ◯No
Complications: _____

Medications
Please list all current medications your child is taking. Check here if NONE ☐
Medication Name: _____ Dose: _____ Prescriber: _____
Medication Name: _____ Dose: _____ Prescriber: _____
Medication Name: _____ Dose: _____ Prescriber: _____
Medication Name: _____ Dose: _____ Prescriber: _____
Medication Name: _____ Dose: _____ Prescriber: _____
Medication Name: _____ Dose: _____ Prescriber: _____

Allergies

Please list any medication allergies/adverse reactions. Check here if NONE KNOWN ☐

Medication Name: _____ Reaction: _____
Medication Name: _____ Reaction: _____
Medication Name: _____ Reaction: _____
Medication Name: _____ Reaction: _____

Please list any food/environmental allergies. Check here if NONE KNOWN ☐

Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____

Family History:

Please mark any family member ever having the problem/disorder listed below.

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other	N/A
Allergy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anesthesia Problem	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ear Infections	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ear Tubes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Snoring/Sleep Apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tonsil Infections	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sinus Infections	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocephalus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Social History

Is/was the patient breastfed? ○Yes ○No
Does the patient currently use a bottle? ○Yes ○No
Does the patient currently use a pacifier ○Yes ○No
Is the patient exposed to cigarette smoke? ○Yes ○No
Is the patient in school/preschool/daycare? ○Yes ○No

School/Daycare Facility:_____
Grade/Level:_____
Has the patient missed school due to symptoms? ○Yes ○No
Is the patient receiving special school support (i.e. special ed, therapy)? ○Yes ○No
Please list all school therapies/services:_____
_____

Does the patient receive private therapy services (i.e. speech, physical, occupational therapy)? ○Yes ○No

Please list any private therapy services:
Therapy Provided: _____ Facility: _____
Therapy Provided: _____ Facility: _____
Therapy Provided: _____ Facility: _____

Please list all members living in the child's household (i.e. mother, father, etc.).

Last Name: _____ First: _____ Age: _____ Relationship:_____
Last Name: _____ First: _____ Age: _____ Relationship:_____
Last Name: _____ First: _____ Age: _____ Relationship:_____
Last Name: _____ First: _____ Age: _____ Relationship:_____
Last Name: _____ First: _____ Age: _____ Relationship:_____
Last Name: _____ First: _____ Age: _____ Relationship:_____

Pets: _____

Review of Systems

Please answer Yes or No if the patient has ever had any of the health issues below. If yes, please explain in the space provided.

Ear/Nose/Throat? ○Yes ○No _____
Cardiovascular? ○Yes ○No _____
Respiratory? ○Yes ○No _____
Gastrointestinal? ○Yes ○No _____
Genitourinary? ○Yes ○No _____
Musculoskeletal? ○Yes ○No _____
Skin? ○Yes ○No _____
Neurological? ○Yes ○No _____
Psychiatric/Behavioral? ○Yes ○No _____
Endocrinological? ○Yes ○No _____
Hematological/Lymphatic? ○Yes ○No _____
Allergic/Immunologic? ○Yes ○No _____

Please list any additional medical problems, medications, allergies, etc. here. Additionally, if there is anything else Dr. Hotchkiss should know about the patient, please provide that additional information in this area.

Consent to Leave Message on Voicemail

Patient Name: _____ DOB: _____

Tampa Children's ENT staff can contact you by telephone – at your request - with information such as laboratory results, or instructions from your doctor. Our office can leave detailed medical information on your answering machine with your consent.

By signing this "Consent to Leave Voicemails", you consent to TCENT leaving a voice mail message containing detailed medical information on the phone number(s) listed below. This information can include, but not be limited to, demographic information (partial or full name, date of birth, address, etc.), billing information, medical information (diagnosis, medications, test results, etc.) and the name of the practice or hospital where you/the patient received services. Additionally, you agree that it is your responsibility to contact the office should you have any questions or concerns about or not understand the information left.

Which phone number(s) may we leave messages that contain the above referenced medical information?

_____

_____

May we leave detailed messages that contain medical information with a family member or representative of your choice (other than the legal guardians)?
If so, please identify them below:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

☐ May not leave detailed medical information on voicemail

I understand that TCENT cannot require me to sign this consent form in order to receive treatment.

I understand that I have the right to revoke this consent at any time by sending a written request to Tampa Children's ENT. My decision to revoke this consent does not apply to any information disclosed in a voicemail prior to the date of my revocation of this consent.

