WELCOME!

****Please fill out this <u>entire</u> form. We cannot file your insurance claim without this information****

Children's Names:

____ DOB _________________ M______ F______

____ DOB _________________ M______ F______

____ DOB _________________ M______ F______

____ DOB _________________ M______ F______

Address: ____

City: ___________________________ State: _____ Zip: ___________ Phone: (___)__________________________

Cell Phone-Dad____________________ Cell Phone-Mom ______________________ Email _________________________________

Would you like to receive our newsletter and updates by email? Circle: **YES** **NO**

Nearest Relative: ____________________________ Phone: (___)___________________ Relationship: _________________

FATHERS NAME:	MOTHERS NAME:
Employer:	Employer:
Occupation:	Occupation:
Work Phone:	Work Phone:
Drivers License #:	Drivers License #:
Social Security #:	Social Security #:
Birthdate:	Birthdate:

REFERRED BY: ___________________________

THIS AREA MUST BE COMPLETED FOR OUR OFFICE TO FILE YOUR INSURANCECLAIMS

<u>Self Pay</u> (Please initial and date): ____________________

<u>Primary Insurance</u>:________________________________Policy Holder Name & SS#:_________________________________

ID or Policy #:_____________________________________Policy Holder Date of Birth _________________________________

GROUP#:____Effective date:____

<u>Secondary Insurance</u>: ______________________________Insured Parent: ____

ID or Policy #:_____________________________________Group#:____

* * * * * * * * * * * * * *

Appointments: There will be a $25.00 fee charged to your account for any missed appointments.

Fee Policy: Payment is expected at the time of service.

Medical Care: I authorize the physicians of Austin Children's Clinic, PA to provide my child with reasonable and proper medical care according to today's standards.

Medical Information: I authorize the physicians of Austin Children's Clinic, PA to release any information concerning my child's illness and treatments to consulting physicians, or to my insurance company or companies or any third party payor so that they may obtain payment for medical services rendered.

Assignment of Benefits: I authorize the insurance company or any third party to pay any benefits directly to the above physicians, realizing I am responsible to pay non-covered services. I understand that if the information I am providing today results in the insurance claims being denied, for any reason, I will be responsible for the full amount billed without the benefits or discounts.

SIGNATURE:____ **DATE**:___________________________

AUSTIN CHILDREN'S CLINIC, PA

CONSENT FORM

Children's Names: **DOB**

___________________________________	_______________________
___________________________________	_______________________
___________________________________	_______________________
___________________________________	_______________________

Please initial each appropriate statement and then sign below to give consent.

Appointment Reminders:

___________ It is OK to leave a message on voice mail, recording device or with any **adult** persons answering my **Home** phone.

___________ It is OK to leave a message on voice mail or a recording device at my/spouse's **Work** phone.

___________ It is OK to mail reminder cards to my home address.

Lab Results:

Our office will not leave messages for positive results or any results on tests of a sensitive nature. Additionally, we will not leave lab results at a work phone number.

___________ It is OK to leave a message **for negative lab results** on voice mail, recording device or with any **adult** persons answering my **Home** phone.

___________ It is NOT OK to leave a message for any lab results. If I am not available at home please try the following number: Phone # ________________ Contact person _____________________.

I understand any changes to or revocation of this consent must be made in writing.

______________________________ ______________________

Signature Parent/Legal Guardian Date

NEW PATIENT QUESTIONNAIRE

PATIENT'S NAME: ______________________ DATE OF BIRTH: __________ SEX: __________

YOUR NAME: ______________________ RELATIONSHIIP TO CHILD: ______________________

HOME ADDRESS: ____

HOW LONG HAS THE CHILD BEEN IN YOUR CARE? ______________ PHONE: ______________

MOTHER'S NAME: ______________ AGE: ________ OCCUPATION: ______________

YEARS OF SCHOOL COMPLETED: ____________

FATHER'S NAME: ______________ AGE: ________ OCCUPATION: ______________

YEARS OF SCHOOL COMPLETED: ____________

WHO LIVES IN THE HOME WITH THE CHILD? NUMBER OF ADULTS: ________ NUMBER OF CHILDREN: ________

PLEASE LIST NAMES AND AGES OF BROTHERS AND SISTERS:

NAME: ______________ AGE: ________ NAME: ______________ AGE: ________

NAME: ______________ AGE: ________ NAME: ______________ AGE: ________

PETS: ______________ TYPE OF HOME: APARTMENT ☐ MOBILE HOME ☐ HOUSE ☐

SMOKERS IN HOUSEHOLD (INSIDE OR OUTSIDE): YES ☐ NO ☐ WHO? ______________

WATER SOURCE: CITY ☐ COUNTY ☐ WELL ☐ BOTTLED ☐

MEDICAL HISTORY

PREGNANCY HISTORY:

DID PATIIENT'S MOTHER USE ANY OF THE FOLLOWING SUBSTANCES OR HAVE ANY OF THE FOLLOWING SYMPTOMS DURING PREGNANCY?

