Great Destinations Pediatrics P.C.

PATIENT'S INFORMATION

Patient's Name: _____ **Sex: M**_____ **F**_____ **DOB:** _____

Patient's Name: _____ **Sex: M**_____ **F**_____ **DOB:** _____

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Patient's Name: _____ **Sex: M**_____ **F**_____ **DOB:** _____

Patient's Name: _____ **Sex: M**_____ **F**_____ **DOB:** _____

Patient's Name: _____ **Sex: M**_____ **F**_____ **DOB:** _____

Patient's Home Address: _____ **Home Phone: (**____**)** _____-_____
Street City ST Zip Code

Marital Status of Child's Parents (please check one):

PARENT'S INFORMATION

Married _____ Single_____ Separated_____ Divorced_____

Please Circle (Natural, Step, Adoptive Parent, Guardian)

Mother's Name: _____ **Maiden Name**_____ Date of Birth: _____

Same as above ☐ Home Address: _____
Street City ST Zip Code

Cell: _____ Email: _____

Employer: _____ SSN# _____

Please Circle (Natural, Step, Adoptive Parent, Guardian)

Father's Name: _____ Date of Birth: _____

Same as above ☐ Home Address: _____
Street City ST Zip Code

Cell: _____ Email: _____

Employer: _____ SSN# _____

INSURANCE INFORMATION

Primary Insurance Company Name:	Name of Policy Holder	Policy/ID Number	Group Number
Primary Insurance Company Name:	Name of Policy Holder	Policy/ID Number	Group Number

Emergency Contact (Not living with you): Name: _____ Phone: (____) _____-_____

How did you hear about our practice? _____If doctor, please name:_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly from my insurance company to the physicians of Great Destinations Pediatrics for Medical treatment(s) provided to my child.
I understand that payment in full of my responsible portion is required at the time of visit. If Great Destinations Pediatrics (GDP) is not a provider on my insurance, full payment is due on the date of service. If GDP is a provider on my insurance, then any deductibles, co-pays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay reasonable charges, attorney fees, and all other costs.
I hereby authorize GDP to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and health care operations of my child.

FINANCIAL/OFFICE POLICY & HIPAA:
I have read and understand the foregoing financial and office policy and agree to abide by the terms of this office policy. I also acknowledge that I have received a copy of the Notice of Privacy Practices, including Omnibus Rule.

_____ _____/_____/_____
Responsible Party Printed Name Date

_____ _____
Responsible Party Signature *Relationship to Patient(s)*

Great Destinations Pediatrics, P.C.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____

CONSENT FORM FOR MEDICAL CARE

The following persons have my permission to authorize medical treatment if I am not available to give my consent. I understand that it is the parent(s) responsibility to notify Great Destinations Pediatrics of any changes with the list of authorized caregivers in writing.

1. Name _____

   Phone _____ Relationship _____

2. Name _____

   Phone _____ Relationship _____

3. Name _____

   Phone _____ Relationship _____

THIS CONSENT WILL BE VALID FROM _____/_____/_____ TO _____/_____/_____

(Today's Date) (Future Date)

AUTHORIZATION FOR TEST RESULTS

Parent/Legal Guardian Contact Information (please choose preferred method):

By checking the Abnormal/Normal boxes below you are giving permission to leave a voicemail or secure email for your child's test results if you cannot be reached at the time of the call.

Abnormal	Normal	
☐	☐	Primary Phone Number on File
☐	☐	Secondary Phone Number on File
☐	☐	Email: _____
☐	☐	Other Contact Name: _____
		Relationship to patient: _____
		Telephone: _____

I UNDERSTAND IT IS MY RESPONSIBILITY TO HAVE THE ORDERED TESTS DONE AND **HAVE BEEN EXPLAINED THE IMPORTANCE AND REASONING FOR THE TESTING. I UNDERSTAND GDP CONTACTS ALL PATIENTS WITH NORMAL AND ABNORMAL TEST RESULTS AND IT IS MY RESPONSIBILITY TO CONTACT GDP IF I HAVE NOT RECEIVED THE RESULTS. THIS AGREEMENT WILL REMAIN IN EFFECT INDEFINITELY.**

BY SIGNING THESE AGREEMENTS I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO INFORM GREAT DESTINATIONS PEDIATRICS OF ANY CHANGE OF INFORMATION.

