SWP SOUTHWEST PEDIATRICS

NEW PATIENT

PAPERWORK PACKET

Please print this packet, fill out all information for your entire family, and return back to our office along with a copy of your insurance card.

Thank you.

CONTENTS

- ❑ Patient Registration Form
- ❑ Financial Policy
- ❑ Credit Card Consent Form
- ❑ Medical History Questionnaire
- ❑ Notice of Privacy Practices

(Please return only last page with the signature portion, the actual Notice is for you to keep for your records)

PLEASE ATTACH A COPY OF:

- ❑ Your Insurance Card
- ❑ Immunization record

SOUTHWEST PEDIATRICS

DATE:_____

PATIENT REGISTRATION FORM

Patient: *Last Name*: _____*First Name:* _____*MI*:_____

DOB: ____/____/_____ *Sex:* _____ *Primary Language:* _____*Secondary:*_____

Ethnicity: Hispanic / Non-Hispanic / Unknown / Decline to Answer
Race: Asian / Black / Hawaiian / White /*American Indian / Alaskan Native/ Decline to Answer*

Mailing Address:

_____

(Street) (City) (State) (Zip)

Primary Contact: _____ Phone Number: (_____) _____

Parent 1: *Name:* _____*Relation to Patient:* _____

Lives with patient? Yes / No Date of Birth: _____/_____/_____ *SSN #:* _____

Address: _____

(Street) (City) (State) (Zip)

Cell Phone: (_____) _____ *Work Phone: (_____)* _____

Home Email: _____*Work Email:* _____

Employer: _____ *Occupation:* _____

Parent 2: *Name:* _____*Relation to Patient:* _____

Lives with patient? Yes / No Date of Birth: _____/_____/_____ *SSN #:* _____

Address: _____

(Street) (City) (State) (Zip)

Cell Phone: (_____) _____ *Work Phone: (_____)* _____

Home Email: _____*Work Email:* _____

Employer: _____ *Occupation:* _____

Emergency Contact (other than parents) Name & Relationship:

Name: _____

Address: _____

Phone Number: (_____) _____ Relation: _____

Insurance:

Primary *Policy Holder's Name: _____SSN#_____*

Policy Holder's Birth of Date: _____/_____/_____ *Policy Holder's Sex: Male /Female*

Insurance Carrier: _____

ID #: _____ Group#: _____

Secondary *Policy Holder's Name: _____SSN#_____*

Policy Holder's Birth of Date: _____/_____/_____ *Policy Holder's Sex: Male /Female*

Insurance Carrier: _____

ID #: _____ Group#: _____

WHO IS THE FINANICAL GUARANTOR – If Financial Guarantor is a contact on previous page only complete first line. This is the person that will receive Billing Statements in the mail. (Parents must agree on this and work arrangements out among themselves for payment issues. Southwest Pediatrics cannot become involved with domestic arguments over who receives Billing Statements. If this becomes a recurring problem you may be asked to find another practice that better suits your needs)

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____/_____/_____ Home Phone _____Cell Phone _____

Do they live with the patient? Yes/ No Name of Employer: _____

Do you have any government issued insurance policies? ❑NO ❑YES:_____
Which parent would you like our office to contact for patient's medical issues, reminder calls, statements, ECT?
_____

How would you prefer to be contacted regarding (circle one):

Medical Issues': Mail Address / Home Phone / Work Phone / Cell Phone / Home Email / Text to Cell

Appointment Reminders: Text to Cell /Home Phone / Work Phone / Cell Phone / Home Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email/Text to Cell

Billing Statements: Home Address / Home Email / Work Email

General Practices Notice: Home Phone / Cell Phone / Home Email /Text to Cell

Patient Portal Notifications: Text to Cell / Home Email / Work Email

Contact Privacy Restraints:

Ok to send: text messages/email/fax **Yes/ No**

Additional Questions:

Is child adopted? Yes/ No If so, please provide proof that you are the legal guardian of the patient.

