PEDIATRIC PARTNERS OF WINTER HAVEN

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

Pediatric Partners of Winter Haven is required by law to protect certain aspects of your health-care information known as Protected Health Information or PHI and to provide you with this Notice of Privacy Practices.

This Notice describes our privacy practices, your legal rights, and lets you know how Pediatric Partners of Winter Haven is permitted to:

- Use and disclose PHI about you
- How you can access and copy that information
- How you may request amendment of that information
- How you may request restrictions on our use and disclosure of your PHI

In most situations we may use this information decried in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

We respect your privacy and treat all health-care information about our patients with care under strict policies of confidentially that all of our staff are committed to following at all times.

PLEASE READ THE FOLLOWING DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT THE HIPAA PRIVACY OFFICER LIAISON AND SOMEONE WILL CONTACT YOU.

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

PURPOSE OF THIS NOTICE: This Notice describes your legal rights, advises you of your privacy practices, and lets you know how Pediatric Partners of Winter Haven is permitted to use and disclose Protected Health Information (PHI) about you.

USES AND DISCLOSURES OF PHI: Pediatric Partners of Winter Haven may use PHI for the proposes of treatment, payment, and health-care operations, in most cases without your written permission. Examples of our use of PHI:

FOR TREATMENT: This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health-care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio and telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

FOR PAYMENT: This includes quality-assurance activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third-party billing company), management of billed claims for services rendered, medical-necessity determinations and reviews, utilization review, and collection of outstanding accounts.

FOR HEALTH-CARE OPERATIONS: This includes quality-assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, and creating reports that do not individually identify you for data-collection purposes.

USE AND DISCLOSURE OF PHI WITHOUT YOUR AUTHORIZATION. Pediatric Partners of Winter Haven is permitted to use PHI without your written authorization or opportunity to object to certain situations, including:

- For Pediatric Partners of Winter Haven's use in treating you or in obtaining payment for services provided to you or in other health-care operations
- For the treatment activities of another health-care provider
- To another health-care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company)
- To another health-care provider (such as your hospital to which you are transported or First Responder Agencies) for the health-care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to the relationship
- For health-care fraud and abuse detection or activities related to compliance with the law
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting

(because you are not present or due to your incapacity or medical emergency), we may, in our professional judgement, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms, and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew

- To a public–health authority in certain situations (such as reporting a birth, death, or disease as required by law, as part of a public–health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to possible communicable disease as required by law
- For health–oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process
- For law–enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime
- For military, national defense and security, and other special government functions
- To avert a serious threat to the health and safety of a person or the public at large
- For workers' compensation purposes, and in compliance with workers' compensation laws
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation
- For research projects, but this will be subject to strict oversight and approvals, and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law
- We may use or disclose health information about you in a way that does not personally identify you or reveal who you are

Any other use or discloser of PHI, other than those listed above will only be made with your written authorization (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). **YOU MAY REVOKE YOUR AUTHORIZATION AT ANY TIME, IN WRITING, EXCEPT TO THE EXTENT THAT WE HAVE ALREADY USED OR DISCLOSED MEDICAL INFORMATION BASED UPON THE AUTHORIZATION.**

PATIENT RIGHTS

As a patient, you have a number of rights with respect to the protection of your PHI, including:

THE RIGHT TO ACCESS, COPY, OR INSPECT YOUR PHI: This means you may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.

We have forms available for you to request access to your PHI. We will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer liaison listed at the end of this Notice.

THE RIGHTS TO AMEND YOUR PHI: You have the right to ask us to amend written medical information that we may have about you. If errors are found, we will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information, but only in certain circumstances. For example, if we believe the information is correct and no errors exist, your request that we amend the medical information that we have about you will be denied, and you should contact in writing the privacy officer listed at the end of this Notice.

THE RIGHT TO REQUEST AN ACCOUNTING OF OUR USE AND DISCLOSURE OF YOUR PHI: You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment, or health–care operations, or when we share your health information with our business associates, such as our billing company or medical facility from/to which we have transported you.

We are also not required to give you an accounting of our uses of protected health information which you have already given us. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact the privacy officer listed at the end of this Notice.

