LOVING CARE PEDIATRICS

TopLine MD Alliance

PATIENT REGISTRATION / DEMOGRAPHIC FORM

Today's date:			Previous PCP (if any):	
PATIENT INFORMATION				
Patient's Full Name (First, MI, Last, Suffix):		Date of Birth	Social Security #:	
Ethnicity:	Race:	Nickname:	Age:	Sex:
Street address:			Phone #:	
City:		State:	Zip Code:	
Grade:	School:		Preferred Language:	

How did you find us? Please check one:
☐ Insurance Plan ☐ Google ☐ Referred by: _____
☐ Family: _____ ☐ Friend: _____ ☐ Close to home
☐ Other: _____

Siblings (names and birthdates):

FAMILY / CONTACT INFORMATION

Patient resides primarily with: ☐ Both Parents ☐ Mother ☐ Father
Legal Guardian: _____ ☐ Other: _____
Parents are: ☐ Married ☐ Divorced ☐ Separated Other

Mother's Name and Birth Date:	Mobile number:
Occupation/Employer:	Email:
Father's Name and Birth Date:	Mobile number:
Occupation/Employer:	Email:

INSURANCE INFORMATION

(Please give insurance card to the receptionist)

Is this patient covered by insurance? ☐ Yes ☐ No (Self-Pay)

Responsible Party:	Birth date:	Address:	Phone:
Occupation:	Employer:	Employer address:	Employer phone:

Name of Primary Insurance Company:

Subscriber's name:	Birth date:	Group #:	Policy #:

Patient's relationship to subscriber: ☐ Self ☐ Child ☐ Other

EMERGENCY CONTACTS (OTHER THAN PARENTS) / CONSENT TO BRING CHILD		
#1: Name (First, Last):	Relationship to patient:	Mobile Number:
Address, City/State and ZIP:		
#2: Name (First, Last):	Relationship to patient:	Mobile Number:
Address, City/State and ZIP:		
#3: Name (First, Last):	Relationship to patient:	Mobile Number:
Address, City/State and ZIP:		

PHARMACY INFORMATION		
Pharmacy Name:	Address, City/State and ZIP:	Phone Number:

Authorization to Release Information

The above information is true to the best of my knowledge. I hereby authorize Loving Care Pediatrics, LLC, to: (1) release any information necessary to insurance carriers regarding myself and/or my dependents illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photo copy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I hereby authorize payment directly to Loving Care Pediatrics, LLC. I understand that I am financially responsible for charges, lab work, preventive assessments, and vaccines not covered by my insurance contract as performed in the office, and for any co-payments and/or deductible amounts as specified in my insurance contract.

I acknowledge that Private Health Information material (HIPAA) is posted, and available upon request.

Parent Name: _____

Signature: _____

Date: _____

FINANCIAL POLICY

Thank you for choosing *Loving Care Pediatrics, LLC* as your health care provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

PAYMENT IS DUE AT THE TIME OF SERVICE
ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT
WE ACCEPT: CASH, CHECK, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from us, your primary care physician if your insurance carrier requires it for your visits. Please allow 3-5 business days for processing referrals.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. For appointments cancelled less than 12 hours in advance, there is a $25.00 fee. No shows / missed appointments will incur a $50.00 fee after the first no show.

NONCOVERED SERVICES: Loving Care Pediatrics, LLC follows the American Academy of Pediatrics Bright Futures Guidelines for preventive care. Many insurance carriers limit what is covered under "preventive care". We strongly believe that these tools are necessary for the total well-being of children and it is not optional. You must pay for these services in full at the time of visit, please let us know if you do not want screenings performed. Screenings may include MCHAT/Developmental Screens, Vision, Hearing, and certain labs or tests.