Other Siblings Seen In Our Office: _____

Whom May We Thank, For Referring You To Our Office? _____

SWP SOUTHWEST PEDIATRICS

FINANCIAL & OFFICE POLICIES

Initial_____ **Authorization to Treat:** I consent to examination and treatment by the personal at *Southwest Pediatrics* for my child and other dependents. This will remain in effect from this date forward unless "written" revocation of such.
Initial_____ **Authorization to release information and Assignment of Benefits:** I hereby authorize the physician to release any information acquired in the course of my child's treatment necessary to process insurance claims. **Authorization to pay benefits to physician:** I hereby authorize payment directly to the physician for the surgical and/or medical benefits, if any, otherwise payable to me for services render, realizing that I am responsible for paying any copayment, deductibles and other fees not covered by my insurance carrier.

Initial_____ **Insurance Plans:** I understand that it is my responsibility to confirm with the insurance company that the physician my child is scheduled with is currently under contract with the patient's plan or be willing to have them be seen at "out of network". If the patient is not on an insurance plan or *Southwest Pediatrics* providers are not contracted with the insurance they have, payment for any services will be paid in full at the time of service. *Southwest Pediatrics* does not accept patients with an HMO or government issued plans such as Medicare/ Medi-Cal. Any questions about coverage on medical, well baby/preventive services, vaccines/immunizations, and labs should be directed to the patient's insurance carrier *prior* to their visits. It is my responsibility to know if a written referral or authorizations is required to see a specialist and if preauthorization is required prior to a procedure for my child. I further understand that not all plans cover or pay in full for well-baby/child physicals, including any hearing, vision or other screenings typically done at physicals and if any abnormal findings are discovered during the physical it may result in paying a copayment/coinsurance. I agree to be responsible for all copays, deductibles, and non-covered services determined by the patient's insurance plan.

Initial_____ **Payments:** I guarantee that I will promptly pay all amounts that have been determined *"patient responsibility"* by my child's insurance company upon receipt of my statement. I understand that patient's health insurance contract is between the insurance companies and the subscriber of my child's policy. If the patient's insurance company does not pay for services rendered by the doctors at *Southwest Pediatrics* within 60 days, the practice may look to me for payment. The practice agrees to refund any overpayment that I have made on my child(ren)'s account after I have verbally requested it, in the event that the insurance eventually pays. Any balance remaining after the health insurance pays, denies or deems non-covered under my child's plan will be my responsibilities. **If I have not paid my bill or have not arranged for a payment plan, the practice may ask for the assistance of an outside collection agency, if my child's account is turned over to a collection agency, my child and all dependents will be dismissed from the practice.**

Initial_____ **Credit Card of File:** I understand that *Southwest Pediatrics* requires all parents to leave a credit card number, or Health Savings Account card number if applicable, with the office. I will further review this policy on the *Credit Card Consent Form* I will sign when I put my card information on file.

Initial_____ **Check In:** Copays, estimated co-insurances amounts, estimated deductible amounts, and past due balances are due at the time of check-in. I understand that *Southwest Pediatrics* accepts cash, checks (under $200) and all major credit cards. A $35 fee will be charged for any returned checks, plus any banks fees incurred. I, or whoever brings the patient in for services, will come prepared to pay at each check-in. If I do not come prepared to pay at my child's appointment, I may be asked to reschedule for a later time so that I may meet my obligation to pay. I agree to bring the patient's current insurance card(s) at each visit, and will notify the practice of any insurance or demographic information changes. For all visits, *Southwest Pediatrics* will ask to verify all information on my child's account so that our records remain current.

Initial_____ **Appointments & Late Arrivals:** I agree to have the patient arrive to appointments on time and understand if we are more than 10 minutes late without calling a No Show Fee will be incurred on my child's account and their appointment may be rescheduled later that day, if time permits, or may have to be rescheduled for another day. I understand that any appointment my child is scheduled for *"after-hours"* or for *"emergency"* bases may have an additional fee associated with those services at that visit. I further understand that *Southwest Pediatrics* does not accept walk in in appointment, if my child is brought in without a scheduled appointment there will be *a $20 walk-in charge* due at time of visit, along with co-pays, coinsurance or deductibles.