PEDIATRIC PARTNERS OF WINTER HAVEN

THE RIGHT TO REQUEST THAT WE RESTRICT THE USES AND DISCLOSURES OF YOUR PHI: You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment, or health-care operations, or to restrict the information that is provided to family, friends, and other individuals involved in your health care. However, if you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a health-care provider to provide you with emergency treatment. PPWH is not required to agree to any restrictions you request, but any restrictions agreed to by PPWH are binding on PPWH.

INTERNET, ELECTRONIC MAIL, AND THE RIGHT TO OBTAIN COPY OF PAPER NOTICE ON REQUEST: If we maintain a web site, we will prominently post a copy of this Notice on our web site and make the Notice available electronically through the web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper, and you may always request a paper copy of the Notice.

REVISIONS TO THE NOTICE: PPWH reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting the Privacy Officer identified below.

YOUR LEGAL RIGHTS AND COMPLAINTS: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments, or complaints, you may direct all inquires to the privacy officer listed at the end of this Notice.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRATICES

NAME OF PATIENT

DATE OF BIRTH

I HEREBY ACKNOWLEDGE THAT I RECEIVED PEDIATRIC PARTNERS OF WINTER HAVEN NOTICE OF THE HIPAA PRIVACY PRACTICES AND CLEARLY UNDERSTAND HOW AND WHAT THEY ARE USED FOR.

SIGNATURE

RELATIONSHIP TO PATIENT

P. 863.293.2144 :: F. 863.293.3732
550 POPE AVE NW :: STE 100 :: WINTER HAVEN, FL 33881

PEDIATRIC PARTNERS OF WINTER HAVEN

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

NAME OF PATIENT ____________________ DATE OF BIRTH ____________________

GUARANTOR'S NAME ____________________ DATE OF BIRTH ____________________

PREVIOUS DOCTOR ____________________

ADDRESS ____________________

CITY, STATE, ZIP ____________________ PHONE/FAX ____________________

INFORMATION AUTHORIZED FOR USE OR DISCLOSURE, OR TO BE OBTAINED:

_______ ALL MEDICAL INFORMATION CONCERNING THIS PATIENT

_______ MEDICAL INFORMATION ON THIS PATIENT COMPILED FROM _______ TO _______

_______ ONLY: _____ HOSPITAL RECORDS _____ EMERGENCY ROOM RECORDS _____ PRENATAL RECORDS

_____ MATERNAL SEROLOGIES _____ NEWBORN MEDICAL RECORDS _____ HEARING SCREEN

DATES OF TREATMENT, IF KNOWN ____________________

THE INFORMATION WILL BE OBTAINED, USED, OR DISCLOSED FOR THE FOLLOWING PURPOSE(S) ONLY:

_____ INSURANCE _____ CONTINUIITY OF CARE _____ LEGAL _____ AT THE REQUEST OF THE PATIENT/PATIENTS

I HEREBY AUTHORIZE PEDIATRIC PARTNERS OF WINTER HAVEN TO RELEASE AND OBTAIN ANY MEDICAL AND OTHER PERTINENT INFORMATION TO AND FROM ALL HEALTH-CARE PRACTITIONERS, PROVIDERS, AGENCIES, SCHOOLS, HOSPITALS, AND INSTITUTIONS FOR THIS PURPOSE OF THE CLIENT'S DIAGNOSIS, CARE, AND TREATMENT. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, EXCEPT REVOCATION WILL NOT APPLY TO INFORMATION ALREADY USED OR DISCLOSED IN RESPONSE TO THIS AUTHORIZATION. I MAY REVOKE THIS DOCUMENT BY PRESENTING MY WRITTEN REVOCATION TO OUR OFFICE BY CERTIFIED MAIL.

EXPIRATION DATE OF THIS AUTHORIZATION IS _____ / _____ / _____

PARENT/GUARDIAN SIGNATURE ____________________ DATE ____________________

PEDIATRIC PARTNERS OF WINTER HAVEN

CLINIC POLICIES AND PROCEDURES

NAME OF PATIENT

DATE OF BIRTH

Thank you for entrusting the care of your child/children to Pediatric Partners of Winter Haven. To make your visit the best possible, we would like a couple minutes of your time to explain the office policies, **and ask that you comply with the policies so that we may provide the best possible service to you and your children.**