RETURNED CHECKS: Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $25.00 NSF fee from the office.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

CONVENIENCE FEES: There is a flat fee of $10.00 for each additional set of School and Sports Clearance forms the office completes on your behalf. We also charge a $25.00 convenience fee for having blood drawn in the office. We also charge a $15.00 walk-in fee.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient Name:_____ **Date:** _____

Patient/Responsible Party Signature: _____

LOVING CARE PEDIATRICS

TopLine MD Alliance

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT MEDICAL RECORDS

Patient Information

Patient's Name:_____ Date of Birth: _____

Address: _____

City:_____ State:_____ Zip Code: _____

Phone #1:_____ Phone #2:_____

From: [DOCTOR | URGENT CARE | HOSPITAL]

Name:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone:_____ Fax: _____

Where do you want the records to be sent?

Name:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone:_____ Fax: _____

What records do you want sent or released?

(Please specify the years of records you wish to be sent or released)

Record Name	Years	Record Name	Years	Record Name	Years

_____

_____

How do you want the information delivered? *(Requests take 7-10 business days for processing)*

❍ Mail ❍ Patient will pick up *(fees apply)* ❍ Fax ❍ Pick up by:_____ *(fees apply)*

Purpose of Release *(Why is it needed?)*

❍ Transfer of care to new physician ❍ Continuing care/Second opinion ❍ Other:

I hereby authorize the use of disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release Loving Care Pediatrics LLC from all liability arising from this disclosure of my health information. I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. For patients and governmental entities: 1.00 per page for the first 25 pages and 25¢ per page for each page in excess of the first 25 pages. For other entities: up to $1.00 per page for each page copied, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Guardian Name (Please Print):_____ **Date:** _____

Signature: _____

(Patient, Parent, Guardian or Legal Representative)

Responsible Party Signature: _____

LOVING CARE PEDIATRICS

CONSENT TO TREAT MINOR

I hereby give consent to Loving Care Pediatrics, LLC to perform any radiology or lab testing examination, anesthetic, vaccines, medications, or medical treatment as deem advisable by Dr. Cubas, as well as any medical assistant or midlevel provider, on staff of Loving Care Pediatrics, LLC to the below named minor.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to any and all such diagnosis, treatments and hospital care which a licensed physician at Loving Care Pediatrics, LLC recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Minor Name: _____

Date of Birth: _____

Signed: _____

Print Name: _____

Date: _____

Please specify relationship to minor:

- ☐ Parent with legal custody
- ☐ Guardian with legal custody

Loving Care Pediatrics

1861 NW 123rd Ave, Pembroke Pines, FL 33026

Telehealth informed consent form

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing, and/or referring the patient to in-person care, as determined clinically appropriate. This "Telehealth Informed Consent" informs the patient ("patient," "you," or "your") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services provided:

Telehealth services offered by Loving Care Pediatrics, LLC, and the Practice's engaged providers (Dr. Cubas) may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate. Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law.

Electronic transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling
- Completion of medical intake forms
- Exchange and review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results via asynchronous communications
- Two-way interactive audio in combination with store-and-forward communications between you and your Provider
- Two-way interactive audio-video interaction between you and your Provider
- Review and treatment recommendations by your Provider based upon output data from medical devices and sound and video files
- Delivery of a consultation report; and/or other electronic transmissions for the purpose of rendering clinical care to you

Expected benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available at the discretion of Dr. Cubas.

Service limitations:

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT LOVING CARE PEDIATRICS, LLC OR YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE DOCTOR.**

- If it is determined during the initial screening of the telehealth visit that you should be seen in person, either in your Provider's office or in a recommended facility, you will not be charged for the telehealth visit. Appropriate emergency questions will be asked at the beginning of the telehealth visit that will determine what will be the best place for you to receive care.

Security measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Possible risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Practice at 954-441-2273.
- The quality of transmitted data may affect the quality of services provided by your Provider. Changes in the environment and test conditions could be impossible to make during delivery of telehealth services.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other clinical judgment errors.

