A division of Florida Pediatric Associates, LLC
6150 Metrowest Blvd., Suite 105 Orlando, Florida 32835
Phone: 407-897-3544 Fax: 407-897-4016 Toll Free: 866-356-3075
www.floridachildneurology.com

Dear Parent/ Guardian,

We are pleased to welcome you to our Patient Portal.

Through our Patient Portal, you will be able to do the following:

- Request a medication refill for your child
- Request an appointment for your child
- View and download your child's medical summary
- Request changes to your child's demographics
- Send and receive secured general messages to and from our office
- Send and receive secured messages to our and from our Billing Department
- Send and receive secured messages to and from our Patient Portal Administrator

To access our Patient Portal, please go to https://portal.floridapediatrics.com/fcn. Use your email address for the User ID and the Pin Number from the letter given to you by our office staff for the initial password. Once you're logged in, you will be asked to change your password and answer two security questions.

We hope you find your Patient Portal very useful and look forward to communicating with you through this new and exciting tool.

Sincerely,

Florida Child Neurology, PLLC.

A division of…

PATIENT PORTAL AGREEMENT FORM

Do NOT use the Patient Portal for emergencies. Call 911
For urgent problems, please call our office at (407) 897-3544

Child's Name:		Date of Birth:	/ /

The Patient Portal is a secure web portal that allows you as a patient's parent or guardian to access your child's personal health information. It also allows you to communicate with our office via secured messaging. Our Patient Portal Web address is: https://portal.floridapediatrics.com/fcn

Here's some important information regarding our Patient Portal:

- Our hours of operation are 8:00 AM-4:30 PM Monday-Thursday and 8:00 AM- 1:00 PM on Friday. We encourage you to use the Patient Portal at any time. However, messages are held for us until we return the next business day.
- Messages are typically handled within two business days. If your Provider is out of the office that day, your request may be held until your doctor returns to the office. You should call our office at (407) 897-3544, if you have an urgent matter to discuss.
- Team members, other than your Provider, may be involved in receiving your messages and routing them to the Provider or other team members to address.
- If you are not receiving emails from us, please check your JUNK email folder before contacting our office.
- By using this Patient Portal, you agree to protect your password from unauthorized individuals. It is your responsibility to notify our office should your password be stolen.
- We strive to keep all the information in your child's medical record correct and complete. If you notice information in your child's record that is incomplete or inaccurate, you agree to notify our office immediately by phone or secured message. In addition, you also agree not to provide false or misleading information.
- You agree to not hold Florida Pediatric Associates, LLC, or its subsidiaries responsible for any network infractions beyond our control.
- We offer the Patient Portal as a convenience to you—at no cost. We do not sell or give away any private information, including email addresses, without your expressed written consent. We reserve the right to suspend or terminate the Patient Portal at any time and for any reason.

The information on our portal is maintained by Florida Pediatric Associates, LLC. You may contact our Patient Portal Administrator at (727) 456-4258 with your questions or (non-patient care related) concerns regarding the Patient Portal, or send a secured message using the link provided on the portal.

I have read, understand, and agree to the above information regarding the Florida Pediatric Associates, LLC's Patient Portal:

Parent/ Guardian Signature: _____ Date: _____

Print Name: _____ Email: _____

Portal Registration Completed By: _____ Assigned PIN #: _____

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PATIENT INFORMATION

PATIENT NAME: _____ DOB:___/___/_____ SSN: ___-___-____ SEX: ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PHONE: (_____)_____-_____ EMAIL: _____

PREFERRED METHOD OF CONTACT: ☐ Home Phone ☐ Cellular ☐ Text Message ☐ Email ☐ Mail

RACE: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian/White

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

Do we treat any of your other family members? If so, please list them here: _____

Primary Care Physician: _____ Phone: (_____)_____-_____ Fax: (_____)_____-_____

Pharmacy: _____ Pharmacy Address: _____ Phone: (____)_____-_____

Whom may we thank for referring you? _____

PARENTS/ LEGAL GUARDIAN INFORMATION

Who has LEGAL custody of the patient? ☐ Parents ☐ Mother Only ☐ Father Only ☐ *Foster Parent ☐ Grandparent ☐ *HRS/Other
If you checked a box with an (*) in front of it, appropriate paperwork MUST be presented before the visit.