_____

Parent Signature Date

PATIENT HISTORY

CHILD'S NAME_____ **DOB**_____

Form completed by: _____ **Relationship to child:** _____

Child's Birth History

Birth Weight_____ Was the baby born at term? _____weeks Place of Birth_____

Was the delivery ☐ Vaginal ☐ Cesarean If Cesarean, why?_____

Any complications during pregnancy or delivery? ☐ Y ☐ N Explain: _____

How long did the baby stay in the hospital after birth? _____ Did baby pass the hearing test? ☐ Y ☐ N

Did baby receive the Hepatitis B vaccine? ☐ Y ☐ N Did the baby receive the Vitamin K vaccine? ☐ Y ☐ N

Did baby have any problems? (i.e. Jaundice, respiratory distress, infection) _____

During pregnancy, did mother: Use tobacco ☐ Y ☐ N Drink Alcohol ☐ Y ☐ N Use drugs or medications ☐ Y ☐ N ☐ Used prenatal vitamins

What_____ When_____

Past Medical History

Has your child ever had any problems with the following? **If YES, please explain:**

☐ Y ☐ N ADHD _____
☐ Y ☐ N Asthma/RAD _____
☐ Y ☐ N Allergies (food/environmental) _____
☐ Y ☐ N Anemia/Blood Disorders _____
☐ Y ☐ N Bones/Joints _____
☐ Y ☐ N Chickenpox _____
☐ Y ☐ N Diabetes _____
☐ Y ☐ N Ears (multiple infections)/Hearing _____
☐ Y ☐ N Eyes/Vision _____

☐ Y ☐ N Gastro _____
(GE Reflux/Constipation/Diarrhea)
☐ Y ☐ N Heart _____
☐ Y ☐ N Repeated infections _____
☐ Y ☐ N Seizures/Headaches _____
☐ Y ☐ N Skin (Eczema) _____
☐ Y ☐ N Urine/Kidneys _____
Other_____

Hospitalizations_____

Surgeries _____

Current Social History

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

Name	Relationship to child	Birth date

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

☐ Y ☐ N If child is under 4'9", do you have them in a booster or car seat?
☐ Y ☐ N If child is less than 2 years old, are they in a rear facing car seat?
☐ Y ☐ N Do you and your child wear your seatbelt?
☐ Y ☐ N Do you have guns in the home?
☐ Y ☐ N If yes to above, do you keep them locked?
☐ Y ☐ N If your child is older than 6 months, do they use sunscreen?
☐ Y ☐ N Do you have pets in the home? _____
☐ Y ☐ N If you have a pool, do you have a gate surrounding it?
☐ Y ☐ N Are all of your medications and cleaners out of reach or locked?
☐ Y ☐ N Does your child wear a bicycle helmet when biking, skating, or horseback Riding?
☐ Y ☐ N Does anyone smoke in or outside of the house, including close relatives and caregivers?
☐ Y ☐ N Is anyone verbally or physically abusing you or your child?

Allergies to medications, food, or insects: _____

_____

Family History

Relationship	Age, if Living	Age at Death & Cause of Death
Pt's Mother	_____	_____
Pt's Father	_____	_____

Patients Siblings

How Many Sisters? _____ How Many Brothers? _____

Family Medical Problems: (*Immediate Family, No greats or extended family*)

Please identify any medical problems blood relatives have or ever have had.

Condition		Family Member(s) **Please indicate Maternal/Paternal**
Allergies	☐ Y ☐ N	_____
Anemia/Blood Disorders	☐ Y ☐ N	_____
Asthma	☐ Y ☐ N	_____
Birth Defects	☐ Y ☐ N	_____
Bone/Joint Disorders	☐ Y ☐ N	_____
Cancer	☐ Y ☐ N	_____
Diabetes	☐ Y ☐ N	_____
Eye or Ear Disorders	☐ Y ☐ N	_____

Condition		Family Member(s) **Please indicate Maternal/Paternal**
Genetic Defects	☐ Y ☐ N	_____
Heart Disease/Problems	☐ Y ☐ N	_____
Hepatitis B or C	☐ Y ☐ N	_____
High Blood Pressure	☐ Y ☐ N	_____
HIV/Aids	☐ Y ☐ N	_____
Kidney Disease/Problems	☐ Y ☐ N	_____
Lung Disease	☐ Y ☐ N	_____
Mental Disease/Disorder	☐ Y ☐ N	_____
Mental Retardation	☐ Y ☐ N	_____
Muscle Disorders	☐ Y ☐ N	_____
Neurological Disorders	☐ Y ☐ N	_____
Rheumatoid Arthritis	☐ Y ☐ N	_____
Rheumatic Fever	☐ Y ☐ N	_____
Seizures/Convulsions	☐ Y ☐ N	_____
Skin Disease	☐ Y ☐ N	_____
Thyroid Disease	☐ Y ☐ N	_____
Tuberculosis	☐ Y ☐ N	_____

Other_____

Authorization to Release Medical Information

Patient Information:

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Address: _____ Phone: _____

I hereby authorize Great Destinations Pediatrics, PC to **SEND** ☐ **RECEIVE** ☐ photocopies of medical records concerning the above-named patient(s) **TO/FROM**:

Practice/Company or person(s) authorized to release/receive records:

Name/Practice/Company: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

For the purposes of: _____

SEND RECORDS TO:

Great Destinations Pediatrics, P.C.
7757 W. Deer Valley Rd, Ste 275 Peoria, AZ 85382
Phone: (623) 878-2800 · **Fax**: (623) 878-9150
Email: Frontdesk@gdpeds.com

Records to be included *(check all that apply)*:

_____ All Medical Records _____ Immunization Records

_____ Consult Reports (*Specialist Name(s)/type of specialty*) _____

_____ Labs, X-rays *(Date(s) of service)* _____

_____ Hospital/Urgent Care Notes *Date(s) of service*: _____

_____ The following information should **NOT** be released (*Please specify*): _____

In accordance with federal regulations, I hereby consent to the release of records pertaining to treatment/diagnosis of the following should records contain this information: Condition relating to drug and/or alcohol abuse, condition related to psychiatric/psychological treatment, AIDS/HIV, and communicable diseases.
This request will remain in effect for 1year from the date of this request. I understand that I may revoke this authorization at any time in writing except to the extent that action based on this authorization has already been taken. PLEASE ALLOW A MINNIMUM OF 14 BUSINESS DAYS FOR ALL MEDICAL RECORD REQUESTS.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship to patient.

STAFF ONLY:

_____ Verified Email _____ Verified DL _____ Employee #1 _____ Employee #2

Fax #1 _____ ***Fax #2*** _____ ***Fax #3*** _____

Great Destinations Office Policies

By signing this form, you understand and agree to the policies of Great Destinations Pediatrics. Our mission is the care of our patient is priority one and that all patients be treated with respect and with the highest quality of care.

Financial Policy

Payments and Insurance Submissions

Great Destinations will submit claims and process payments with the insurance company on your behalf. Payment in full for accounts 60 days or older, not paid by the insurance company will be your responsibility. Non-insured, high deductible amounts not yet met, and if coverage can not be verified by the insurance company at time of service will need to pay for charges at the time of service. It is your responsibility to know what is covered vs not covered by your insurance plan.

_____ Initial

Returned Checks:

Great Destinations policy on **returned checks is a fee of $30.00** added to the account. The service charge must be paid in full in 3 business days by either cash or credit card. The patient's account will then be required to pay all services by cash or credit card moving forward.

_____Initial

Appointments:

We require a 24-hour notice of cancellation prior to your scheduled appointment. Appointment time is scheduled for one patient, should you have more than one child needing to be seen a second appointment must be scheduled, we do not allow "add ons". If an appointment is missed and not canceled within the 24-hour timeframe a **fee of $25.00** will be charged to the account. Same day appointments must be canceled 2 hours prior to your scheduled appointment time to avoid the No Show Fee.

_____Initial

Medical Records/Requested forms:

All medical releases need to be submitted in writing using the Medical Release FROM/TO on the GDP website or obtained from the front desk and must be submitted by a parent or legal guardian. Medical records released to new PCP are free of charge. Vaccine records are provided free of charge. PHI (Personal Health Information - medical records) requested by a parent or legal guidance must be submitted in writing using the Medical Release FROM GDP form and received via mail, email, fax or drop off. PHI are required to be in either paper or electronic form, per parent or legal guardian's request. GDP will provide the electronic form for the PHI, no outside device will be used due to risk of security. Parent or legal guardian may request the PHI to be mail, emailed or faxed and understand the risk in transmitting private information through those various means and GDP is not liable for any security risks during transit. GDP has 5 business days to comply with this request that is submitted via email, fax, or

mail. Walk in requests may take up to 10 days to process this request. A processing **fee of $25.00** is required, as allowed through the HIPPA Privacy rule.

_____Initial

FMLA Forms:

If you are requesting the completion of FMLA forms you must email, fax or drop off the form with your portion completed. Once the office has completed the form, it can be faxed or mailed to you or any other party designated by you at time of request. Prepayment of a processing **fee of $25.00** is required. You may pay at the time of drop off or by calling the billing department at 623-878-2800 ext 103.

_____Initial

Divorce/Separated Parents:
Great Destinations Pediatrics' providers and staff are dedicated to our patients and providing quality medical care to your child(ren). Our focus is on your child's medical, emotional, psychological, and physiological health. We are not party to or to be involved in any legal issues involving divorce, separation, or custody agreements. Please read and agree to the following so that we may provide care for your child(ren).