Patient acknowledgments:

By checking the box associated with "Telehealth Informed Consent," you acknowledge that you understand and agree to the contents above and further agree with the following:

1. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that our Providers are not able to connect me directly to any local emergency services.
2. I acknowledge that I have been given an opportunity to select a provider; Or, I have elected to consult with the next available provider. I acknowledge that prior to the consultation, I have been given the provider's credentials.
3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of the Practice. I agree to hold harmless the Practice for delays in evaluation or for information lost due to such technical failures.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason.
5. I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted by individuals at my location, or at a testing facility, at the direction of our Providers.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that it is necessary to provide a complete and accurate medical history and will update my medical health records periodically, but no less than once a year.
8. I understand persons may be present during the consultation other than my Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.
9. I understand I have the right to object to the videotaping of the telehealth consultation.
10. I understand there is no guarantee that I will be treated by our Providers. Our Providers reserve the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of our Providers, the provision of the Service is not medically or ethically appropriate.
11. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.

12. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Practice will take steps to make sure my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners engaged by Practice who may be located in other areas, including out of state.
13. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records and/or consultation report, which will be provided to me at reasonable cost of preparation, shipping and delivery.
14. I understand that I may be asked if I have a primary care doctor and, if so, whether I consent to sending a copy of my medical records and/or consultation report to my primary care doctor. Upon my consent, Practice will send copy of my medical records and/or consultation report to my primary care doctor, which will be billed to me at reasonable cost of preparation, shipping and delivery.
15. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

16. I understand that I may not be covered under my current health insurance plan for telehealth services.

Patient Informed Consent

I have carefully read this form and fully understand its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with "Telehealth Informed Consent", I acknowledge that I understand and agree with the above and hereby consent to receive Practice's telehealth services:

☐ **ACCEPT.** By checking the Box for this "**TELEHEALTH INFORMED CONSENT**" I hereby state that I have read, understood, and agree to the terms of this document.

Patient's name	Parent/Legal guardian's name
Patient's signature	Parent/Legal guardian's name
Date	Date

CONSENT FOR VOICE AND TEXT MESSAGING COMMUNICATION

In an effort to relay Normal results faster to our patients we have implemented Electronic Medical Records.

I understand that in order for Loving Care Pediatrics LLC to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to Loving Care Pediatrics LLC.

I further understand that in order for Loving Care Pediatrics LLC to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to Loving Care Pediatrics LLC I also understand that my healthcare information at Loving Care Pediatrics LLC is protected and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Messages

I give my written express consent to Loving Care Pediatrics LLC to leave detailed messages on my voicemail/answering machine about my NORMAL lab results, diagnostic and/or imaging results, prescription information, or appointment reminders. No abnormal results will be communicated via our automated system.

Patient Name (Please Print): _____ Date: _____

Patient Signature: _____ Cell #: _____

(this number will be used for messaging)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that I must provide written notice in order to revoke this consent.

CONSENT, PERMISSION AND RELEASE FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to Loving Care Pediatrics LLC to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name)_____ , age (if minor) _____. Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by Loving Care Pediatrics LLC and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing. I acknowledge that Loving Care Pediatrics LLC is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released. Loving Care Pediatrics LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold Loving Care Pediatrics LLC, its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production. I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

Signature: _____Date:_____

Name of Parent/Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian (under age 18): _____

Witness Name: _____

Witness Signature: _____ Date: _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold Loving Care Pediatrics LLC responsible for instances of these violations.

LOVING CARE PEDIATRICS

TopLine MD Alliance

OFFICE POLICY

Appointment Policy

- ♡ Visits are by appointments only.
- ♡ Walk in patients without scheduled appointments will be offered the next available appointment. $15 convenient fee applies.
- ♡ We strive to accommodate same day sick appointments, however, during peak seasons it may be difficult. We ask for your patience and will try to schedule for the following day.
- ♡ **Please arrive 10 mins prior to appointment time.** This allows the staff time to update any required information (forms, insurance, etc).
- ♡ **Late arrivals**
  - We encourage you to call the office If running late. Patients who arrive more than 10 minutes late for a well check appointment or 15 mins late for a sick appointment may be asked to reschedule for a later time if available. If late more than 20 minutes the appointment will be rescheduled for another day.

Same day cancellations/No Shows

- Appointments cancelled <12 hours will incur a $25 fee.
- No show appointments will incur a $50 fee (after the first no show).