	YES	NO	DON'T KNOW	DOCTOR'S NOTES
MEDICATION (PLEASE NAME)				
STREET DRUGS (PLEASE NAME)				
ALCOHOL				
SMOKING				
VAGINAL INFECTION:				
GONORRHEA				
CHLAMYDIA				
HERPES				
GROUP B STREP INFEECTION				
OTHER PROBLEMS:				

BIRTH HISTORY:

	DOCTOR'S NOTES
HOW LONG WAS THE PREGNANCY: __________ WEEKS	
PREVIOUS PREGNANCIES: TOTAL ____ MISCARRIAGES ____ STILLBIRTHS ____	
EXPLANTION OF MISCARRIAGE:	
IN WHICH HOSPITAL WAS THE BABY BORN?	
OBSTETRICIAN:	
WHAT WAS THE BABY'S BIRTH WEIGHT?	
HOW LONG DID THE BABY STAY IN THE HOSPITAL?	
WAS THE DELIVERY - VAGINAL? ☐ OR C-SECTION? ☐	
DID THE BABY HAVE ANY PROBLEMS? Y ☐ N ☐ DON'T KNOW ☐	
DID YOUR BABY PASS THE HEARING SCREEN?	
DID YOUR BABY RECEIVE THE HEPATITIS B VACCINE?	
DATE OF HEP B VACCINE IF KNOWN:	

DEVELOPMENTAL HISTORY: DOES NOT APPLY TO NEWBORNS

AT WHAT AGE (APPROXIMATELY) DID YOUR CHILD?

	AGE		AGE
ROLL FRONT TO BACK		HAVE FIRST SPECIFIC WORD OTHER THAN MAMA OR DADA	
ROLL BACK TO FRONT		MAKE A TWO WORD SENTENCE	
SIT WITHOUT SUPPORT		PEDAL TRICYCLE	
WALK WITHOUT SUPPORT		DRESS SELF	

CHILD'S MEDICAL HISTORY: DOES NOT APPLY TO NEWBORNS	YES	NO	PLEASE EXPLAIN IF ANSWER IS YES:
ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? *(If **NO** - Please Explain)*			
HAS YOUR CHILD EVER BEEN HOSPITALIZED OVERNIGHT:			
HAS YOUR CHILD EVER HAD SURGERY?			
DOES YOUR CHILD HAVE ANY ALLERGIES:			
TO WHAT?			
DOES YOUR CHILD GET REGULAR DENTAL CARE?			
IS YOUR CHILD ON ANY MEDICATIONS? OTC OR PRESCRIPTION			
PLEASE LIST:			
HAS YOUR CHILD GONE TO THE E/R THIS PAST YEAR?			
HAS YOUR CHILD EVER HAD:			
EAR INFECTIONS			
MORE THAN 2 STREP THROATS			
PNEUMONIA			
HEART PROBLEMS			
CHICKENPOX			
ANY MAJOR ILLNESS/INJURY			
REACTION TO ANY IMMUNIZATION OR MEDICATION			
URINARY TRACT INFECTION			
WHEEZING OR EVER REQUIRED A BREATHING TREATMENT			
WHOOPING COUGH			
TB (TUBERCULOSIS)			

FAMILY HISTORY:

CHECK IF CLOSE BLOOD RELATIVES HAVE THE FOLLOWING:

	YES	NO	WHO?		YES	NO	WHO?
ASTHMA				HEART ATTACK < 50 YEARS			
ECZEMA				URINE INFECTIONS			
SICKLE CELL DISEASE				HAY FEVER			
CYSTIC FIBROSIS				HIGH BLOOD PRESSURE			
TUBERCULOSIS				ANEMIA/BLOOD PROBLEMS			
KIDNEY INFECTIONS				LEARNING PROBLEMS			
DIABETES				SEIZURES			
HYPERACTIVITY				EMOTIONAL PROBLEMS			
MENTAL RETARDATION				BORN W/ HEART PROBS			
SUDDEN DEATH				DEATH SHORTLY AFTER BIRTH			
BIRTH DEFECTS							

SCHOOL/DAYCARE BEHAVIOR HISTORY (DOES NOT APPLY TO NEWBORNS):

CHILD'S SCHOOL | GRADE

DOES CHILD ATTEND SPECIAL CLASSES OR SPECIAL HELP?

ARE YOU CONCERNED ABOUT SCHOOL BEHAVIOR PROBLEMS?

DOES YOUR CHILD HAVE PROBLEMS WITH :

	YES	NO	DOES'NT APPLY
FREQUENT NIGHTMARES			
DIFFICULT TO CONTROL			
FIGHTING A LOT			
TROUBLE MAKING FRIENDS			
BEDWETTING OR STOOLING PROBS			
VISION/HEARING			
APPETITE			

NAME OF CHILD'S PREVIOUS DOCTOR:

ADDRESS/PHONE NUMBER:

ARE THERE ANY SPECIFIC ISSUES YOU WOULD LIKE TO DISCUSS WITH YOUR DOCTOR? ______________________

____

SIGNATURE OF PERSON COMPLETING FORM: ______________________ DATE: __________

RELATIONSHIP: __________ PATIENT'S NAME: ______________________ DOB: __________

REVIEWED BY DR. ______________________

PLEASE PROVIDE US WITH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD.