1. The physicians, medical assistants, office, and billing staff will not be put in the middle of domestic issues or disagreements over the phone or in the office.
2. Please make decisions regarding appointments, vaccinating and/or any office procedures PRIOR to visiting our practice.
3. Only in situations where there is a confirmed, documented COURT ORDER, will one of the parent's be denied access to the minor child's health records or visits at the office. Great Destinations Pediatrics must have a copy of the COURT ORDER on file along with a letter from the authorized parent's attorney stating what role Great Destinations Pediatrics is required to adhere to per the COURT ORDER.
4. If there is NOT a court order on file with our office, either parent or legal guardian can sign a "Consent to Treat" form that authorizes any named individuals (like grandparents, nannies, etc.) to bring your child to our practice, be present during the visit and consent to any treatment during the visit. We will not be involved in any disputes regarding named individuals on the consent form unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for the visit and/or obtain a copy of the visit summary. This is subject to medical records fees.
5. It is both parents' responsibility to communicate with each other about the patient's care, office visits dates and any other pertinent information relevant to the patient. It is not the responsibility of the physicians to communicate visit information to each custodial parent separately. Our providers will not call the parent who did not attend the visit.
6. Additionally, we will not call the other parent for consent regarding appointments scheduled, restrict either parent's involvement in the patient's care unless authorized by law nor tolerate appointment scheduling/cancelling patterns of behavior between parents.
7. Furthermore, payments including copays, deductibles, co-insurance or any additional fees charged by your insurance are due **at the time of service** regardless of which parent is responsible for medical expenses. We are not a party to your divorce agreement. We will collect payment from the parent who brings the child to their visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from

the other parent. Any disputes about payments that end up in the collections process, will be due at the next time of service or the patient will not be seen.

8. If we feel any if the above points are becoming an issue at the office and/or compromising patient care, we have the right to discharge the family from the practice.

By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in the discharge of your family from the practice.

_____Initial

_____ _____

Patient Name Date of Birth Patient Name Date of Birth

_____ _____

Patient Name Date of Birth Patient Name Date of Birth

_____ _____

Patient Name Date of Birth Patient Name Date of Birth

_____ _____

Patient (18 yrs. or older) or Guardian Signature Date

_____ _____

Guardian Name Print Relationship to Patient

OMNIBUS Rule

HIPAA NOTICE OF PRIVACY PRACTICES

GREAT DESTINATIONS PEDIATRICS
7757 W DEER VALLEY RD STE 275
PEORIA, AZ 85382

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION under the HIPAA Omnibus Rule of 2013.

PLEASE REVIEW IT CAREFULLY

For purposes of this Notice "us" "we" and "our" refers to the Name of this Healthcare Facility: GREAT DESTINATIONS PEDIATRICS and "you" or "your" refers to our patients (or their legal representatives as determined by us in accordance with state informed consent law). When you receive healthcare services from us, we will obtain access to your medical information (i.e. your health history). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

The Federal Health Insurance Portability & Accountability Act of 2013, HIPAA Omnibus Rule, (formally HIPAA 1996 & HI TECH of 2004) require us to maintain the confidentiality of all your healthcare records and other identifiable patient health information (PHI) used by or disclosed to us in any form, whether electronic, on paper, or spoken. HIPAA is a Federal Law that gives you significant new rights to understand and control how your health information is used. Federal HIPAA Omnibus Rule and state law provide penalties for covered entities, business associates, and their subcontractors and records owners, respectively that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPAA requires us to provide you with the Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for health-care services. If you have any questions about this Notice, please ask to speak to our HIPAA Privacy Officer.

Our doctors, clinical staff, employees, Business Associates (outside contractors we hire), their subcontractors and other involved parties follow the policies and procedures set forth in this Notice. If at this facility, your primary caretaker / doctor is unavailable to assist you (i.e. illness, on-call coverage, vacation, etc.), we may provide you with the name of another healthcare provider outside our practice for you to consult with. If we do so, that provider will follow the policies and procedures set forth in this Notice or those established for his or her practice, so long as they substantially conform to those for our practice.

OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we must have your signature on a written, dated Consent Form and/or an Authorization Form of Acknowledgement of this Notice, before we will use or disclose your PHI for certain purposes as detailed in the rules below.

Documentation – You will be asked to sign an Authorization / Acknowledgement form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our Privacy Officer. You may take back or revoke your consent or authorization at any time (unless we already have acted based on it) by submitting our Revocation Form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (i.e. if after we provide services to you, you revoke your authorization / acknowledgement in order to prevent us billing or collecting for those services, your revocation will have no effect because we relied on your authorization/ acknowledgement to provide services before you revoked it).

General Rule – If you do not sign our authorization/ acknowledgement form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. By law, we are unable to submit claims to payers under assignment of benefits without your signature on our authorization/ acknowledgement form. You will however be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule. We will not condition treatment on you signing an authorization / acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the authorization/ acknowledgement or revoke it.