Prescription Refills

- ♡ Same day refills guaranteed if child meets criteria for the need of medication and you call office before 4 pm.
- ♡ ADD(H) medications require visits every 3 months . No medication will be refilled if a visit has not occurred within that time frame.
- ♡ Asthma/Allergy/Eczema medications will be refilled if patient has been seen for the condition within the past 6 months.
- ♡ **Medications will not be refilled if called during after hours or on weekends.**

Forms

- ♡ School forms/camp/sports/immunization forms will be completed at time of visit. Any extra school/immunization copies needed will carry a $10 fee per form.
- ♡ Forms dropped off in office may take up to 3 business days. If needed in less time, a $10 rush fee will be charged.
- ♡ FMLA paperwork, insurance letter or any letter on behalf of the patient or parents have a 7-10 day turnaround time. The office will call when they are complete.

Signature: _____ Date: _____

Notice of Privacy Practices
Loving Care Pediatrics, LLC

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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have 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 our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

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

Right to Request Confidential communication. 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 by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

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.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Loving Care Pediatrics, LLC
1861 NW 123rd Avenue
Pembroke Pines, FL 33026
(954) 441-2273

Please sign the accompanying "Acknowledgement" form

Aviso De Prácticas De Privacidad
Loving Care Pediatrics, LLC

ESTE AVISO DESCRIBE CÓMO LA INFORMACIÓN MÉDICA SOBRE USTED PUEDE USAR Y DIVULGADA Y CÓMO USTED PUEDE OBTENER ACCESO A ESTA INFORMACIÓN. POR FAVOR, LÉALA CON ATENCIÓN.

Cómo podemos usar y divulgar su información médica: Se describe como sigue es las maneras en que podemos usar y divulgar información de salud que le identifica a usted (información de salud). Excepto para los siguientes propósitos, vamos a utilizar y divulgar su información médica sólo con su permiso por escrito. Usted puede revocar tal autorización en cualquier momento por escrito a nuestra práctica.

Tratamiento:
Podemos usar y divulgar su información médica para su tratamiento y para proporcionarle los servicios de salud relacionados con el tratamiento. Por ejemplo, podemos divulgar información médica a doctores, enfermeras, técnicos y otro personal, incluyendo personas fuera de nuestra oficina, que participan en su atención médica y necesitan la información para proporcionarle atención médica.

Pago:
Podemos usar y divulgar su información médica para que nosotros u otros podemos facturar y recibir pago de usted, una compañía de seguros o un tercero para el tratamiento y los servicios que recibió. Por ejemplo, podemos dar su información de plan de salud para que pagarán por su tratamiento.

Operaciones de atención médicos:
Podemos utilizar y divulgar información médica para fines de atención médica de la operación. Estos usos y divulgaciones son necesarios para asegurarse de que todos nuestros pacientes reciban atención de calidad y para operar y administrar nuestra oficina. Por ejemplo, podemos utilizar y divulgar información para asegurarse de que el cuidado médico que recibe es de la más alta calidad. También podemos compartir información con otras entidades que tienen una relación con usted (por ejemplo, su plan de salud) para sus actividades de atención médica de la operación.

Recordatorios de citas, salud y alternativas de tratamiento, beneficios y servicios relacionados. Podemos utilizar y divulgar información médica para contactarle y recordarle que usted tiene una cita con nosotros. También podemos usar y divulgar información médica para informarle sobre alternativas de tratamiento o beneficios relacionados con la salud y servicios que puedan ser de su interés.

Individuos involucrados en su cuidado o el pago de su atención. Cuando sea apropiado, podemos compartir información médica con una persona que participa en su atención médica o el pago de su atención, como su familia o un amigo cercano. También podemos notificar a su familia sobre su ubicación o condición general o divulgar dicha información a una entidad en un esfuerzo de alivio de desastre.

Investigación. Bajo ciertas circunstancias, podemos usar y divulgar información médica para la investigación. Por ejemplo, un proyecto de investigación puede involucrar comparar la salud de los pacientes que recibieron un tratamiento a aquellos que recibieron otro, para la misma condición. Antes de que usemos o divulguemos información médica para la investigación, el proyecto pasará por un proceso de aprobación especial. Incluso sin autorización especial, podemos permitir los investigadores registros para ayudarles a identificar a los pacientes que pueden incluirse en su proyecto de investigación o para otros propósitos similares, siempre y cuando no retire ni tomar una copia de cualquier información de salud.

