Date: _____

Primary Language: _____

Translator Needed? □Yes □ No

Family Data Sheet

Children (patients of Pediatric Medical Group)

	First Name	Last Name	DOB	Ethnicity	Gender
1)					□ Male □ Female □ Other
2)					□ Male □ Female □ Other
3)					□ Male □ Female □ Other

Home Address: _____
Street City Zip

Main Phone Number: _____ **Email Address:** _____

Emergency Contact: □ **Mother** □ **Father** □ **Other:** _____

Other Emergency Contact: _____
First Name Last Name Relationship Phone Number

Father/Legal Guardian □ Single □ Divorced □ Married

Name DOB

SSN: REQUIRED Driver's License. #

Employer Father/Legal Guardian Phone Number

Email

Mother/Legal Guardian □ Single □ Divorced □ Married

Name DOB

SSN: REQUIRED Driver's License. #

Employer Mother/Legal Guardian Phone Number

Email

Requirements for: Divorced Parents: Please provide all legal documents related to custody arrangements. It is your responsibility to update Pediatric Medical Group of Riverside, INC. with any custody changes. Court documentation is required.

Insurance

□ **Uninsured**

#1 Primary Insurance Co. Name: _____ □ HMO □ PPO □ EPO/POS □ IEHP □ Other_____

ID Number Group Number Subscriber Name Relationship

#2 Secondary Insurance Co. Name: _____ □ HMO □ PPO □ EPO/POS □ IEHP □ Other_____

ID Number Group Number Subscriber Name Relationship

Treatment Authorization

TO: Pediatric Medical Group of Riverside, INC.

In the absence of either or both undersigned, you are hereby authorized and instructed to perform any necessary or convenient medical services which might be required for the above-listed child without any further authorization or consent upon the part of undersigned. This authorization extends to hospitalization and/or surgery, your employment of such other medical doctors that are either necessary or desirable to assist you and providing for nursing and other medical or incidental services which might be required.

Parent/Guardian Name **Date**

Signature: _____

Authorization to Release Information and Payment Authorization

I hereby authorize the release of any information required by my insurance company and I request that payments be made directly to:

Pediatric Medical Group of Riverside, INC.

Parent/Guardian Name **Date**

Signature: _____

CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH THIS CHILD:

During which month of pregnancy did you first see the doctor?_____Month
How long was your pregnancy? _____Months

Where was baby born? _____
If baby was born at home, were blood tests for newborn screening done? ☐ Yes ☐ No

Did you have any illnesses or problems? (including sexually transmitted or other communicable diseases)	YES	NO	Did you use any non-prescribed drugs? (tobacco, alcohol, "street drugs:, over-the-counter or home remedies)	YES	NO
Did you take any medications prescribed by your doctor?	YES	NO	Did the baby go home with you from the hospital?	YES	NO
Did you have a difficulty/abnormal delivery/C-section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the 1st week of life?	YES	NO	Did baby receive any shots for Hepatitis B?	YES	NO

CHILD'S HISTORY: ☐ Male ☐ Female Is this child adopted? ☐ YES ☐ NO Birth Weight: _____pounds _____ounces Length: _____ inches

Has your child ever had (Please circle Yes or No):

Measles, Chickenpox, Mumps, Rubella	YES	NO	Vomiting after eating, refusal to eat	YES	NO
Tuberculosis or positive TB Test	YES	NO	Muscle, joint or bone problems	YES	NO
Tonsillitis/Sore Throat	YES	NO	Skin problems	YES	NO
Problems with eyes or vision	YES	NO	Headaches or dizziness	YES	NO
Problems with ears or hearing	YES	NO	Convulsions, seizures, epilepsy	YES	NO
Difficulty breathing/snoring at night	YES	NO	Diabetes	YES	NO
Heart problems	YES	NO	Thyroid problems	YES	NO
Asthma, bronchitis, or pneumonia	YES	NO	Allergies	YES	NO
Anemia, bleeding problems, blood transfusions	YES	NO	Problems with development of school performance	YES	NO
Stomachaches	YES	NO	Serious illness or accident	YES	NO
Diarrhea, Soiling self with stool	YES	NO	Surgery or hospitalization	YES	NO
Bladder Kidney Problems, Wetting self or bed	YES	NO	(GIRLS) Has she stared her periods?	YES	NO
Constipation	YES	NO	(GIRLS) Are there problems with her periods?	YES	NO