MOTHER/ GUARDIAN'S NAME: _____ DOB: ___/___/_____ SSN: ___-___-____

EMAIL: _____ PREFERRED LANGUAGE: _____

Check here, if address is same as patient's: ☐

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____-_____ CELLULAR: (_____)_____-_____ WORK: (_____)_____-_____
May we use this cellular number for text messages and appointment reminders? ☐ YES ☐ NO

EMPLOYER: _____ OCCUPATION: _____
PREFERRED METHOD OF CONTACT: ☐ Home Phone ☐ Cellular ☐ Text Message ☐ Email ☐ Mail

FATHER/ GUARDIAN'S NAME: _____ DOB: ___/___/_____ SSN: ___-___-____

EMAIL: _____ PREFERRED LANGUAGE: _____

Check here, if address is same as patient's: ☐

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____-_____ CELLULAR: (_____)_____-_____ WORK: (_____)_____-_____
May we use this cellular number for text messages and appointment reminders? ☐ YES ☐ NO

EMPLOYER: _____ OCCUPATION: _____
PREFERRED METHOD OF CONTACT: ☐ Home Phone ☐ Cellular ☐ Text Message ☐ Email ☐ Mail

EMERGENCY CONTACTS

NAME: _____ RELATIONSHIP TO PATIENT:_____ PHONE: (___)_____-_____

NAME: _____ RELATIONSHIP TO PATIENT:_____ PHONE: (___)_____-_____

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INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____ POLICY #: _____ GROUP:_____

POLICY HOLDER: _____ DOB:_____/_____/_____ SSN: _____-_____-_____

RELATIONSHIP TO PATIENT: _____

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

ELIGIBILITY PHONE NUMBER: _____

SECONDARY INSURANCE CARRIER: _____ POLICY #: _____ GROUP:_____

POLICY HOLDER: _____ DOB:_____/_____/_____ SSN: _____-_____-_____

RELATIONSHIP TO PATIENT: _____

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

ELIGIBILITY PHONE NUMBER: _____

ASSIGNMENT OF BENEFITS/ ACKNOWLEDGMENTS

I request that payment of authorized insurance benefits be made on my behalf to Florida Pediatric Associates, LLC, for any medical services provided to me by that organization (Florida Child Neurology). I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier, or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company, or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes to my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form, I am accepting responsibility as explained above for all payment for all services received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Parent Guardian Signature: _____ Date: _____

OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL—at the time services are rendered—from the patient or the person accompanying the minor child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit, you will be responsible for payment of services—IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fees.

I have read and understand the office policy for payment and agree to the terms as stated.

Parent Guardian Signature: _____ Date: _____

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PATIENT HISTORY FORM

DATE: _____ ACCOUNT #: _____

PATIENT NAME: _____ DOB:___/___/_____ SSN: ___-___-_____ SEX: ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PHONE: (_____)_____-_____ EMAIL: _____

Primary Care Physician: _____ Phone: (_____)_____-_____ Fax: (_____)_____-_____

Pharmacy: _____ Pharmacy Address: _____ Phone: (____)_____-_____

If you were referred by someone other than your PCP, please list that physician's name here: _____

What is the main reason for your visit to Florida Child Neurology today?

PATIENT'S PAST MEDICAL HISTORY

Any past medical problems/ diagnosis? ☐ Yes ☐ No If Yes, please explain: _____

Any past hospitalizations? ☐ Yes ☐ No If Yes, please explain: _____

Any past surgeries? ☐ Yes ☐ No If Yes, please explain: _____

Any allergies? ☐ Yes ☐ No If Yes, please explain: _____

Does your child use tobacco products? ☐ Yes ☐ No If Yes, please explain: _____

Please list all prescriptions, over-the-counter (ex. Advil), vitamins, or herbal medications that your child currently takes, and their doses.

MEDICATION	DOSE (How much and how often?)

Please list all prior ADHD, Epilepsy, or Migraine medications your child has taken. (You may use the back of this page if necessary)

MEDICATION	DOSE (How much and how often?)

BIRTH HISTORY

Birth Weight: _____ **Birth Length:** _____ **Gestational Age (Weeks):** _____

Was your child born prematurely? ☐ Yes ☐ No If Yes, how many weeks premature? _____

Type Of Delivery: ☐ Vaginal ☐ C-Section Length of stay in the hospital/nursery: _____

Did you experience any complications during pregnancy? ☐ Yes ☐ No If Yes, please explain: _____

DEVELOPMENTAL HISTORY/ MILESTONES

Please indicate the age that your child…

First Smiled:_____ First Sat Unassisted: _____ First Walked: _____ Spoke First Words: _____ Toilet Trained: _____

Dressed Independently: _____ Spoke First Phrases/Sentences: _____

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PRIOR TESTING AND STUDIES

Please tell us about any past studies that your child (or you) had. Examples: EEG, CT, MRI, Sleep Study
**If you need extra space, please use the back of this page.