Las actividades de recaudación de fondos. Podemos utilizar o divulgar su información médica protegida, según sea necesario, para poder ubicarte para actividades de recaudación de fondos. Usted tiene el derecho de optar por no recibir comunicaciones de recaudación de fondos. (Opcional) Si no quieres recibir estos materiales, por favor envíe una solicitud por escrito al oficial de privacidad.

SITUACIONES ESPECIALES:

Requeridas por la ley. Divulgaremos información de salud cuando así lo requiere la ley internacional, federal, estatal o local.

Para evitar una amenaza grave para la salud o seguridad. Podemos usar y divulgar su información médica cuando sea necesario para prevenir una amenaza grave a su salud y seguridad o la salud y seguridad del público u otra persona. Revelaciones, sin embargo, se hará sólo a alguien que puede ayudar a prevenir la amenaza.

Asociados de negocios. Podemos divulgar información médica a nuestros asociados de negocios que realizan funciones en nuestro nombre o nos proporcionan servicios si la información es necesaria para dichas funciones o servicios. Por ejemplo, podemos utilizar otra compañía para realizar la facturación de servicios en nuestro nombre. Todos nuestros asociados de negocios están obligados a proteger la privacidad de su información y no se les permite usar o divulgar cualquier información que como se especifica en el contrato.

Violación de datos con fines de notificación. Podemos utilizar su información de contacto para proporcionar avisos requeridos legalmente de adquisición no autorizada, el acceso o la divulgación de su información médica. Podemos enviar aviso directamente a usted o notificar al patrocinador de su plan a través del cual recibe cobertura.

Donación de órganos y tejido. Si usted es un donante de órganos, podemos utilizar o divulgar información de salud a organizaciones que manejan la adquisición de órganos u otras entidades que participan en licitaciones; banca o transporte de órganos, ojos o tejidos para facilitar de órganos, ojos o tejidos donación; y trasplante.

Militares y veteranos. Si usted es un miembro de las fuerzas armadas, podemos divulgar información médica según lo requerido por las autoridades de comando militar. También podemos divulgar información médica a la autoridad militar extranjera correspondiente si eres un miembro de un ejército extranjero.

Compensación. Podemos divulgar información de salud para la compensación de trabajadores o programas similares. Estos programas proporcionan beneficios por accidente de trabajo o enfermedad.

Salud pública riesgos. Podemos divulgar información médica para actividades de salud pública. Estas actividades generalmente incluyen revelaciones para prevenir o controlar enfermedades, lesiones o incapacidades; nacimientos de informe y muertes; abuso de informe o negligencia; reacciones de informe a medicamentos o problemas con productos; notificar a las personas retiradas de productos que pueden estar usando; una persona que han estado expuesta a una enfermedad o puede estar en riesgo de contraer o propagar una enfermedad o condición; y la autoridad de gobierno apropiada si creemos que un paciente ha sido víctima de abuso, negligencia o violencia doméstica. Solamente haremos esta divulgación si usted está de acuerdo o cuando lo requiera o autorice la ley.

SUS DERECHOS:

Usted tiene los siguientes derechos con respecto a la información médica que tenemos sobre usted:

Acceso a registros electrónicos. La tecnología de la información de salud para la salud económica y clínica. Ley de alta tecnología permite a las personas para pedir copias *electrónicas* de su PHI contenida en registros electrónicos de salud o solicitar por escrito o electrónicamente otra persona reciba una copia electrónica de estos registros. Las reglas finales de ómnibus amplían el derecho de una persona para acceder a los registros electrónicos o dirigir que ser enviado a otra persona para incluir no sólo registros electrónicos de salud sino también todos los registros en uno o más conjuntos de registros designados. Si la persona solicita una copia electrónica, deben ser proporcionados en el formato solicitado o en un formato de acuerdo mutuo. Entidades cubiertas pueden cobrar a individuos por el costo de cualquier medio electrónico (como una unidad flash USB) utilizado para proporcionar una copia de la PHI de la electrónica.