Healthcare Treatment, Payment and Operations Rule

With your signed consent, we may use or disclose your PHI in order:

- To provide you with or coordinate healthcare treatment and services. For example, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other healthcare providers, schedule lab work for you, etc.
- To bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan or provide your x-rays because your health plan requires them for payment; Remember, you will be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under this new Omnibus Rule.
- To run our office, assess the quality of care our patients receive and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you by telephone, mail or otherwise remind you of scheduled appointments, we may leave messages with whomever answers your telephone or email to contact us (but we will not give out detailed PHI), we may call you by name from the waiting room, we may ask you to put your name on a sign-in sheet, (we will cover your name just after checking you in), we may tell you about or recommend health-related products and complementary or alternative treatments that may interest you, we may review your PHI to evaluate our staff's performance, or our Privacy Officer may review your records to assist you with complaints. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, please notify us in writing at our address listed above and we will not use or disclose your PHI for these purposes.
- New HIPAA Omnibus Rule does not require that we provide the above notice regarding Appointment Reminders, Treatment Information or Health Benefits, but we are including these as a courtesy so you understand our business practices with regards to your (PHI) protected health information.

Additionally you should be made aware of these protection laws on your behalf, under the new HIPAA Omnibus Rule:

- That **Health Insurance plans** that underwrite cannot use or disclose genetic information for underwriting purposes (this excludes certain long-term care plans). Health plans that post their NOPPs on their web sites must post these Omnibus Rule changes on their sites by the effective date of the Omnibus Rule, as well as notify you by US Mail by the Omnibus Rules effective date. Plans that do not post their NOPPs on their Web sites must provide you information about Omnibus Rule changes within 60 days of these federal revisions.
- **Psychotherapy Notes** maintained by a healthcare provider, must state in their NOPPs that they can allow "use and disclosure" of such notes only with your written authorization.

Special Rules

Notwithstanding anything else contained in this Notice, only in accordance with applicable HIPAA Omnibus Rule, and under strictly limited circumstances, we may use or disclose your PHI without your permission, consent or authorization for the following purposes:

- When required under federal, state or local law
- When necessary in emergencies to prevent a serious threat to your health and safety or the health and safety of other persons
- When necessary for public health reasons (i.e. prevention or control of disease, injury or disability, reporting information such as adverse reactions to anesthesia, ineffective or dangerous medications or products, suspected abuse, neglect or exploitation of children, disabled adults or the elderly, or domestic violence)
- For federal or state government health-care oversight activities (i.e. civil rights laws, fraud and abuse investigations, audits, investigations, inspections, licensure or permitting, government programs, etc.)
- For judicial and administrative proceedings and law enforcement purposes (i.e. in response to a warrant, subpoena or court order, by providing PHI to coroners, medical examiners and funeral directors to locate missing persons, identify deceased persons or determine cause of death)
- For Worker's Compensation purposes (i.e. we may disclose your PHI if you have claimed health benefits for a work-related injury or illness)
- For intelligence, counterintelligence or other national security purposes (i.e. Veterans Affairs, U.S. military command, other government authorities or foreign military authorities may require us to release PHI about you)
- For organ and tissue donation (i.e. if you are an organ donor, we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation)

- For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality (i.e. if the researcher will have access to your PHI because involved in your clinical care, we will ask you to sign an authorization)
- To create a collection of information that is "de-identified" (i.e. it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you)
- To family members, friends and others, but only if you are present and verbally give permission. We give you an opportunity to object and if you do not, we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (i.e. you bring someone with you into the operatory or exam room during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (i.e. to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (i.e. your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI, but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed. **As per HIPAA law 164.512(j) (i)... (A) Is necessary to prevent or lessen a serious or imminent threat to the health and safety of a person or the public and (B) Is to person or persons reasonably able to prevent or lessen that threat.**

Minimum Necessary Rule

Our staff will not use or access your PHI unless it is necessary to do their jobs (i.e. doctors uninvolved in your care will not access your PHI; ancillary clinical staff caring for you will not access your billing information; billing staff will not access your PHI except as needed to complete the claim form for the latest visit; janitorial staff will not access your PHI). All of our team members are trained in HIPAA Privacy rules and sign strict Confidentiality Contracts with regards to protecting and keeping private your PHI. So do our Business Associates and their
Subcontractors. Know that your PHI is protected several layers deep with regards to our business relations. Also, we disclose to others outside our staff, only as much of your PHI as is necessary to accomplish the recipient's lawful purposes. Still in certain cases, we may use and disclose the entire contents of your medical record:

- To you (and your legal representatives as stated above) and anyone else you list on a Consent or Authorization to receive a copy of your records
- To healthcare providers for treatment purposes (i.e. making diagnosis and treatment decisions or agreeing with prior recommendations in the medical record)
- To the U.S. Department of Health and Human Services (i.e. in connection with a HIPAA complaint)
- To others as required under federal or state law
- To our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPAA (i.e. clerks who copy records need access to your entire medical record)