TEST/ STUDY NAME	DATE	LOCATION	RESULTS

FAMILY HISTORY

Please use the following symbols to indicate which, if any, family member has or had any of the following:
M= Mother F= Father S= Sibling MGM= Maternal Grandmother MGF= Maternal Grandfather MU= Maternal Uncle MA= Maternal Aunt
PGM= Paternal Grandmother PGF= Paternal Grandfather PU= Paternal Uncle PA= Paternal Aunt O= Other Family Member

Unremarkable		Macrocephalus	
Unknown		Mental Illness	
Aspergers		Metabolic Disorder	
Ataxia		Migraines	
Autism		Narcolepsy	
Birth Defects		Neurofibromatosis	
Cerebral Palsy		Seizures	
Communication Disorder		Tics	
Developmental Delay		Tourette's	
Genetic Disorder		Obsessive Compulsive Disorder	
Headaches		Other:	
Other:		Other:	

PATIENT'S SOCIAL HISTORY

Please list all members living in the household (Example: mother, father, etc.): _____

_____

Are there any pets in the home? If so, please list what types of pets: _____

Is your child in school/ preschool/ daycare? ☐ Yes ☐ No If yes, what grade? _____

Has your child missed school days because of their symptoms? ☐ Yes ☐ No If yes, please explain: _____

_____

Does your child have school support such as Special Ed or Therapies? ☐ Yes ☐ No If yes, what type? _____

_____

Please list any family, social, or school stressors currently known: _____

_____

_____

Please list your child's favorite activities, sports, or extra-curricular activities: _____

_____

Is there anything else you feel we need to know about your child in order to better treat him or her?_____

_____

_____

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Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Please complete this form at each visit so that we may remain up to date with any changes to your child's health.

GENERAL	YES	NO	GASTROINTESTINAL (G.I.)	YES	NO
Overweight			Abdominal Pain		
Weight Loss			Chronic Constipation		
Fever			Alternating		
Lethargy/ Fatigue			Constipation/Diarrhea/Jaundice		
Picky Eater			Nausea		
Developmental Delay			Loss of Appetite		
HEAD AND NECK	**YES**	**NO**	Reflux		
Eye Changes			Swallowing Difficulties		
Wears Glasses			Vomiting		
Nasal Congestion			**GENITOURINARY**	**YES**	**NO**
Sinus Infections			Difficulty Urinating		
Frequent Colds			Blood in Urine		
PE Tubes			Bedwetting		
Tooth Decay			**MUSCLES/ JOINTS**	**YES**	**NO**
Mouth Ulcers or Braces			Joint Pain		
SKIN	**YES**	**NO**	Joint Swelling		
Rashes			Joint Redness		
Itching			Sports Injury		
RESPIRATORY	**YES**	**NO**	Uses Wheelchair		
Cough			**HEMATOLOGY**	**YES**	**NO**
Asthma/Wheezing			Abnormal Bruising		
Frequent Bronchitis			Bleeding		
Pneumonia			Anemia		
NEUROLOGICAL	**YES**	**NO**	Sickle Cell Disease/ Trait		
Headaches/Migraines			**PSYCHIATRIC**	**YES**	**NO**
Dizziness			Anxiety		
Fainting			Depression		
Head Trauma			Developmental Delay		
Seizures			Behavior Problems		
Sleep Problems			Mood Changes		
Speech Problems/ Therapy			Inpatient Admission		
Tremors			**ALLERGY**	**YES**	**NO**
CARDIAC	**YES**	**NO**	Uticaria		
Congenital Problems			Allergic Rash		
Murmur			Eczema		
High Blood Pressure			Hay Fever		
Fainting			Recurrent Infections		
Heart Rhythm Changes			Seasonal Medications		

Please further explain any YES answers from above:

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PERMISSION TO TREAT

I, _____ (print name of legal guardian) hereby authorize Florida Child Neurology, PLLC, and its personnel to provide medical services, such as medical examinations and treatments, as they deem best for the child's physical or mental welfare.

Print Child's Name: _____ DOB: _____/_____/_____ SS#: _____-_____-_____

I authorize the following person(s) to bring my child in for treatment and to discuss necessary treatments, medications, and to even authorize any tests or labs, that may be deemed necessary by the medical staff of Florida Child Neurology—up to and including admission to the hospital.

Name: _____ Mother: _____

Name: _____ Father: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

** All of the above will provide identification to be placed in the patient's medical chart.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to biological parents, step-parents, referring physicians, other practitioners, and my insurance company.

I have been advised and understand the Notice of Privacy Practices of Florida Child Neurology, PLLC.