Initial_____ **No Shows:** Initial_____ **No Shows:** Patients who do not keep their appointment deprive others of an opportunity to see their doctor. *Southwest Pediatrics* requires prior notice for canceling any appointments. There will be a *$20 no-show charge* for sick visit appointment and a $50 no- show charge for well child physical appointments if they are not canceled 24 hours prior to the appointment time. I understand cancelations will need to be made with the office staff since they will *not* accept cancelations through their answering service after-hours. **If more than 3 appointments are missed without notification, the practice reserves the right to dismiss the patient.**

Initial_____ **Minors:** I understand if my child is under the age of 18 a parent, guardian, or authorized person must accompany my child for all visits.

Initial_____ **Service Fees & Indemnification:** I understand if my child has school, camp, sports forms etc. to be completed by *Southwest Pediatrics*, there is a $10 'form fee' charge . *Southwest Pediatrics* will have a 3-5 day turnaround time for forms to be completed and ready for me to pick up. If a form is needed sooner than 3 days, there is an additional $5 'rush from fee'. I also acknowledge if I request immunizations records for my child there will be a $5 processing fee if printed in the office. If I or whoever brings my child in, voluntarily separate vaccines from the well child/physical visit there will be a $25 charge for any additional appointment to receive the missed vaccines. I further agree that the practice will charge a $25 fee for requesting medical record on my child. I also agree to indemnify and hold harmless *Southwest Pediatrics*, its owners, officers and employees for any claims, lawsuits, causes of action, and/or damages of any nature caused by my breach of this financial policy, *Southwest Pediatrics* office policies, and for any claims made by the patient's insurance carrier regarding my child's account.

Initial_____ **Authorization to release information:** I hereby authorize *Southwest Pediatrics* to send immunization, medication records and/ or routine physical forms to my child's school or other physicians at my verbal request.

Initial_____ **Notice of Office Policies**: I am aware of the office policies of *Southwest Pediatrics*. I understand that I may view these policies on the website **www.swpediatrics.com,** or ask for a copy or explanation of the policies while in the office.

Initial_____ **Notice of Privacy Practice Acknowledgement:** I, the undersigned, have received a copy of *Southwest Pediatrics*, NOTICE OF PRIVACY PRATICES as required by law. I am also aware that I may obtain a copy at any time online at **www.swpediatrics.com** and that I may obtain information by asking the front office staff any questions that I may have.

I, the undersigned, hereby authorize *Southwest Pediatrics*, its representatives, physicians, and staff to share any and all medical and financial information with the following individual(s). The individuals listed below have authorization to bring my child into that office for treatment. All copays, co-insurance or deductibles are due at the time of service.

Both parents will automatically have authorization unless **court documents are presented and specifically stating one is not authorized.**

❑ **At this time I do not want to authorize anyone other than parent(s)/guardian(s).**

Name: _____Relationship:_____ Name: _____Relationship:_____

Name: _____Relationship:_____ Name: _____Relationship:_____

Name: _____Relationship:_____ Name: _____Relationship:_____

I have read, understood and agreed to the above financial and office policies. By signing below I am aware that I will be considered the '*Financial Guarantor*' and will be responsible for any payment that becomes due as outlined above.
The patients that I am financially responsible are:

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Parent/ Guardian Signature: _____ Date: _____

Relationship to Patient _____

SWP SOUTHWEST PEDIATRICS

CREDIT CARD CONSENT FORM

We now use a Credit Card Merchant Service called Instamed, which gives us the ability to swipe your credit card, debit card, or health savings account card to accept payment in the office and have the number securely stored on a remote server with Instamed. The full credit card number is NOT visible to us and is NOT stored in our office.

We want to assure you that our software has been thoroughly vetted according to the strict data retention rules required by the merchant processing system. The only information stored at our office in our secure, encrypted system, is the name on the card, the expiration date, and the last 4 digits of the card number.

We require your credit card information to be stored for future payment for some of the following reasons:

- Your insurance company may not reimburse us for medical services or only make partial payment, because of the following:
  - Deductible has not been met for the current calendar year
  - Co-insurance may be applied to the charges
  - Service may be deemed as not a payable benefit for your plan.
  - Policy has terminated, or there is a gap in coverage.
  - Newborn has not been added to the policy and are not covered under parent's benefits.
- You may have a copayment for medical services.
- You wish to set up a payment plan for a large balance on account.