FAMILY HISTORY: Does mother (M), father (F), brother (B), sister (S), aunt (A), uncle (U), or grandparent (GP) have:

			Which Family Member?				Which Family Member?
YES	NO	Diabetes		YES	NO	High blood pressure	
YES	NO	Epilepsy or convulsions		YES	NO	Bleeding disorder	
YES	NO	Mental retardation		YES	NO	Tuberculosis	
YES	NO	Heart disease		YES	NO	Allergy	
YES	NO	Cancer		YES	NO	Lung or breathing problems	
YES	NO	Kidney or urinary disease		YES	NO	Eye disorder	
YES	NO	Bone or joint problems		YES	NO	Ear disorder	

PARENT INFORMATION:

	Mother:	Father:
Age:	_____	_____
Height:	_____	_____
Occupation:	_____	_____

HOUSEHOLD INFORMATION: Number of people in home _____
Are both parents living in the home? ☐ Yes ☐ No
Does anyone in the home smoke, or use drugs or alcohol? ☐ Yes ☐ No
Language spoken in the home: _____
Do you live in a: ☐ House ☐ Apartment ☐ Mobile Home ☐ Shelter ☐ Homeless

Patient Identification:

Signature: _____ Date: _____

Relationship to Child: _____

Reviewer's
Signature: _____ Date: _____

Patient(s) name:

_____

_____

Office Policies

1) We do not accept walk-ins. Please call and make an appointment. If a patient is more than 15 minutes late, they will be required to reschedule the appointment.
2) Co-payments are due at each office encounter. We do not accept checks.
3) Patients must update any new information. (Address, phone number, insurance, etc.)
4) The office will bill your insurance company first; it is your responsibility for deductibles, co-payments, share of cost and remainder of balances.
5) Due to OSHA Regulations, no food or drinks are allowed in the office. (Water is acceptable)
6) No cell phone use in the office. If you must make a call, please step outside.
7) It is required for each parent(s) or guardian(s) to provide their social security number and a valid state ID or driver's license. This is our office policy, there are no exceptions.

Vandalism Policy

1) Appropriate behavior in and around Pediatric Medical Group's office and grounds is expected.
2) Parents/guardians are responsible to always supervise their children(s) actions and behavior properly. Our staff cannot be responsible for your children.
3) In the events of any intentional or unintentional vandalism, damage, defacing, or marring of Pediatric Medical Group property the patient and/or family **will be asked to leave the practice.**

Immunization Policy

I agree to follow the current guidelines and recommendations of the American Academy of Pediatrics (AAP) and Centers for Disease Control and Prevention (CDC).
This includes immunization scheduled requirements, treatments, and medical recommendations. (EXCLUDING COVID VACCINE)

Please sign in agreement to the above policies.
Failure to comply will result in dismissal from Pediatric Medical Group of Riverside, INC.

_____ _____

Parent/Guardian Name Date

_____

Signature

Pediatric Medical Group of Riverside, INC. 6950 Brockton Avenue, #5 Riverside, CA 92506

Pediatric Medical Group
OF RIVERSIDE, INC.

6950 Brockton Avenue STE 5 Riverside, CA 92506
Tel: (951) 686-8223 Fax: (951) 686-9617

Patient Partnership Plan

Patient Name: _____ DOB: _____

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.). **These health screenings are tests that can help detect life-threatening diseases and conditions**. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time.
I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.
Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____	_____	_____
Patient/Parent Signature	Date	Physician Signature

Pediatric Medical Group of Riverside, Inc.

Financial Policy

Our goal at **Pediatric Medical Group of Riverside, Inc.** is to provide and maintain great physician-patient relationships. Letting you know in advance of our financial policies allows for a good flow of communication and ensures that we achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

Uninsured Payment Policy

We offer a Time-of-Service Payment Discount to those of our patients that may not have insurance coverage. We understand that it is sometimes difficult to pay your bill in full when the total amount is out of pocket.

Therefore, we offer a discount off of our regular visit fees when you make payment at the time that services are received because by paying at your visit you help to keep costs down for our office. By eliminating the expense of billing, mailing and follow up, we are happy to pass those savings along to you.

Credit Cards: For your convenience, we accept Visa and MasterCard. Payments by credit card may also be made over the phone directly with our Billing Office.