I understand that I am entitled to a copy of this completed consent form.

Name (print): _____ Relationship to patient: _____

Signature: _____ Date: _____

Child's Name: _____ **Date of Birth:** _____

Florida Pediatric Associates, LLC
Patient Portal Agreement Form

******DO NOT use the Patient Portal for emergencies, CALL 911******

For urgent problems, please call our office at **(813) 262-1330**

The Patient Portal is a secure web portal that allows you as a patient's parent or guardian to access your child's personal health information. It also allows you to communicate with our office via secured messaging. Our Patient Portal Web address is: ***https://portal.fountainheadonline.net/tcent***

Important Information:

- Our hours of operation are **8:30 AM – 5:00 PM Monday – Friday**. We encourage you to use the Patient Portal at any time. However, messages are held for us until we return the next business day.
- Messages are typically handled within two business days. If your Provider is out of the office that day, your request may be held until your doctor returns to the office. You must call our office at **(813) 262-1330** if you have an urgent matter to discuss.
- Staff members other than your Provider may be involved in receiving your messages and routing them to the Provider or other staff personnel to address.
- If you are not receiving emails from us, please check your JUNK email folder before contacting our office.
- By using this patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify our office should your password be stolen.
- We strive to keep all of the information in your child's medical record correct and complete. If you notice information in your child's record that is incomplete or inaccurate, you agree to notify our office immediately by phone or secured message. In addition, you also agree not to provide false or misleading information.
- You agree to not hold Florida Pediatric Associates, LLC or its subsidiaries responsible for any network infractions beyond our control.
- We offer the patient portal as a convenience to you at no cost. We do not sell or give away any private information, including email addresses, without your expressed written consent. We reserve the right to suspend or terminate the patient portal at any time and for any reason.

The information on our portal is maintained by Florida Pediatric Associates, LLC. You may contact our Patient Portal Administrator at 727-456-4258 with your questions or concerns (non-patient care related) regarding the patient portal or send a secured message using the link provided on the portal.

I have read, understand and agree to the above information regarding the Florida Pediatric Associates, LLCs, Patient Portal:

Signature: _____

Print Name: _____

Email Address: _____

Portal Registration Completed by: _____ ***Assigned PIN #:*** _____

TAMPA CHILDREN'S ENT

Ear, Nose and Throat Specialists

Karin S. Hotchkiss, M.D.

Office Policies

Patient Name: _____ **D.O.B.**: ____/____/_____

Thank you for choosing Tampa Children's ENT. It is our goal to provide you with the best possible care. Please review our policies and guidelines outlined below. Your cooperation with our policies will enable us to serve you in the best possible manner.

Office Payment Policy

Payment is expected **in full** at the time services are rendered by the person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and/or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made **prior to your appointment**. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services **in full**. Obtain insurance authorization and/or referrals (if necessary) prior to your visit to avoid delays or rescheduling.

If you have a billing question, please contact our billing office for clarification:
Patient Last Name **A-L** call Elizabeth Forziano 727-322-7935
Patient Last Name **M-Z** call Gayle Matteson 727-456-4242

Diagnostic Testing

Please complete all prescribed diagnostic testing in a timely manner (7-10 days unless otherwise specified). If your insurance plan denies any lab test, x-ray, surgery, or other diagnostic exam that is prescribed we ask that you notify our office as soon as possible. If an appeal letter is requested we will be happy to provide it, however, your insurance company may still choose to deny coverage even with an appeal letter.

Late Arrival/Cancellation

Patients arriving more than **15 minutes** after scheduled appointment time may be rescheduled. Occasionally late arrivals may be seen at the end of the clinic **at Dr. Hotchkiss' discretion.** If you call to alert us of your late arrival we will try our best to work you into the day's schedule but cannot guarantee you will be seen that day. We appreciate your compliance with this in order to avoid long waits. Cancellation of office visits and in-office procedures require at least **24 hours notice** or are subject to a **$30.00 charge**. Surgery cancellations other than illness require **72 hours notice** or are subject to a **$100.00 charge**. Excessive "no show" visits without notification may result in the discharge of the patient from this clinic.

Medical Records/FMLA

Medical records may be copied upon written request for **$1.00 per page**. There is no charge for medical records sent directly to another health care provider. You may be asked to sign a release of information prior to the records being sent. There will be a **$25.00 charge** for all medical leave papers filled out by this office.

HIPAA

Our Notice of Privacy Practices, required by HIPAA, is attached for your review. You may wish to save a copy for your records. This document is also available in our office.

