PREMIER PEDIATRIC & ADOLESCENT CARE

NOTICE OF PRIVACY PRACTICE

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

The United States government has enacted a law known as HIPPA. This is an unfunded mandate that we must follow. This notice is to inform you of how we will handle your health information. Your information has always been kept sacred and safe in our office and we will continue to do so in the future.

Basically, we will use any information regarding your health condition to:

- Provide treatment
- For payment purposes with your carrier, and
- For the ongoing operation of our office

Treatment is, of course, based on the information you give us during your appointment, your office visit, and during the course of treatment. We may use this information to inform other health care providers of your situation when we request a consultation with them. The information may be used to inform the hospital of scheduled tests, x-rays, or procedures.

Payment is based upon those services provided and your carrier often demands copies of your health information to process claim.

The day-to-day operations of the office revolve around your health information. Internal audits to improve quality of care, training health care assistants, making decisions regarding business management planning and development all depend upon the information you provide to us.

Legally, we are a non-covered entity under the law. All of our transcription and billing is done in the office. Nothing is transmitted over the intranet.

There are several times when we have no control over your health information. This is, there are times as specified in state and federal statutes when we must surrender your information. Please see the complete policy manual for a complete discussion of these instances.

You also have several rights also under HIPPA regarding your medical information. You have a right to inspect and request copies. You have the right to request amendments be made to your records. You have the right to an accounting of disclosures. You have the right to request confidential communications with the office. You have the right to a paper copy of this notice. By law, we are required to have your signature in your medical record to attest to the fact that you have received and read this notice.

If you have further questions, please contact the office staff with your concerns. If you are concerned that your privacy rights are being violated, you may file a complaint directly with our office at the location and number above. You may also file directly with the Secretary of Department of Human Services. According to law, you must file your complaint within 180 days of when you knew or should have known of the circumstance that led to the complaint and must be submitted in writing. Our office staff can assist you with contact information. You will not be penalized for filing a complaint.

Thank you for taking the time to read this notice and to sign the required form for your chart. Please rest assured that your information will always be treated as a sacred trust, just as we always have, and always will treat our patient-doctor relationship

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT AND CONSENT

The notice of Privacy Practices tells you how we may use and share your health records. Please read it. We will use and share your health records:

- **To treat you**
- **To bill for the services we provide**
- **To run our business**
- **As required by law**

All the ways we may use and share your health records are explained in More detain the Notice of Privacy practices. You have the right to:

- **Look at and receive a copy of your health records**
- **Receive a list of whom we have given your health records to**
- **Ask us to correct a mistake in your health records**
- **Ask that we not use or share your health records**
- **Ask us to change the way we contact you**

All of these rights are explained in more detail in the Notice of Privacy Practices.

I HAVE RECEIVED A COPY OF PREMIER PEDIATRIC'S NOTICE OF PRIVACY PRACTICES.

_____ ____/____/____

Signature of Patient or Legal Representative **Today's Date**

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Relationship of Legal Representative to Patient

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