We will notify you of your balance with one statement sent by mail after receiving the explanation of benefits (EOB) from your insurance company clarifying the reason for the money outstanding on the account(s). Once notified, you will have 30 days to discuss any questions or concerns regarding your balance(s) with us, or take care of the balance(s) on your patient portal online.

If we do not hear back from you or you do not pay your balance within the 30 days, we will attempt to make one courtesy call with the phone numbers on file. If we are unable to contact you, we will automatically charge your card for the amount due on the account(s).

Our Billing department will send you a receipt of any charges that are made to your card.

AUTHORIZATION

By signing below, I authorize Southwest Pediatrics to keep a credit card on file for future payments and to charge all balances accrued on the patients listed below with the information saved. I further understand that if a payment is denied by the credit card on file, I will not be able to schedule any further appointments with Southwest Pediatrics until the balance has been paid in full and account may be sent to outside collection agency and my child(ren) may be discharged from the practice. I am aware that if any of my personal information has changed, I am responsible to notify Southwest Pediatrics of the change(s) to ensure they have the most current information to contact me or process payment accurately.

_____

Your Child(ren)'s name

_____

Guarantor Printed Name

_____ _____

Guarantor Signature Date

❑ I have reviewed and understand Southwest Pediatrics' Financial Policy and Notice of Privacy Act

SWP SOUTHWEST PEDIATRICS

Initial History Questionnaire

Patient Name _____ DOB _____ Age _____ ❑ M ❑ F

Household Information

Please list all those living in the child's home.

Name	DOB	Relationship	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live.

_____

_____

Birth History ■ Don't know birth history

Birth weight_____ Weeks Gestation_____

Were there any prenatal or neonatal complications? ❑Y ❑N

Explain _____

_____

During pregnancy, did mother:

Use tobacco ❑Y ❑N Drink alcohol ❑Y ❑N

Use drugs ❑Y ❑N Use medications ❑Y ❑N

What_____ When _____

Was the delivery ❑Vaginal ❑Cesarean If cesarean, why,_____

_____

_____

Was initial feeding ❑Breast milk ❑Formula

Did your baby go home with mother from the hospital?

❑Y ❑N Explain_____

_____

_____

General DK= don't know

Do you consider your child to be in good health? ❑Y ❑N ❑DK Explain _____

Does your child have any serious illnesses or medical conditions? ❑Y ❑N ❑DK Explain _____

Has your child had any surgery? ❑Y ❑N ❑DK Explain _____

Has your child ever been hospitalized? ❑Y ❑N ❑DK Explain _____

Is your child allergic to medicine or drugs? ❑Y ❑N ❑DK Explain _____

Is your child allergic to any foods? ❑Y ❑N ❑DK Explain _____

Biological Family History DK= don't know

Have any family members had the following?

Childhood hearing loss ❑Y ❑N ❑DK Who _____ Comments _____

Nasal allergies ❑Y ❑N ❑DK Who _____ Comments _____

Asthma ❑Y ❑N ❑DK Who _____ Comments _____

Tuberculosis ❑Y ❑N ❑DK Who _____ Comments _____

Heart disease (before 55 years old) ❑Y ❑N ❑DK Who _____ Comments _____

High cholesterol ❑Y ❑N ❑DK Who _____ Comments _____

Anemia ❑Y ❑N ❑DK Who _____ Comments _____

Bleeding disorder ❑Y ❑N ❑DK Who _____ Comments _____

Dental decay ❑Y ❑N ❑DK Who _____ Comments _____

Cancer (before 55 years old) ❑Y ❑N ❑DK Who _____ Comments _____

Liver disease ❑Y ❑N ❑DK Who _____ Comments _____

Biological Family History (continued from front side) DK= don't know

Kidney disease	❑Y ❑N ❑DK Who _____	Comments _____
Diabetes (before 55 years old)	❑Y ❑N ❑DK Who _____	Comments _____
Bed-wetting (after 10 years old)	❑Y ❑N ❑DK Who _____	Comments _____
Obesity	❑Y ❑N ❑DK Who _____	Comments _____
Epilepsy or convulsions	❑Y ❑N ❑DK Who _____	Comments _____
Alcohol abuse	❑Y ❑N ❑DK Who _____	Comments _____
Drug abuse	❑Y ❑N ❑DK Who _____	Comments _____
Mental illness/ depression	❑Y ❑N ❑DK Who _____	Comments _____
Developmental disability	❑Y ❑N ❑DK Who _____	Comments _____
Immune problems, HIV, or AIDS	❑Y ❑N ❑DK Who _____	Comments _____