Assignment of Benefits/Guarantor Agreement

I request that payment of authorized insurance benefits be made on my behalf to Florida Pediatric Associates, LLC for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A

4200 N. Armenia Ave
Suite 5
Tampa, FL 33607

10817 Bloomingdale Ave
Riverview, FL 33578

(813) 262-1330
FAX (813) 262-1335

www.TampaChildrensENT.com

copy of this authorization will be sent to the Health Care Financing Administration, my insurance company, or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible for any balance not covered by my insurance carrier. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting responsibility as explained above for all payment for products and services received. I further understand and agree that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fees.

I acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I have read and understand the office policy for payment and agree to the terms as stated.

_____ _____ **Date**: ____/____/_____

Signature of Responsible Party **Relationship to Patient**

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PLEASE NOTE:
State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect __JULY 1, 2013__ and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided the law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date the changes were made.

You may request a copy of our Notice of Privacy Practices at any time by contacting our Privacy Officer, _*Lee Ann Atkinson*__. Information on contacting us can be found at the end of this notice.

OUR COMMITMENT TO YOUR PRIVACY
We understand that information about you and your health care is personal. We create a record of the care and services you receive from Florida Pediatric Associates, LLC (FPA) and are committed to protecting that information about you.
We are required by law to 1) Make sure health information that identifies you is kept private. 2) Give you this Notice of our privacy practices. 3) Follow the terms of the Notice that is currently in effect.

ROUTINE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI)
(Please note: for the purposes of this document the terms "you" will pertain to the patient and/or legal guardian if appropriate)
TREATMENT: Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you. Many of the people who work in our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment.
PAYMENT: Our practice may use and disclose your PHI 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 the details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use you PHI to bill you directly for services and items.
HEALTH CARE OPERATIONS: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may do this, our practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.
APPOINTMENT REMINDERS: Our practice may use and disclose your PHI to contact you and remind you of an appointment.
TREATMENT OPTIONS: Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives; or communicate with you regarding the scheduling, ordering or results of tests.
HEALTH RELATED BENEFITS AND SERVICES: Most uses and disclosures of PHI for marketing purposes and disclosures that constitute sale of protected health information require authorization.
RELEASE OF INFORMATION TO FAMILY & FRIENDS: Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of your child. For example, a parent or guardian may ask that a babysitter or aunt take their child to the doctor for treatment. In this example, this person would have access to the child's medical information; *however this person must be listed on the consent for treatment form in the patient's chart and be able to present valid picture ID at the time they present to our office.*
Additionally, a parent may not speak English fluently and may have an interpreter assist them at the appointment, this person would have access to the child's medical information.
OTHER: Uses and disclosures not described in this NPP will be made only with authorization from you, the individual.

USE AND DISCLOSURE OF YOUR PHI IN SPECIAL CIRCUMSTANCES
DISCLOSURES REQUIRED BY LAW: Our practice will use and disclose your PHI when we are required to do so by federal, state or local law; such as for law enforcement purposes, suspected abuse or neglect reporting, health oversights or audits, funeral arrangements, organ donation, public health purposes or in the case of a medical emergency.

PUBLIC HEALTH: Our practice may disclose your PHI 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

HEALTH OVERSIGHT ACTIVITIES: Our practice may disclose your PHI 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.

LAWSUIT OR SIMILAR PROCEEDING: Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

NATIONAL SECURITY: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

NOTICE OF PRIVACY PRACTICES

YOUR PRIVACY RIGHTS AS OUR PATIENT

You have the following rights regarding the PHI we maintain about you:

CONFIDENTIAL COMMUNICATIONS: You have the right to request that we 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 specifying the requested method of contact, or the location where you wish to be contacted. At our discretion, we will accommodate all reasonable requests. You are not required to give a reason for your request.

ACCESS: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit the completed request form. You may contact our Privacy Officer for a copy of this form. Once approved an appointment can be made to review your records, during the process of review no records may be removed from the office. Copies, if requested, *will be $1.00 per page for the first 25 pages and $0.25 per page for every page over 25*. The individual office *may* choose to waive this fee at the discretion of the physician. We will try to accommodate all reasonable requests, however if we deny your request to inspect and/or copy your record you may request a written reason for the denial. You have a right to obtain a copy of your health information within the designated record set maintained in electronic form in electronic format. We will send the electronic form of your health information to you via unencrypted email if you acknowledge the risk of the sending of unencrypted emails.

