



Información del Paciente

Apellido: _____ Primer Nombre: _____ Medio: _____

FDN: ___/___/___ SSN: ___-___-___ Género: M F

Raza: Afroamericano/Negro Asiático Origen Étnico: Hispano
Indio Americano o Nativo de Alaska Caucásico No Hispanos
Nativo de Hawai o las islas del Pacífico Rechazar

Dirección: _____ Ciudad: _____ Estado: _____ Código Postal : _____

Teléfono Principal: (____) ____-____ Teléfono Secundaria: (____) ____-____

Correo Electrónico: _____ Idioma Preferido: _____

Médico de Atención Primaria : _____ Teléfono del Médico: (____) ____-____

Farmacia: _____ Teléfono del Farmacia: (____) ____-____

Proveedores adicionales para recibir informes:

Médico: _____ Teléfono del Médico: (____) ____-____

Médico: _____ Teléfono del Médico: (____) ____-____

Quién tiene la custodia legal / tutela legal del paciente?

LosPadres Abuelo u otro Familiar (especificar): _____

MadreSólo Padres de Crianza: _____

PadreSólo Estado Custodio/Otro (especificar): _____

Información de la Madre

Apellido: _____ Primer Nombre: _____ Medio: _____

FDN: ___/___/___ SSN: ___-___-___

Dirección: _____ Ciudad: _____ Estado: _____ Código Postal : _____
(si es diferente del niño)

Teléfono Principal: (____) ____-____ Teléfono Secundaria: (____) ____-____

Lugar de Trabajo: _____ Ocupación: _____

Teléfono del Trabajo: (____) ____-____

Información de la Padre

Apellido: _____ Primer Nombre: _____ Medio: _____

FDN: ___/___/___ SSN: ___-___-___

Dirección: _____ Ciudad: _____ Estado: _____ Código Postal : _____
(si es diferente del niño)

Teléfono Principal: (____) ____-____ Teléfono Secundaria: (____) ____-____

Lugar de Trabajo: _____ Ocupación: _____

Teléfono del Trabajo: (____) ____-____

Contactos de Emergencia: (por favor proporcione 2)

Nombre: _____ Teléfono: (____) ____-____ Relación: _____

Nombre: _____ Teléfono: (____) ____-____ Relación: _____

La Historia Social

El paciente fue amamantado cuando era un bebe? Si No
 Está el paciente actualmente con leche materna? Si No
 Tiene el paciente en la actualidad el uso de una botella? Si No
 El paciente actualmente utiliza un chupete? Si No
 Está el paciente en la escuela/preescolar/guardería? Si No

Escuela/Guardería Fondo: _____

Grado/Nivel: _____

Tiene el paciente de la escuela perdidos debido a los síntomas? Si No

Es el paciente que recibe el apoyo de la escuela especial (es decir, de educación especial, terapia)? Si No

Por favor escriba todas las terapias/servicios: _____

Tiene el paciente reciba los servicios privados de tratamiento

(es decir, del habla, terapia fisica, ocupacional)? Si No

Por favor escriba cualquiera de los servicios de terapia privada.:

Tipo de Terapia: _____ Facilidad: _____

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Tipo de Terapia: _____ Facilidad: _____

Por favor una lista de todos los miembros que viven en la hogar (madre, padre, etc.) .

Apellido: _____ Primer: _____ Edad: _____ Relación: _____

Apellido: _____ Primer: _____ Edad: _____ Relación: _____

Apellido: _____ Primer: _____ Edad: _____ Relación: _____

Apellido: _____ Primer: _____ Edad: _____ Relación: _____

Apellido: _____ Primer: _____ Edad: _____ Relación: _____

Animales: _____

Revisión de los Sistemas

Por favor responda Si o No si el paciente ha tenido alguna vez cualquiera de los problemas de salud más adelante. Encaso afirmativo, explique en el espacio.