Additional family history _____

_____

Past History DK= don't know

Does your child have, or has your child had,

Chickenpox	❑Y ❑N ❑DK When _____
Frequent ear infections	❑Y ❑N ❑DK Explain _____
Problems with ears or hearing	❑Y ❑N ❑DK Explain _____
Nasal allergies	❑Y ❑N ❑DK Explain _____
Problems with eyes or vision	❑Y ❑N ❑DK Explain _____
Asthma, bronchiolitis, or pneumonia	❑Y ❑N ❑DK Explain _____
Any heart problem or heart murmur	❑Y ❑N ❑DK Explain _____
Anemia or bleeding disorder	❑Y ❑N ❑DK Explain _____
Blood transfusion	❑Y ❑N ❑DK Explain _____
HIV	❑Y ❑N ❑DK Explain _____
Organ transplant	❑Y ❑N ❑DK Explain _____
Malignancy/ bone marrow transplant	❑Y ❑N ❑DK Explain _____
Chemotherapy	❑Y ❑N ❑DK Explain _____
Frequent abdominal pain	❑Y ❑N ❑DK Explain _____
Constipation requiring doctor visits	❑Y ❑N ❑DK Explain _____
Recurrent urinary tract infections and problems	❑Y ❑N ❑DK Explain _____
Congenital cataracts/ retinoblastoma	❑Y ❑N ❑DK Explain _____
Metabolic/ Genetic disorders	❑Y ❑N ❑DK Explain _____
Cancer	❑Y ❑N ❑DK Explain _____
Kidney disease or urologic malformations	❑Y ❑N ❑DK Explain _____
Bed-wetting (after 5 years old)	❑Y ❑N ❑DK Explain _____
Sleep problems; snoring	❑Y ❑N ❑DK Explain _____
Chronic or recurrent skin problems (acne, eczema)	❑Y ❑N ❑DK Explain _____
Frequent headaches	❑Y ❑N ❑DK Explain _____
Convulsions or other neurological problems	❑Y ❑N ❑DK Explain _____
Obesity	❑Y ❑N ❑DK Explain _____
Diabetes	❑Y ❑N ❑DK Explain _____
Thyroid or other endocrine problems	❑Y ❑N ❑DK Explain _____
High blood pressure	❑Y ❑N ❑DK Explain _____
History of serious injuries/fractures/concussions	❑Y ❑N ❑DK Explain _____
Use of alcohol or drugs	❑Y ❑N ❑DK Explain _____
Tobacco use	❑Y ❑N ❑DK Explain _____
ADHD/anxiety/mood problems/depression	❑Y ❑N ❑DK Explain _____
Developmental delay	❑Y ❑N ❑DK Explain _____
Dental decay	❑Y ❑N ❑DK Explain _____
History of family violence	❑Y ❑N ❑DK Explain _____
Sexually transmitted infections	❑Y ❑N ❑DK Explain _____
Pregnancy	❑Y ❑N ❑DK Explain _____
Problems with periods (for females)	❑Y ❑N ❑DK Explain _____

Had first period ❑ Y ❑ N Age of first period _____

Any other significant problems _____

_____

Effective November 08, 2018

Please keep this notice for your records

NOTICE OF PRIVACY PRACTICES

SOUTHWEST PEDIATRICS, A MEDICAL CORPORATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact one of the front desk receptionists or ask to speak with our Privacy Officer, Amy Saunders.

WHO WILL FOLLOW THIS NOTICE

This notice describes the policies of Southwest Pediatrics, (hereinafter referred to as "SWP") and that of all employees, staff and other personnel of SWP.

For persons eighteen (18) years old and above who continue to receive care at SWP, this document pertains to your privacy rights as an adult.
This notice also describes the standards we will ask the Business Associates of SWP to adhere to should they have access to your child's medical information during routine work for the practice.