Please note: *we can only discount our services. Discounts cannot be applied to products such as lab tests because we have to buy those products and need to collect what those products cost us to purchase. VFC (vaccine for children) rates may be available for some of our cash clients.*

For patients in networks in which we participate:

We accept the following insurances: RPN (Riverside Physician's Network) HMOs: PPOs Aetna, Blue Cross, Blue Shield, Cigna, HealthNet, Pacificare, TriCare and United. We also accept IEHP. If you have Medi-Cal please contact our insurance and billing office at 951-686-3636

Co-pays: *It is our policy and contractual obligation with your insurer to collect co-payments, co-insurance and deductibles at the time of service.*

1. On arrival, please check in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card any time there is an insurance change. This is your verification of the correct insurance and consent to bill the insurer on your child's behalf. If the insurance company that you designate is incorrect, the insurance company to which the claim is submitted will be denied by them and you will be billed for those services. Most insurance companies have timely filing limits, and by the time a claim is denied, it may be too late to collect from the correct insurance company. Therefore you will be responsible for payment even if your correct insurance company denied the claim.

2. If we are your primary care physician, please make sure that our name or phone number appears on your card (if applicable). If your insurance company has not been informed that we are your primary care physician as of this date, you may be financially responsible for the visit because they will deny payment to us for services rendered if we are not the physician on file in their system.

3. According to your insurance plan, you are responsible for paying any and all copayments, deductibles, and coinsurances, and we have a contractual obligation with your insurer to collect those payments. If we do not, we may be held liable for fraud.

4. We will submit to secondary insurance plans but please clearly inform us if there is more than one insurance and which one is primary.

5. Please make it a priority to understand your benefit plan, regardless of how complex it seems to be. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered, as we cannot track all of our patients individual plans. If you are not sure what is required, we are happy

to have you call your insurance company from our office and find out prior to services being rendered.

6. If you owe us a balance (except if there is a payment plan in place) we require that for scheduled appointments all prior balances must be paid prior to that visit.

7. Co-payments and co-insurance is always due at the time of service. A **$10 processing fee (or service fee)** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the next business day, as it costs us at least that much to bill you for it.

8. Once we receive your insurance plan's explanation of benefits, any balances due from you will be billed upon receipt of that explanation. Your payment is due within 10 business days of your receipt of your bill.

9. If previous arrangements have not been made for a payment plan, any account balance outstanding greater than 28 days will be charged a $10 re-bill fee. Unfortunately, if we do not hear from you within 60 days, those overdue balances will have to be forwarded to an external agency for collection.

10. We require 24-hour notice for canceling any appointments. If appointments are cancelled or broken more than three times, we will bill you a **$25** charge.

11. When signing up for an appointment, please understand that this time slot is no longer available for another patient. Therefore, if you "no show" (or don't come to an appointment that you have scheduled without informing us), this is not only an inconvenience to us but also to our other patients. If you "no show" for three appointments within the family, we may need to ask you to find another physician.

12. Banks charge us for returned checks and it costs us to reprocess your bill and follow up with you, so in the event that any checks are returned for insufficient funds, we will need to charge you a **$25** fee which includes our bank fee.

13. Advance notice is needed for all non-emergent referrals, so please give us 3 to 5 business days to create a referral for you. While we will make every effort to refer you to a physician participating in your plan, if you are requesting a referral to a specific provider it is your responsibility to know if that selected specialist participates in your plan. Please note that your plan may not cover referrals to out-of-network providers and therefore those charges may be billed directly to you.

14. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a 'well' visit. Not all plans cover annual physicals or hearing and vision screenings. For any services not covered, you will be responsible for payment at the time of visit.

15. **Forms**: There is a $25.00 fee for all FMLA forms and letters. Payment is due upon request. Please leave your forms with our front office staff, and allow 24 hours for completion. There will be a $10.00 fee for additional yellow immunization cards.

16. Not all services provided by our office are covered by every plan. Any service determined as 'not covered' by your plan will be billed to your account, so please check with your insurer about any services that may be excluded in your policy.

17. **Outside Services**: Please be advised that you may receive separate bills for any lab test, cultures, x-rays, etc. that are performed by or sent to outside sources for analysis. Any inquires regarding these charges should be made directly to that facility's business office. It is the responsibility of the insured to be aware of the covered facilities for outside services (i.e. specialists, hospitals, labs, radiologist, etc.) PMG is not responsible for any out of pocket expense due from a non-covered outside service provider.

I have read and understand Pediatric Medical Group of Riverside, Inc.'s office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined herein. I also understand that policies may change without notice.

Patient Name(s)

_____

_____

_____

_____

_____

_____

Responsible party member's name Relationship

_____

Responsible party member's signature Date

Pediatric Medical Group of Riverside, INC.