Oído/Nariz/Garganta? Si No _____

Cardiovasculares? Si No _____

Respiratorias? Si No _____

Gastrointestinal? Si No _____

Genitourinario? Si No _____

Músculo esqueléticos? Si No _____

Piel? Si No _____

Neurológico? Si No _____

Psiquiátricos/del comportamiento? Si No _____

Endocrinológicas? Si No _____

Hematológica/Linfática? Si No _____

Alérgica/Inmunológico? Si No _____

Por favor escriba cualquier problema medico adicional, medicamentos, alergias, etc. aquí. Además, si hay algo mas su doctor debe saber sobre el paciente, por favor proporcione la información adicional en esta ár

PRENATAL E HISTORIA DE NACIMIENTO

Lista drogas / medicamentos toma durante el embarazo:

El peso al nacer: ____ libras ____ oz

La partó fue por:

- Cesarean
- Vaginal
- Recámara

Marque todos los que pertenecen a su bebé:

- madre tuvo rubéola (sarampión), citomegalovirus (CMV), herpes, toxoplasmosis o la sífilis durante el embarazo
- bebé necesita una transfusión de sangre poco después del nacimiento debido a hiperbilirrubinemia (es decir, ictericia)
- bebé requiere ventilación mecánica (máquina para respirar) durante 5 o más días después del nacimiento
- bebé estaba en la UCIN después del nacimiento y ECMO requerida (forzado de oxígeno en el tejido)
- bebé tenía una infección después del nacimiento, como meningitis, paperas, sarampión o
- bebé fue hospitalizado después de nacer y requiere suero de anitbiotics o quimioterapia
- bebé traumatismo craneal sufrido (es decir, una caída grave que causa una conmoción cerebral o fractura del cráneo)
- bebé ha sido diagnosticado con un síndrome o trastorno en particular (por ejemplo, síndrome de Down, el paladar hendido)
- bebé ha tenido o actualmente tiene una infección o líquido detrás del tímpano
- Bebé tenía Anoxia (color azul) después del nacimiento
- Bebé fue ictericia (color amarillo) después del tratamiento que requiere nacimiento:
 - fototerapia o la luz solar o directa manta calefactora
- bebé tenía problemas de deglución después del nacimiento
- bebé tenía dificultades para chupar después del nacimiento

HISTORIA DE AUDIENCIA

Marque todo lo que corresponda:

- El bebé sobresalta a sonidos fuertes (lanza los brazos hacia fuera)
- El bebé se calma por el padre o la voz del cuidador

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? If so, please identify them below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____


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: _____



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: _____



Ear, Nose and Throat Specialists

Políticas de la Oficina

Paciente Nombre: _____ F.D.N.: ____/____/____

Gracias por elegir Tampa Children's ENT. Es nuestra meta para ofrecerle la mejor atención posible. Por favor revise nuestras políticas y directrices que se describen a continuación. Su cooperación con nuestras políticas nos permitirá servirle de la mejor manera posible.

Oficina Política de Pago

Se espera el pago en su totalidad en el momento de los servicios son prestados por la persona que acompañe al niño durante el tratamiento. Si nuestra oficina es un proveedor que participa con su compañía de seguros, todos los servicios no cubiertos, copagos y / o deducibles serán recogidos en el momento de cada visita. Arreglos para otra cosa que el pago total al momento del servicio se debe hacer antes de su cita. Es la responsabilidad del garante para entender y aceptar las directrices establecidas en el plan de seguro de la persona. Si usted es incapaz de proporcionarnos información completa de seguros en el momento de su visita, usted será responsable del pago de los servicios en su totalidad. Obtener la autorización del seguro y /o referencias (si es necesario) antes de su visita a fin de evitar retrasos o reprogramación.

Si usted tiene una pregunta de facturación, por favor póngase en contacto con nuestra oficina de facturación de aclaración:
Paciente Apellido A-L telefonar a Elizabeth Forziano 727-322-7935
Paciente Apellido M-Z telefonar a Gayle Matteson 727-456-4242

Pruebas de diagnóstico

Por favor, complete todas las pruebas de diagnóstico prescritas en el momento oportuno (70-10 días a menos que se especifique lo contrario). Si su plan de seguro niega cualquier prueba de laboratorio, rayos X, cirugía u otro examen de diagnóstico que se prescribe le pedimos que se notifique a nuestra oficina lo más pronto posible. Si una carta de apelación se solicita estaremos encantados de proporcionar, sin embargo, su compañía de seguros aún puede optar por negar la cobertura, incluso con una carta de apelación.