THANK YOU VERY MUCH!!

Austin Children's Clinic, PA

Financial Policy

Thank you for choosing us as your healthcare providers. The following is information we hope will help you understand our insurance and payment policies.

Your agreement with this policy is required prior to any treatment.

- Insurance: We file insurance only with insurance companies with which we have a contracted agreement. In the event that we are not contracted with your insurance you will be required to pay for your visit at the time of service and you will be given a receipt that you can use to file the claim yourself.

- Payment: Payment for all copays, coinsurance and deductibles are expected at the time of service and must be paid by the person accompanying the child. If you do not have insurance you will be expected to pay in full at the time of service, unless prior arrangements have been made. In the event you are unable to pay a balance we encourage you to contact our billing office to arrange a budget agreement. There will be a $10.00 billing fee added to any copay that is not paid at the time of service.

- Account Guarantor: In divorce situations, it is the policy of our office that the insured parent is the guarantor of the account (the parent responsible for payment of the account). We are unable to negotiate settlement of your medical bills between you and your ex-spouse. ** ***All copays, coinsurance and deductibles must be paid at the time of service by the person accompanying the child**.***

- Deductibles**:** Many insurance plans now have deductibles instead of copays. Payment for deductible is expected at the time of service unless you have a Health Saving Account (HSA). Deductibles without HSA's will be estimated by our staff using allowables provided by your insurance company. If you have an HSA we will file the claim to your insurance and you will be billed for any amount not covered. If it is determined that your HSA has been exhausted we will collect the deductible amount at the time of service.

- Covered Benefits: Not all procedures or supplies ordered by the doctor may be considered a covered benefit. Also, some policies do not cover well child visits or immunizations. Payment for any service that is considered "not a covered service" will be collected at the time of service or will be billed to your after your insurance denies payment.

- After Hours Telephone Calls: For your convenience a doctor is available for after hours telephone calls. Unfortunately, most insurances will not pay for this service. The charge for this service is $20.00 per call and will be billed directly to you, not your insurance company. Upon request we will provide you with a receipt for this service if you would like to pursue reimbursement with your insurance company.

- Health Forms and Immunization Records: Health Forms (for school, sports or daycare) and immunization records are best managed at the time of your child's well check. Our staff may complete forms at other times as long as your child has had a well check within the last year. There is no charge for this service at the time of the well child exam; however, a charge may apply at any other time.

- Cancelled/Missed Appointments: Please call at least 24 hours in advance to cancel an appointment. Appointments cancelled with less than 24 hours notice may be charged a $25.00 fee. Appointments missed without notification will be charged a $25.00 fee.

Signature: ____________________________________ Date: __________________________

Relationship to Patient: ___________________________

Name of Patient(s): ______________________________________

____

____

Fees are subject to change without notice.

AUSTIN CHILDREN'S CLINIC. PA
11673 JOLLYVILLE RD.; SUITE 104
AUSTIN, TX 78759

NOTICE OF PRIVACY PRACTICES

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.

EFFECTIVE SEPTEMBER 5, 2013

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Austin Children's Clinic, PA, including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

H. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

I. **Appointment Reminders and Health Related Benefits and Services**. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

J. **Business Associates.** There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

K. **Individuals Involved in Your Care or Payment for Your Care.** We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

L. **As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

M. **To Avert an Imminent Threat of Injury to Health or Safety.** We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

N. **Organ and Tissue Donation.** If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

O. **Research.** We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is “de-identified.”

P. **Military and Veterans.** If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

Q. **Workers’ Compensation.** We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers’ compensation insurance or a state workers’ compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

R. **Public Health Risks.** We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify 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.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

S. **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

T. **Legal Matters.** If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

U. Law Enforcement, National Security and Intelligence Activities. In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

V. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

W. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

X. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

Y. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Z. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. <u>Right to Amend</u>. If you feel the medical information we have about you 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 the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. <u>Right to an Accounting of Disclosures</u>. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. <u>Right to Request Restrictions</u>. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. <u>Right to Request Confidential Communications</u>. 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 at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. <u>Right to a Paper Copy of This Notice</u>. 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. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Austin Children's Clinic, PA
Attn: HIPAA Officer
11673 Jollyville Rd.; Suite 104
Austin, TX 78759
512-338-5130

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

Austin Children's Clinic, PA
Attn: HIPAA Officer
11673 Jollyville Rd.; Suite 104
Austin, TX 78759
512-338-5130

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

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Patient Name: ________________________________ Patient Date of Birth: ____________________________
(Please Print Name)

Patient Name: ________________________________ Patient Date of Birth: ____________________________
(Please Print Name)\

Patient Name: ________________________________ Patient Date of Birth: ____________________________
(Please Print Name)

Patient Name: ________________________________ Patient Date of Birth: ____________________________
(Please Print Name)

SIGNATURES:

Patient/Legal Representative: ___________________________________ Date:_______________

If Legal Representative, relationship to Patient: ____

Witness (optional) : ____Date:______________