6950 Brockton Avenue Suite 5 Riverside, CA 92506
Tel: (951) 686-8223 Fax: (951) 686-9617

NOTICE OF PRIVACY PRACTICES

Pediatric Medical Group of Riverside, INC. 6950 Brockton Avenue Suite 5, Riverside, CA 92506

PRIVACY OFFICER: Roberta Clark Tel: (951) 686-8223

EFFECTIVE DATE: 05/01/2018

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Health Information

This medical practice collects medical and related identifiable patient information (such as billing information, claims information, referral and health plan information) and stores it in a chart, in administrative or billing files, and on a computer. The medical record is the property of this medical practice, but the information in the medical record is accessible to the patient. This information is considered "protected health information" (PHI) under the HIPAA Privacy Rule. The law permits us to use or disclose health information for the following purposes without the patient's written authorization:

1. Treatment. We use medical information to provide medical care. We disclose medical information to our employees and others who are involved in providing the care our patients need. For example, we may share medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription, or a laboratory that performs a test. We may also disclose medical information to members of patients' families or others who can help them-when they are sick or injured, or following the patient's death.

2. Payment. We use and disclose PHI to obtain payment for the services we provide. For example, we give health plans the information they require for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to our patients.

3. Health Care Operations. We may use and disclose PHI to operate this medical practice e. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get health plans to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and

audits, including fraud and abuse detection and compliance programs, and business planning and management. We may also share PHI with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of this PHI. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, health care clearinghouse, or one of their business associates, California law prohibits all recipients of health care information from further disclosing it except as specifically required or permitted by law.

a. We may also share PHI with other health care providers, health care clearinghouses, or health plans that have a relationship with our patients when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind our patients about appointments. If the patient is not home, we may leave this information on the patient's answering machine or in a message left with the person answering the phone.

5. Sign-in Sheet. We may use and disclose medical information about our patients by having them sign in when they arrive at our office. We may also call out their names when we are ready to see them.

6. Notification and Communication with Family. We may disclose our patients' health information to notify or assist in notifying a family member, personal representative or another person responsible for their care about their location or general condition in the event of their death, unless a patient had instructed us otherwise. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with our patient's care or helps pay for care. If our patient is able and available to agree or object, we will give the patient the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over the patient's objection if we believe it is necessary to respond to the emergency circumstances. If our patient is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient's family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact our patients to encourage them to purchase or use products or services related to their treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to them. We may similarly describe products or services provided by this practice and tell our patients which health plans we participate in. We may receive financial compensation to talk with our patients face-to-face, to provide them with small promotional gifts, or to cover our cost of reminding them to take and refill medication or otherwise communicate about a drug or biologic that is currently prescribed for the patient, but only if the patient either:
(1) has a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise the patient about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) the patient is a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while the patient has a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) the patient's right to opt-out of future remunerated communications by calling the communicator's toil-free number. We will not otherwise use or disclose PHI for marketing purposes or accept any payment for other marketing g communications without the patient's prior written authorization. The authorization will

disclose whether we receive any financial compensation for any marketing activity our patients authorize, and we will stop any future marketing activity to the extent the patient revokes that authorization.

8. Sale of Health Information. We will not sell our patients' health information without their prior written authorization. The authorization will disclose that we will receive compensation for PHI if the patient authorizes us to sell it, and we will stop any future sales of information to the extent that the patient revokes that authorization.

9. Required by Law. As required by law, we will use and disclose our patients' health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose our patients' health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform our patients or their personal representative promptly unless in our best professional judgment, we believe the notification would place a patient at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose our patients' health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose our patients' health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about our patients in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify them of the request and they have not objected, or if their objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose out patients' health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose our patients' health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose our patients' health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose our patients' health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if the patient has agreed to the disclosure on behalf of themselves or their dependent.

18. Specialized Government Functions. We may disclose our patients' health information for military or national security purposes or to correctional institutions or law enforcement officers that have the patient in their lawful custody.

19. Workers' Compensation. We may disclose our patients' health information as necessary to comply with workers' compensation laws.
For example, to the extent our patients' care is covered by workers' compensation, we will make periodic reports to their employer about their conditions. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, our patients' health information/record will become the property of the new owner, although our patients will maintain the right to request that copies of their health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify our patients as required by law. If they have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Other disclosures specified in our Notice of Privacy Practices. We may disclose our patients' health information as otherwise described in our Notice of Privacy Practices.