Derecho a inspeccionar y copiar. Usted tiene el derecho de inspeccionar y copiar información de salud que pueden utilizarse para tomar decisiones sobre su cuidado o el pago de su atención. Esto incluye registros médicos y de facturación, excepto las notas de psicoterapia. Para inspeccionar y copiar esta información de salud, debe hacer su petición, por escrito.

Derecho a enmendar. Si usted cree que la información de salud que tenemos es incorrecta o incompleta, puede pedirnos que enmendemos la información. Usted tiene el derecho de pedir una enmienda mientras la información se mantiene por o para nuestra oficina. Para solicitar una enmienda, usted debe hacer su petición, por escrito.

Derecho a una contabilidad de accesos. Usted tiene el derecho de solicitar una lista de ciertas revelaciones que hicimos de información médica para fines que no sean de tratamiento, pago y operaciones de atención médica o que proporcionaste autorización por escrito. Para solicitar una contabilidad de accesos, usted debe hacer su petición, por escrito.

Derecho a solicitar restricciones. Usted tiene el derecho a solicitar una restricción o limitación en la información médica que utilizamos o revelamos para tratamiento, pago u operaciones de atención médica. Usted también tiene derecho a solicitar un límite en la información de salud que divulguemos a alguien involucrado en su cuidado o el pago de su atención, como un familiar o amigo. Por ejemplo, usted puede pedir que no compartamos información sobre un determinado diagnóstico o tratamiento con su cónyuge. Para solicitar una restricción, usted debe hacer su petición, por escrito.

No estamos obligados a aceptar su petición. Si estamos de acuerdo, cumpliremos con su petición a menos que la información es necesaria para proporcionarle tratamiento de emergencia.

Derecho a la comunicación mediante solicitud confidencial. Usted tiene el derecho a solicitar que nos comuniquemos con usted acerca de asuntos médicos de una cierta manera o en cierto lugar. Por ejemplo, usted puede solicitar que sólo te contactamos por correo o en el trabajo. Para solicitar comunicación confidencial, usted debe hacer su petición, por escrito. Su petición debe especificar cómo o dónde desea ser contactado. Acomodamos las peticiones razonables.

Derecho a una copia impresa de esta notificación. Usted tiene el derecho a una copia impresa de esta notificación. Usted puede pedirnos que le dará una copia de este aviso en cualquier momento.

CAMBIOS A ESTE AVISO:

Nos reservamos el derecho de cambiar este aviso a la nueva notificación se aplica a la información de salud que ya tenemos así como cualquier información que recibamos en el futuro. Publicaremos una copia de nuestra notificación actual en nuestra oficina. La notificación contendrá la fecha de vigencia en la primera página, en la esquina superior derecha.

QUEJAS:

Si usted cree que sus derechos de privacidad han sido violados, puede presentar una queja con nuestra oficina o con el Secretario del Departamento de salud y servicios humanos. Todas las quejas deben hacerse por escrito. Usted no será penalizado por presentar una queja.

Loving Care Pediatrics, LLC
1861 NW 123rd Avenue
Pembroke Pines, FL 33026
(954) 441-2273

Por favor firmar el "Reconocimiento"

English Notice of Nondiscrimination

This medical practice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This medical practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This medical practice:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

○ Qualified sign language interpreters

○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

○ Qualified interpreters

○ Information written in other languages

If you need these services, contact the office administrator.

If you believe that this medical practice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the office administrator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the office administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish Notice of Nondiscrimination / Aviso español de no discriminación

Esta práctica médica cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Esta práctica médica no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

Esta práctica médica:

• Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:

- ○ Intérpretes de lenguaje de señas capacitados.
- ○ Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).

• Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:

- ○ Intérpretes capacitados.
- ○ Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con el administrador de la oficina.

Si considera que esta práctica médica no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: el administrador de la oficina. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el administrador de la oficina está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.