OUR COMMITMENT TO YOUR PRIVACY

We understand that medical information about your child is personal. We are committed to protecting medical information about your child. We create a record of the care and services your child receives at SWP. We need this record to provide your child with quality care and to comply with certain legal requirements. This notice applies to all of the records of your child's care generated at SWP.

This notice will tell you about the ways in which we may use and disclose medical information about your child. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies your child is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about your child; and
- follow the terms of the notice that is currently in effect.

DEFINITION

Medical information about your child includes: medical history, physical findings, test results, diagnoses, and treatments. It also includes medical and social information about your family that has relevance to your child's healthcare.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOUR CHILD

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

We may use medical information about your child to provide your child with medical treatment or services. We may disclose medical information about your child to doctors, nurses, technicians, medical/nursing students, or other personnel of SWP who are involved in taking care of your child. Different areas/locations of SWP also may share medical information about your child in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about your child to professionals outside of SWP who may be involved in your child's medical care. For example, a doctor involved in treating a child's broken bone needs to know if that child has diabetes or other medical conditions that might complicate the healing process. Finally, we may disclose medical information to anyone who accompanies a patient to their doctor's visit, including but not limited to family members, friends, or childcare professionals. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office. In this example, the babysitter may have access to this child's medical information.

For Payment:

We may use and disclose medical information about your child so that the treatment and services you receive at SWP may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a procedure your child received at SWP so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment your child is going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations:

We may use and disclose medical information about your child in order to operate our business. As examples of the ways in which we may use and disclose your child's health information for our operations, our practice may use medical information to evaluate the quality of care received as SWP, or to conduct cost-management and business planning activities for our practice.

Methods of Communication:

It is our practice to confirm appointments and report normal/negative laboratory results by telephone. Therefore, we may use and disclose medical information to contact you as a reminder that your child has an appointment at SWP. Furthermore, we may use and disclose medical information when reporting laboratory results that are negative or considered to be within normal limits. It is our practice to leave messages on an answering device (answering machine, voice mail, etc.) if we are unable to reach you by telephone.
In some instances, a request will be made to transmit a child's personal health information via facsimile ("fax") or electronic mail ("email"). It should be noted that neither of these methods of communication are preferred since they are not as secure as other methods of communication. Every effort will be made to verify the intended recipient, confirm receipt, and emphasize that the child's personal health information is confidential.

Treatment Alternatives:
We may use and disclose medical information to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services:
We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Child's Care or Payment for Your Child's Care:
We may release medical information about your child to a friend or family member who is clearly involved in your child's medical care. We may also give information to someone who helps pay for your child's care.

CHLA Health Network:
The terms of this notice of Privacy Practices apply to Southwest Pediatrics' organized health care arrangement, operating as a clinically integrated health care arrangement, which is composed of Children's Hospital Los Angeles Health Network ("Network"), Southwest Pediatrics, and other individual physician and group practice participants (collectively, the "Participants"). Southwest Pediatrics and the other Participants in the organized health care arrangement are licensed healthcare professionals seeing and treating pediatric patients in Southern California. As members of this clinically integrated and organized healthcare arrangement, Southwest Pediatrics and Participants may share your personal health and medical information as necessary to perform treatment, payment and health care operations to the extent permitted by law.

Research:
Under certain circumstances, we may use and disclose medical information about your child for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received a medication to those who were treated prior to the availability of that medication. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about your child to people *preparing* to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave SWP. We will always require that a researcher sign a pledge (a legal commitment) to honor the confidential nature of your child's medical information. The researcher must satisfy the following requirements: the use or disclosure involves no more than a minimal risk to your child's privacy based on (1) an adequate plan to protect the identifiers from improper use and disclosure, (2) 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 (3) adequate written assurance that the protected medical information 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, and for other research for which the use or disclosure would otherwise be permitted.

As Required By Law:
We will disclose medical information about your child when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety:
We may use and disclose medical information about your child when necessary to prevent a serious threat to your child's health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Organ and Tissue Donation:
If your child is an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans:
If you are a member of the armed forces, we may release medical information about your child as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Public Health Risks:
We may disclose medical information about your child for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we suspect a patient has been the victim of abuse, neglect or domestic violence. We will make this disclosure as required by law.