AMENDMENT: You may ask us to amend your health information if you believe it is inaccurate or incomplete, and you may request that the amendment be in effect for as long as it is maintained by our practice. Your request for an amendment, must be in writing (the appropriate form can be requested from office staff) and must include an explanation of why the information should be amended. We will deny your request if you fail to submit your request with supporting explanation in writing. Also, we may deny your request if you ask us to amend information that is not created by us, or is not part of the medical information maintained by us, or if we find that the information we possess is accurate and complete. If we deny your request you will receive the denial in writing; you have a right to appeal the decision – but it must be done in writing.

RESTRICTIONS: You have the right to request that we restrict the uses or disclosure of your health information for treatment, payment or healthcare operations purposes. We are not required to comply with any other requests for restrictions, but if we do, we will abide by the written agreement (except in the case of a medical emergency). Additionally, you have a right to request that we place additional restrictions on our use or disclosure of your health information to a health plan. Specifically you have the right to request that we restrict the use or disclosure of health information to a health plan (insurance company) for purposes of payment or operations, IF you pay for the service out-of-pocket IN FULL at the time the service is provided. This request MUST be made in writing (the appropriate form can be requested from office staff). This requirement does not apply to disclosures for treatment, such as disclosures to a referring physician for continuation of care. This office is required to comply with any requests that limit disclosures to a health plan when the service has been paid out-of-pocket and in full by the patient. Such restrictions do not override disclosures that are otherwise required by law. Additionally if initial payment for services, that have a request for restriction applied to them, is returned or invalid; our office will make a good faith attempt to collect payment – if this is unsuccessful we have the right to then submit a claim for these services to the health plan.

ACCOUNTING OF DISCLOSURES: All of our patients have the right to request an accounting of all disclosures made. All requests for an accounting of disclosures must be submitted in writing (the appropriate form can be requested from office staff) and include: a time period, that must not exceed 6 years prior to the date of the request and/or be dated prior to April 14, 2003 – as information prior to that date was not required to be tracked. The first list you request within a 12-month period is free of charge. We may charge you for any additional lists requested within the same 12-month period. We will notify you of the costs involved with any additional requests prior to their completion, allowing you to withdraw your request before you incur any costs.

BREACH NOTIFICATION REQUIREMENTS: In the event that unsecured protected information about you is "breached", we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform The Department of Health and Human Services and take any other steps that are required by law.

RIGHT TO FILE A COMPLAINT: If you believe your privacy rights have been violated, you may file a complaint with our practice and/or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please submit it in writing and to the attention of the Privacy Officer (the appropriate form can be requested from office staff). We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the Department of Health and Human Services.

RIGHT TO A PAPER COPY OF THIS NOTICE: You are entitled to receive a paper copy of our Notice of Privacy Practices. To obtain a paper copy of this Notice, contact our Privacy Officer in writing.

MINORS AND PERSONS WITH LEGAL GUARDIANS:

Minors and certain disabled adults are entitled to the privacy protection of their health information. Because, by law, they cannot make health decisions for themselves, a parent or guardian can make medical decisions on their behalf. Therefore parents and guardians can authorize the use and release of PHI and also hold all rights listed in this notice or the behalf of the minor child or disabled adult.

Under certain situations defined by law, minors can make independent healthcare decisions without parent or guardian knowledge or consent. In those situations, the minor may hold all rights listed in this notice. If the minor chooses to inform the parent or guardian, then all privacy rights regarding PHI may transfer to the parent or guardian. There are also certain situations where access, use or release of a minor's PHI may occur without the consent of the parent or guardian, i.e. when the health or safety of the minor is in danger and PHI is necessary to protect the minor.

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 we have created or maintained in the past, and for any 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, and you may request a copy of our most current Notice at any time.

HOW TO CONTACT US:

Please direct any questions about this Notice to our Privacy Officer at 727-456-4244

Privacy Officer address:
Florida Pediatric Associates, LLC
Attn: Privacy Officer
1033 Dr. Martin Luther King Jr. St. N, Ste 108
St. Petersburg, FL 33701

Medical Information Department address:
Florida Pediatric Associates, LLC
Attn: Medical Information Department
1033 Dr. Martin Luther King Jr. St. N, Ste 108
St. Petersburg, FL 33701

FLORIDA PEDIATRIC ASSOCIATES, LLC
FOUNTAINHEAD PRACTICE MANAGEMENT SOLUTIONS, LLC
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