Llegada tarde / Cancelación

Los pacientes que llegan a más de 15 minutos después de la cita puede ser reprogramada. De vez en cuando llegan tarde se puede ver al final de la clínica a criterio del Doctor. Si usted llama para avisarnos de su llegada tardía que haremos nuestro mejor esfuerzo para trabajar en el horario del día, pero no puede garantizar que se verá ese día. Le agradecemos su cumplimiento de la presente a fin de evitar largas esperas. La cancelación de las visitas al consultorio y procedimientos en la oficina requiere al menos 24 horas de antelación o están sujetos a un cargo de \$ 30.00. Cancelaciones de la cirugía que no sea una enfermedad requieren 72 horas de aviso, o están sujetos a un cargo de \$ 100.00. Excesivos no muestran las visitas sin previo aviso puede resultar en la salida del paciente de esta clínica.

Registros Médicos / FMLA

Los registros médicos pueden ser copiados previa solicitud por escrito de \$ 1.00 por página. No hay ningún cargo para los registros médicos enviados directamente a otro proveedor de atención médica. Se le puede pedir que firme una liberación de información previa a los registros que se envían. Habrá un cargo de \$ 25.00 para todos los documentos de licencia médica cumplimentado por esta oficina

HIPAA

Nuestro Aviso de Prácticas de Privacidad, requerido por HIPAA, se adjunta para su revisión. Es posible que desee guardar una copia para sus registros. Este documento también está disponible en nuestra oficina.

Asignación de Beneficios y acuerdo de fiadores

Solicito que el pago de beneficios autorizados se hagan en mi nombre a la Florida Pediatric Associates, LLC por los servicios médicos proporcionados a mí por esa organización. Yo autorizo la divulgación de cualquier información médica o de otras índoles necesarias para determinar estos beneficios o los beneficios pagaderos para el equipo o servicios relacionados con la organización, la Administración de Cuidado de la Salud de Financiamiento, mi compañía de seguros o entidad médica. A copia de esta autorización será enviada a la Health Care Financing Administration, mi compañía de seguros u otra entidad si así lo solicita. El original se conservará en los archivos de la organización.

2814 W. Virginia Ave
Tampa, FL 33607

10817 Bloomingdale Ave
Riverview, FL 33578

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

www.TampaChildrensENT.com

A Division of Florida Pediatric Associates, LLC

Yo entiendo que soy financieramente responsable por cualquier saldo no cubierto por mi seguro. Es mi responsabilidad notificar a la organización de cualquier cambio en mi cobertura de salud. En algunos casos, los beneficios exactos de seguros no se puede determinar hasta que la compañía de seguros recibe la reclamación. Yo soy responsable de toda la factura o el saldo de la cuenta según lo determinado por la organización y / o mi compañía de seguros de salud si las reclamaciones presentadas o cualquier parte de ellos se les niega el pago

Entiendo que al firmar este formulario estoy aceptando la responsabilidad como se explicó anteriormente para todo el pago de productos y servicios recibidos. Además, entiendo y estoy de acuerdo que si no realiza los pagos a tiempo en mi cuenta, voy a ser responsable por cualquier y todos los costos razonables de la colección, incluyendo las tasas de presentación así como los honorarios razonables de abogados

Yo reconozco que he recibido una copia del Aviso de la organización de prácticas de privacidad. Este reconocimiento es requerido por la Health Insurance Portability and Accountability Act (HIPAA) para asegurarse de que he sido informado de mis derechos de privacidad.

He leído y entiendo la política de la oficina de pago y de acuerdo con los términos del Contrato

Firma de la Persona Responsable

Relación

Fecha: ____ / ____ / ____

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 your 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 on 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