If an appointment is not cancelled/rescheduled 24 hours prior to your appointment time, you may be charged a **fee of $40.** This is your liability and must be paid before your child is seen for any future appointment. **THIS IS DUE AND PAYABLE BY THE PARENT/GUARDIAN AND IS NOT BILLED TO THE INSURANCE COMPANY.**

IT IS THE POLICY OF THIS OFFICE THAT, AFTER THREE MISSED APPOINTMENTS WITHOUT 24-HOUR PRIOR NOTICE, WE MAY DISMISS ALL FAMILY MEMBERS. THERE IS ALSO A ZERO-TOLERANCE POLICY FOR CURSING AND RUDE/ DISRUPTIVE BEHAVIOR. SUCH BEHAVIOR WILL RESULT IN YOUR DISMISSAL FROM THE PRACTICE.

It is very important that you arrive on time for your appointment. **IF YOU ARE MORE THAN 5 MINUTES LATE, WE MAY HAVE TO RESCHEDULE YOUR APPOINTMENT.**

If you are requesting any type of paperwork, school forms, shot records, etc., we require a minimum of 48 hours notice, and a fee may be required for these as well. These are items that must be done between patients, or at the end of the day. It is very difficult for us to do them immediately, if you just stop by the office. WE WILL REQUIRE 48 HOURS.

If you would like for someone other than yourself to bring your child for treatment, we MUST have the necessary release forms completed before the child can be seen. **We must have written permission in the chart by the LEGAL GUARDIAN of the child allowing permission for the child to be seen without you present OR WE WILL NOT SEE THE CHILD!** It is your responsibility to ensure that if someone else brings your child/children, they must have the insurance card and their photo ID, make sure the insurance is active, and that we are assigned as your primary care physician.

PLEASE TURN OFF ALL CELL PHONES AS WE HAVE A NO CELL PHONE POLICY!! IT IS YOUR RESPONSIBILITY TO LET ANYONE YOU HAVE CONSENTED TO BRING IN YOUR CHILD/CHILDREN AWARE OF THIS POLICY.

FINANCIAL: Please be advised that you are required to show a copy of your current insurance card and valid photo ID at EVERY VISIT. You are also responsible for any and all copays, deductibles, no-show fees, or visits deemed not covered by your insurance carrier. If your account goes to collections, you hereby agree that you are responsible for all additional legal fees as required by law. Please understand that we do not bill secondary insurance companies. PEDIATRIC PARTNERS WILL ONLY BILL AS PRIMARY INSURANCE.

SIGNATURE OF PARENT/GUARDIAN

DATE

PEDIATRIC PARTNERS OF WINTER HAVEN

PARENT/GUARDIAN INFORMATION CONSENT FORM

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY PEDIATRIC PARTNERS OF WINTER HAVEN OF ANY AND ALL CHANGES IN THE INFORMATION RECORDED ON THIS FORM AND TO PROVIDE THE OFFICE WITH INFORMATION IF THERE ARE ANY CUSTODY RESTRICTIONS INVOLVING MY CHILD.

LAST NAME OF PATIENT (APELLIDO DEL PACIENTE) | FIRST (PRIMERO) | MI

DATE OF BIRTH (FECHA DE NACIMIENTO)

SSN (NUMERO DE SERGURO SOCIAL)

COURT ORDER ON FILE (ORDEN DE LA CORTE EN EL ARCHIVO)

STREET ADDRESS (DIRECCION) | APT# | CITY | STATE | ZIP CODE

MAILING ADDRESS (DIRECCION DE CORREO) | APT# | CITY | STATE | ZIP CODE

THE PEOPLE BELOW ARE THE ONLY ONES WHO MAY BE ALLOWED TO SEEK MEDICAL CARE AND/OR TREATMENT FOR MY CHILD AT PEDIATRIC PARTNERS. I ALSO UNDERSTAND A PHOTO COPY OF THE INDIVIDUALS WILL BE REQUIRED AT EACH VISIT AND A COPY WILL BE MADE AND PLACED IN MY CHILD'S CHART. PLEASE NOTE: ANYONE YOU ARE GRANTING PERMISSION TO MUST BE OVER THE AGE OF 18.

FATHER'S NAME (NOMBRE DE PADRE) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

MOTHER'S NAME (NOMBRE DE MADRE) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

CHILD LIVES WITH (PACIENTE VIVE CON) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

RELATIONSHIP TO CHILD (RELACION AL PACIENTE)

PLEASE LIST ANY SIBLINGS OF THIS CHILD WHO ALSO COME TO OUR OFFICE.