In accordance with HIPAA law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requestor's purpose. Our Privacy Officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For non-routine requests or disclosures, our Privacy Officer will make a minimum necessary determination based on, but not limited to, the following factors:

- The amount of information being disclosed
- The number of individuals or entities to whom the information is being disclosed
- The importance of the use or disclosure
- The likelihood of further disclosure
- Whether the same result could be achieved with de-identified information
- The technology available to protect confidentiality of the information
- The cost to implement administrative, technical and security procedures to protect confidentiality

If we believe that a request from others for disclosure of your entire medical record is unnecessary, we will ask the requestor to document why this is needed, retain that documentation and make it available to you upon request.

Incidental Disclosure Rule

We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it (i.e. we shred all paper containing PHI, require employees to speak with privacy precautions when discussing PHI with you, we use computer passwords and change them periodically (i.e. when an employee leaves us), we use firewall and router protection to the federal standard, we back up our PHI data off-site and encrypted to federal standard, we do not allow unauthorized access to areas where PHI is stored or filed and/or we have any unsupervised business associates sign Business Associate Confidentiality Agreements).

However, in the event that there is a breach in protecting your PHI, we will follow Federal Guide Lines to HIPAA Omnibus Rule Standard to first evaluate the breach situation using the Omnibus Rule, 4-Factor Formula for Breach Assessment. Then we will document the situation, retain copies of the situation on file, and report all breaches (other than low probability as prescribed by the Omnibus Rule) to the US Department of Health and Human Services at:
http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html

We will also make proper notification to you and any other parties of significance as required by HIPAA Law.

Business Associate Rule

Business Associates are defined as: an entity, (non-employee) that in the course of their work will directly / indirectly use, transmit, view, transport, hear, interpret, process or offer PHI for this Facility.

Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure. Nothing in our Business Associate agreement will allow our Business Associate to violate this re-disclosure prohibition. Under Omnibus Rule, Business Associates will sign a strict confidentiality agreement binding them to keep your PHI protected and report any compromise of such information to us, you and the United States Department of Health and Human Services, as well as other required entities. Our Business Associates will also follow Omnibus Rule and have any of their Subcontractors that may directly or indirectly have contact with your PHI, sign Confidentiality Agreements to Federal Omnibus Standard.

Super-confidential Information Rule

If we have PHI about you regarding communicable diseases, disease testing, alcohol or substance abuse diagnosis and treatment, or psychotherapy and mental health records (super-confidential information under the law), we will not disclose it under the General or Healthcare Treatment, Payment and Operations Rules (see above) without your first signing and properly completing our Consent form (i.e. you specifically must initial the type of super-confidential information we are allowed to disclose). If you do not specifically authorize disclosure by initialing the super-confidential information, we will not disclose it unless authorized under the Special Rules (see above) (i.e. we are required by law to disclose it). If we disclose super-confidential information (either because you have initialed the consent form or the Special Rules authorizing us to do so), we will comply with state and federal law that requires us to warn the recipient in writing that re-disclosure is prohibited.

Changes to Privacy Policies Rule

We reserve the right to change our privacy practices (by changing the terms of this Notice) at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past (i.e. to PHI about you that we had before the changes took effect). If we make changes, we will post the changed Notice, along with its effective date, in our office and on our website. Also, upon request, you will be given a copy of our current Notice.

Authorization Rule

We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on our specifically worded, written Authorization / Acknowledgement Form (not a Consent or an Acknowledgement). If we need your Authorization, we must obtain it via a specific Authorization Form, which may be separate from any Authorization / Acknowledgement we may have obtained from you. We will not condition your treatment here on whether you sign the Authorization (or not).

Marketing and Fund Raising Rules

Limitations on the disclosure of PHI regarding Remuneration

The disclosure or sale of your PHI without authorization is prohibited. Under the new HIPAA Omnibus Rule, this would exclude disclosures for public health purposes, for treatment / payment for healthcare, for the sale, transfer, merger, or consolidation of all or part of this facility and for related due diligence, to any of our Business Associates, in connection with the business associate's performance of activities for this facility, to a patient or beneficiary upon request, and as required by law. In addition, the disclosure of your PHI for research purposes or for any other purpose permitted by HIPAA will not be considered a prohibited disclosure if the only reimbursement received is "a reasonable, cost-based fee" to cover the cost to prepare and transmit your PHI which would be expressly permitted by law. Notably, under the Omnibus Rule, an authorization to disclose PHI must state that the disclosure will result in remuneration to the Covered Entity. Notwithstanding the changes in the Omnibus Rule, the disclosure of limited data sets (a form of PHI with a number of identifiers removed in accordance with specific HIPAA requirements) for remuneration pursuant to existing agreements is permissible until September 22, 2014, so long as the agreement is not modified within one year before that date.