Health Oversight Activities:
We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes:
If you or your child is involved in a lawsuit or a dispute, we may disclose medical information about your child in response to a court or administrative order. We may also disclose medical information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement:
We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;

- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct involving our practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors:
We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities:
We may release medical information about your child to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others:
We may disclose medical information about your child to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates:
If your child is an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about your child to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide your child with health care; (2) to protect your child's health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Certain protected information requires an authorization before any information can be released. They include: psychotherapy notes, any information used for marketing purposes, and the sale of SWP's patient information. We will contact you if any of these circumstances arise.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOUR CHILD:

You have the following rights regarding medical information we maintain about your child:

Right to Inspect and Copy:
You have the right to inspect and copy medical information that may be used to make decisions about your child's care. Usually, this includes medical and billing records, but does not include psychotherapy notes or notes made as a result of a confidential visit by an adolescent if 1) you have approved this confidential visit, or 2) the law otherwise protects the confidentiality of this visit.

To inspect and copy medical information that may be used to make decisions about your child, you must submit your request in writing to SWP, Attention: Medical Records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by PAC will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend:
If you feel that medical information we have about your child is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for SWP.

To request an amendment, your request must be made in writing and submitted to SWP, Attention: Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for SWP;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is without question accurate and complete.

Right to an Accounting of Disclosures:
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about your child. Exception: disclosures to individuals made as part of treatment, payment, or healthcare operations activities above are not tracked (every physician, therapist, and/or nurse, etc. involved with your child's care) and, therefore, will not be included in the accounting of disclosures provided to you. To request this list or accounting of disclosures, you must submit your request in writing to SWP, Attention: Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions:
You have the right to request a restriction or limitation on the medical information we use or disclose about your child for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about your child to someone who is involved in your care or the payment for your child's care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery your child had to a specific family member. You have the right to request any services rendered and are paid in full, out-of-pocket, to be restricted from disclosure to insurance companies.

***We are not required to agree to your request*.** If we do agree, we will comply with your request unless the information is needed to provide emergency treatment to your child.

To request restrictions, you must make your request in writing to SWP, Attention: Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example: disclosures to a grandparent; disclosures to Blue Cross Blue Shield.

Right to Request Confidential Communications:
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you must make your request in writing to SWP, Attention: Privacy Officer. You are not required to state the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Refuse Fundraising Materials:
You have the right to request that we do not send you information regarding fundraising events put on or sponsored by SWP.
To opt out of receiving fundraising communications, you must make your request in writing to SWP, Attention: Privacy Officer. You are not required to state the reason for your request.

Right to a Paper Copy of This Notice:
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.
You may obtain an electronic copy of this notice at our website, www.pediatric-adolescent-care.com
To obtain a paper copy of this notice, ask one of the front desk receptionists or the Privacy Officer for this practice.

BREACH NOTIFICATION
If a breach occurs regarding your protected information, SWP will notify you in writing of the breach as well as what we have done to correct the error. If applicable, steps to further protect your information will be provided.

CHANGES TO THIS NOTICE
The terms of this notice will apply to all records containing your child's private health information that are created and 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 a visible location at all times, and you may request a copy of our most current Notice at any time. The Notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with SWP or with the Secretary of the Department of Health and Human Services. To file a complaint with SWP, contact the Privacy Officer at SWP, 9802 Stockdale Hwy., Suite 103, Bakersfield, CA 93311. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission.
If you provide us permission to use or disclose medical information about your child for a specific purpose beyond that covered in this notice above, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about your child for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to your child.

For: Notice of Privacy Practice **effective 11/08/2018**

Please complete and return back with other "New Patient Paperwork"

SWP SOUTHWEST PEDIATRICS

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: _____

You have the right to refuse to sign this acknowledgement.

_____
Print Patient's Name

I, _____, have
Signature of Parent/Guardian

received a copy of Southwest Pediatrics, NOTICE OF PRIVACY PRACTICES as required by law.

FOR OFFICE USE ONLY

On the date above we made a "good faith effort" to obtain written acknowledgement of receipt of our NOTICE OF PRIVACY PRACTICES we were unable to obtain acknowledgement for the following reasons:

____ Parent/Guardian refused to sign

____ Other _____

____ Employee attempting to gain acknowledgment: _____