23. Psychotherapy Notes. We will not use or disclose our patients' psychotherapy notes without their prior written authorization except for the following: (1) treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if the patient sues us or brings some other legal proceeding, (4) if the law requires us to disclose the information to the patient or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning the patient's psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner following the patient's death. To the extent the patient revokes an authorization to use or disclose their psychotherapy notes, we will stop using or disclosing these notes.

24. Research We may disclose our patients' health information to researchers conducting research with respect to which their written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

25. Fundraising. We may use or disclose our patients' demographic information, the dates that they received treatment, the department of service, their treating physician, outcome information and health insurance status in order to contact them for our fundraising activities. If they do not want to receive these materials, the patient can notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, the patient should notify the Privacy Officer if they decide they want to start receiving these solicitations again.

B. When this Medical Practice May Not Use or Disclose Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies individual patients without their written authorization. If a patient authorizes this medical practice to use or disclose health information for another purpose, the patient may revoke the authorization in writing at any time.

C. Our Patients' Health Information Rights

1. Right to Request Special Privacy Protections. Our patients have the right to request restrictions on certain uses and disclosures of their health information by a written request specifying what information they want to limit, and what limitations on our use or disclosure of that information they wish to have imposed. If our patients tell us not to disclose information to their commercial health plan concerning health care items or services for which they paid for in full out-of -pocket, we will abide by their request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify our patients of our decision.

2. Right to Request Confidential Communications. Our patients have the right to request that they receive their health information in a specific way or at a specific location. For example, they may ask that we send information to a particular email account or to their work address. We will comply with all reasonable requests submitted in writing which specify how or where our patients wish to receive these communications.

3. Right to Inspect and Copy. Our patients have the right to inspect and copy their health information, with limited exceptions. To access their medical information, our patients must submit a written request detailing what information they want access to, whether they want to inspect it or get a copy of it, and if they want a copy, their preferred form and format. We will provide copies in the requested form and format if it is readily producible, or we will provide our patients with an alternative format they find acceptable, or if we can't agree and we maintain the record in an electronic format, their choice of a readable electronic or hardcopy format. We will also send a copy to any other person our patients designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny our patients' request under limited circumstances. If we deny a request to access a child's records or the records of an incapacitated adult because we believe allowing access would be reasonably likely to cause substantial harm to the patient, the guardian or legal representative will have a right to appeal our decision. If we deny a patient's request to access their psychotherapy notes, our patients will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement Our patients have a right to request that we amend their health information if they believe it is incorrect or incomplete. Our patients must make a request to amend in writing, and include the reasons they believe the information is inaccurate or incomplete. We are not required to change our patients' health information, and will provide them with information about this medical practice's denial and how they can disagree with the denial. We may deny their request if we do not have the information, if we did not create the information (unless the person or entity that created the information Is no longer available to make the amendment}, if they would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny a request, our patients may submit a written statement of their disagreement with that decision, and we may, in turn, prepare a written rebuttal. Our patients also have the right to request that we add to their record a statement of up to 250 words concerning anything in the record they believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. Our patients have a right to receive an accounting of disclosures of their health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to them or pursuant to their written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the

disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to Impede their activities.

6. Right to Paper Copy of Notice of Privacy Practices. Our patients have a right to notice of our legal duties and privacy practices with respect to their health information, including a right to a paper copy of this Notice of Privacy Practices, even if they have previously requested its receipt by email. If we have a website, we must post our current Notice of Privacy Practices on our website.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles our patients' health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If our patients are not satisfied with the manner in which this office handles a complaint, they may submit a formal complaint to:
Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(800) 368-1019; (800) 537-7697 (TDD)
(202) 619-3818 (fax)
OCRMail@hhs.gov

Pediatric Medical Group of Riverside, Inc.

6950 Brockton Avenue STE 5 Riverside, CA 92506
Tel: (951) 686-8223 Fax: (951) 686-9617

HIPPA Acknowledgment

Privacy Officer: Office Manager Telephone# (951) 686-3636

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

◯ I would like to receive a copy of any amended Notice of Privacy Practices by mail at:

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

◯ Parent or guardian of minor patient
◯ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

SPANISH/ESPAÑOL

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

◯ Me gustaría recibir una copia del Aviso de Prácticas de Privacidad modificada por mail a:

_____

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

◯ El padre o tutor del paciente menor de edad
◯ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____

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