Limitation on the Use of PHI for Paid Marketing

We will, in accordance with Federal and State Laws, obtain your written authorization to use or disclose your PHI for marketing purposes, (i.e.: to use your photo in ads) but not for activities that constitute treatment or healthcare operations. To clarify, ***Marketing*** is defined by HIPAA's Omnibus Rule, as "a communication about a product or service that encourages recipients . . . to purchase or use the product or service." Under the Omnibus Rule, we will obtain a written authorization from you prior to recommending you to an alternative therapist, or non-associated Healthcare Covered Entity.

Under Omnibus Rule we will obtain your written authorization prior to using your PHI or making any treatment or healthcare recommendations, should financial remuneration for making the communication be involved from a third party whose product or service we might promote (i.e.: businesses offering this facility incentives to promote their products or services to you). This will also apply to our Business Associate who may receive such remuneration for making a treatment or healthcare recommendations to you. All such recommendations will be limited without your expressed written permission.

We must clarify to you that financial remuneration does not include "as in-kind payments" and payments for a purpose to implement a disease management program. Any promotional gifts of nominal value are not subject to the authorization requirement, and we will abide by the set terms of the law to accept or reject these.

The only exclusion to this would include: "refill reminders", so long as the remuneration for making such a communication is "reasonably related to our cost" for making such a communication. In accordance with law, this facility and our Business Associates will only ever seek reimbursement from you for permissible costs that include: labor, supplies, and postage. Please note that "generic equivalents" , "adherence to take medication as directed" and "self-administered drug or delivery system communications" are all considered to be "refill reminders."

Face-to-face marketing communications, such as sharing with you, a written product brochure or pamphlet, is permissible under current HIPAA Law.

Flexibility on the Use of PHI for Fundraising

Under the HIPAA Omnibus Rule use of PHI is more flexible and does not require your authorization should we choose to include you in any fund raising efforts attempted at this facility? However, we will offer the opportunity for you to "opt out" of receiving future fundraising communications. Simply let us know that you want to "opt out" of such situations. There will be a statement on your ***HIPAA Patient Acknowledgement Form*** where you can choose to "opt out". Our commitment to care and treat you will in no way effect your decision to participate or not participate in our fund raising efforts.

Improvements to Requirements for Authorizations Related to Research

Under HIPAA Omnibus Rule, we may seek authorizations from you for the use of your PHI for future research. However, we would have to make clear what those uses are in detail.

Also, if we request of you a compound authorization with regards to research, this facility would clarify that when a compound authorization is used, and research-related treatment is conditioned upon your authorization, the compound authorization will differentiate between the conditioned and unconditioned components.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

If you got this Notice via email or website, you have the right to get, at any time, a paper copy by asking our Privacy Officer. Also, you have the following additional rights regarding PHI we maintain about you:

To Inspect and Copy

You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to our Privacy Officer. Original records will not leave the premises, will be available for inspection only during our regular business hours, and only if our Privacy Officer is present at all times. You may ask us to give you the copies in a format other than photocopies (and we will do so unless we determine that it is impractical) or ask us to prepare a summary in lieu of the copies. We may charge you a fee not to exceed state law to recover our costs (including postage, supplies, and staff time as applicable, but excluding staff time for search and retrieval) to duplicate or summarize your PHI. We will not condition release of the copies on summary of payment of your outstanding balance for professional services if you have one). We will comply with Federal Law to provide your PHI in an electronic format within the 30 days, to Federal specification, when you provide us with proper written request. Paper copy will also be made available. We will respond to requests in a timely manner, without delay for legal review, or, in less than thirty days if submitted in writing, and in ten business days or less if malpractice litigation or pre-suit production is involved. We may deny your request in certain limited circumstances (i.e. we do not have the PHI; it came from a confidential source, etc.). If we deny your request, you may ask for a review of that decision. If required by law, we will select a licensed health-care professional (other than the person who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed healthcare professional who is not affiliated with us, we will ensure a Business Associate Agreement is executed that prevents re-disclosure of your PHI without your consent by that outside professional.

To Request Amendment / Correction

If another doctor involved in your care tells us in writing to change your PHI, we will do so as expeditiously as possible upon receipt of the changes and will send you written confirmation that we have made the changes. If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it (so long as we have it) by submitting a "**Request for Amendment / Correction**" form to our Privacy Officer. We will act on your request within 30 days from receipt but we may extend our response time (within the 30-day period) no more than once and by no more than 30 days, or as per Federal Law allowances, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within five business days, make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language, and send the changes within 5 business days to persons you ask us to and persons we know may rely on incorrect or incomplete PHI to your detriment (or already have). We may deny your request under certain circumstances (i.e. it is not in writing, it does not give a reason why you want the change, we did not create the PHI you want changed (and the entity that did can be contacted), it was compiled for use in litigation, or we determine it is accurate and complete). If we deny your request, we will (in writing within 5 business days) tell you why and how to file a complaint with us if you disagree, that you may submit a written disagreement with our denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosure of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Services.