CHILD'S NAME (NOMBRE DEL NINO) | DOB (FECHA DE NACIMIENTO)

CHILD'S NAME (NOMBRE DEL NINO) | DOB (FECHA DE NACIMIENTO)

CHILD'S NAME (NOMBRE DEL NINO) | DOB (FECHA DE NACIMIENTO)

PEDIATRIC PARTNERS OF WINTER HAVEN

OTHER PERSONS THAT YOU CONSENT TO BRING CHILD IN: (MUST BE 18 YEARS OLD OR OLDER)

OTHER (NAME) (OTRO) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

RELATIONSHIP TO CHILD (RELACION AL PACIENTE)

OTHER (NAME) (OTRO) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

RELATIONSHIP TO CHILD (RELACION AL PACIENTE)

OTHER (NAME) (OTRO) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

RELATIONSHIP TO CHILD (RELACION AL PACIENTE)

IN CASE OF INCIDENT WHERE I AM NOT ABLE TO BRING MY CHILD FOR HIS/HER APPOINTMENT, OR IF EMERGENCY TREATMENT IS REQUIRED, I UNDERSTAND THAT ONE OF THE OTHER PERSONS LISTED ON THE OTHER SIDE OF THIS FORM WILL BE ALLOWED TO ARRANGE AND SEEK TREATMENT FOR MY CHILD.

BY SIGNING BELOW, I AM AWARE THAT IT IS SOLELY MY RESPONSIBILITY TO NOTIFY PEDIATRIC PARTNERS OF ANY/ALL CHANGES IN THE INFORMATION RECORDED ON THIS FORM AS WELL AS ALL FINANCIAL RESPONSIBILITIES AND TO PROVIDE THE OFFICE WITH ANY AND ALL CUSTODY RESTRICTIONS INVOLVING MY CHILD.

(PRINT) PARENT/GUARDIAN NAME (GUARDIAN NOMBRE) | RELATIONSHIP TO PATIENT (RELACION AL PACIENTE)

SIGNATURE OF PARENT/GUARDIAN (LA FIRMA) | DATE (LA FECHA)

P. 863.293.2144 :: F. 863.293.3732
550 POPE AVE NW :: STE 100 :: WINTER HAVEN, FL 33881

PEDIATRIC PARTNERS OF WINTER HAVEN

PHOTO RELEASE FORM

I, the undersigned, do hereby grant permission to Pediatric Partners/Owl Now Urgent Care/Trinity Medical Group to post my/my child's photos or other item, hereinafter referred to as "Materials," on their Pediatric Partners/Owl Now Urgent Care/Trinity Medical Group Facebook pages or any other future social media.

By granting permission as directed above, I am giving Pediatric Partners/Owl Now Urgent Care/Trinity Medical Group permission to use these images. The use may include reproduction, distribution, derivative works, display, and performance, both private and public.

The use may be in composite or modified forms and in any media, now known or later developed, including without limitation newspapers, television, the Internet, and social media.The use may be for any purpose throughout the world and in perpetuity, including, without limitation, education, trade, advertising, and promotion.

I waive the right to inspect or approve the uses of any printed or electronic copy. I hereby release Pediatric Partners/Owl Now Urgent Care/Trinity Medical Group and its assigns and licensees from any claims that may arise from these uses, including without limitation claims of defamation or invasion of privacy, or of infringement of moral rights or rights of publicity or copyright.

I have read this Release and consent to my/my child's inclusion in the Materials and will not contest the rights granted in this Release, and shall assist and support you in any and all legal proceeding for affirmation of this Agreement, should you choose to have a court of law affirm this Agreement.

INDICATE ONE (1) OF THE FOLLOWING:

☐ Yes I agree to the above statements, and hereby grant permission.
☐ No I would not like my/my child's photo released, but I have read and understand the form.

(PRINT) PARENT/GUARDIAN NAME
(GUARDIAN HOMBRE)

DATE
(LA FECHA)

SIGNATURE OF PARENT/GUARDIAN
(LA FIRMA)

pediatricpartners

P. 863.293.2144 :: F. 863.293.3732
550 POPE AVE NW :: STE 100 :: WINTER HAVEN, FL 33881