To an Accounting of Disclosures

You may ask us for a list of those who got your PHI from us by submitting a "**Request for Accounting of Disclosures**" form to us. The list will not cover some disclosures (i.e. PHI given to you, given to your legal representative, given to others for treatment, payment or health-care-operations purposes). Your request must state in what form you want the list (i.e. paper or electronically) and the time period you want us to cover, which may be up to but not more than the last six years (excluding dates before April 14, 2003). If you ask us for this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you want to withdraw or modify your request to avoid the cost.

To Request Restrictions

You may ask us to limit how your PHI is used and disclosed (i.e. in addition to our rules as set forth in this Notice) by submitting a written "**Request for Restrictions on Use, Disclosure**" form to us (i.e. you may not want us to disclose your surgery to family members or friends involved in paying for our services or providing your home care). If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations. Also, in some circumstances we may be unable to grant your request (i.e. we are required by law to use or disclose your PHI in a manner that you want restricted, you signed an Authorization Form, which you may revoke, that allows us to use or disclose your PHI in the manner you want restricted; in an emergency).

To Request Alternative Communications

You may ask us to communicate with you in a different way or at a different place by submitting a written "**Request for Alternative Communication**" Form to us. We will not ask you why and we will accommodate all reasonable requests (which may include: to send appointment reminders in closed envelopes rather than by postcards, to send your PHI to a post office box instead of your home address, to communicate with you at a telephone number other than your home number). You must tell us the alternative means or location you want us to use and explain to our satisfaction how payment to us will be made if we communicate with you as you request.

To Complain or Get More Information

We will follow our rules as set forth in this Notice. If you want more information or if you believe your privacy rights have been violated (i.e. you disagree with a decision of ours about inspection / copying, amendment / correction, accounting of disclosures, restrictions or alternative communications), we want to make it right. We never will penalize you for filing a complaint. To do so, please file a formal, written complaint within 180 days with:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201
877.696.6775

Or, submit a written Complaint form to us at the following address:

Our Privacy Officer: KRISTIN SHEPHERD
Office Name: *GREAT DESTINATIONS PEDIATRICS*
Office Address: *7757 W DEER VALLEY RD STE 275*
PEORIA, AZ 85382
Office Phone: *(623) 878-2800*
Office Fax: *(623) 878-9150*
Email Address: *OFFICEMANAGER@GDPEDS.COM*

You may get your **"HIPAA Complaint"** form by calling our privacy officer.

These privacy practices are in accordance with the original HIPAA enforcement effective April 14, 2003, and undated to Omnibus Rule effective March 26, 2013 and will remain in effect until we replace them as specified by Federal and/or State Law.

Faxing and Emailing Rule

When you request us to fax or email your PHI as an alternative communication, we may agree to do so, but only after having our Privacy Officer or treating doctor review that request. For this communication, our Privacy Officer will confirm that the fax number or email address is correct before sending the message and ensure that the intended recipient has sole access to the fax machine or computer before sending the message; confirm receipt, locate our fax machine or computer in a secure location so unauthorized access and viewing is prevented; use a fax cover sheet so the PHI is not the first page to print out (because unauthorized persons may view the top page); and attach an appropriate notice to the message. Our emails are all encrypted per Federal Standard for your protection.

Practice Transition Rule

If we sell our practice, our patient records (including but not limited to your PHI) may be disclosed and physical custody may be transferred to the purchasing healthcare provider, but only in accordance with the law. The healthcare provider who is the new records owner will be solely responsible for ensuring privacy of your PHI after the transfer and you agree that we will have no responsibility for (or duty associated with) transferred records. If all the owners of our practice die, our patient records (including but not limited to your PHI) must be transferred to another healthcare provider within 90 days to comply with State & Federal Laws. Before we transfer records in either of these two situations, our Privacy Officer will obtain a Business Associate Agreement from the purchaser and review your PHI for super-confidential information (i.e. communicable disease records), which will not be transferred without your express written authorization (indicated by your initials on our Consent form).

Inactive Patient Records

We will retain your records for seven years from your last treatment or examination, at which point you will become an inactive patient in our practice and we may destroy your records at that time (but records of inactive minor patients will not be destroyed before the child's eighteenth birthday). We will do so only in accordance with the law (i.e. in a confidential manner, with a Business Associate Agreement prohibiting re-disclosure if necessary).

Collections

If we use or disclose your PHI for collections purposes, we will do so only in accordance with the law.