_____ _____
Signature of Legal Guardian Date

Relationship to Patient: _____

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ACKNOWLEDGEMENT OF FEE SCHEDULE FOR LETTERS, FORMS, MEDICAL RECORDS, AND NO-SHOW

PATIENT'S NAME: _____ PATIENT'S DOB: _____/_____/_____

Please note our policies and fee schedule for the following requests:

1. **LETTERS:** A service fee of $25.00 will be charged for each official letter provided by our physicians and/ or providers of service.
2. **FORMS:** Parents are responsible for completing the demographic data (Name, Address, DOB, etc.) of their child before giving the form to the physician or provider to complete. The physician or provider will then complete the form after the patient has been evaluated for care. Examples of forms: FMLA, SSI, School Health, Disability Forms, Dept of Motor Vehicles, and similar forms. The fee will be $25.00 for a one-page form and $35.00 for multiple page forms.
3. **COPIES:** The fee for copies of medical records is $1.00 per page up to 25 pages. Each additional page will be $.25 cents as provided/ allowed by state law. ****Please note, copies of medical records only applies to information generated through Florida Child Neurology during the care and treatment of the patient.** A CD copy of in-house EEG studies will be $25.00 per study day.

If the patient/parent/ guardian needs a copy of the latest diagnostic test, lab, or office visit for the continuation of care/treatment with another physician and/or provider, Florida Child Neurology can send the records directly to the physician—provided that the appropriate medical release forms have been signed.

The requesting party must pay fees in advance along with a signed release of medical records form (if required). This fee is an additional cost and is not billable to insurance.

All records, letters, and/or forms will be completed within 7-10 business days after payment is received. We will do everything possible to complete requests sooner. Documents may be picked up at our office or mailed. Our staff will call when the documents are ready. An additional fee of $5.00 may be charged for postage for mailing of larger records.

"No-Show" and Cancellation Policy

* Please initial each line

_____ A "No-Show" is a failure for the patient to show up for their appointment.
_____ Canceling an appointment with less than 24 hour notice is considered a "No-Show" and will be charged a fee.
_____ The fee for a "No-Show" is $35.00 and must be paid before the next patient appointment.
_____ Missing three (3) or more appointments within a year due to "No-Shows" or with inadequate notice may result in the patient being discharged from the clinic. Patient dismissal is at the discretion of the physician/provider.
_____ Only emergency medical treatment will be available to the patient within the first thirty (30) days of dismissal.

I acknowledge that I have read and understand the above fees and policies.

_____ _____
Parent/Guardian/Caregiver Signature Date

_____
Printed Name

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PLEASE NOTE:
State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect __JULY 1, 2013__ and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided the law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date the changes were made.

You may request a copy of our Notice of Privacy Practices at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this notice.

OUR COMMITMENT TO YOUR PRIVACY
We understand that information about you and your health care is personal. We create a record of the care and services you receive from Florida Pediatric Associates, LLC (FPA) and are committed to protecting that information about you.
We are required by law to 1) Make sure health information that identifies you is kept private. 2) Give you this Notice of our privacy practices. 3) Follow the terms of the Notice that is currently in effect.

ROUTINE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI)
(Please note: for the purposes of this document the terms "you" will pertain to the patient and/or legal guardian if appropriate)
TREATMENT: Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you. Many of the people who work in our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment.
PAYMENT: Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with the details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use you PHI to bill you directly for services and items.
HEALTH CARE OPERATIONS: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may do this, our practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.
APPOINTMENT REMINDERS: Our practice may use and disclose your PHI to contact you and remind you of an appointment.
TREATMENT OPTIONS: Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives; or communicate with you regarding the scheduling, ordering or results of tests.
HEALTH RELATED BENEFITS AND SERVICES: Most uses and disclosures of PHI for marketing purposes and disclosures that constitute sale of protected health information require authorization.
RELEASE OF INFORMATION TO FAMILY & FRIENDS: Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of your child. For example, a parent or guardian may ask that a babysitter or aunt take their child to the doctor for treatment. In this example, this person would have access to the child's medical information; *however this person must be listed on the consent for treatment form in the patient's chart and be able to present valid picture ID at the time they present to our office.*
Additionally, a parent may not speak English fluently and may have an interpreter assist them at the appointment, this person would have access to the child's medical information.
OTHER: Uses and disclosures not described in this NPP will be made only with authorization from you, the individual.

USE AND DISCLOSURE OF YOUR PHI IN SPECIAL CIRCUMSTANCES
DISCLOSURES REQUIRED BY LAW: Our practice will use and disclose your PHI when we are required to do so by federal, state or local law; such as for law enforcement purposes, suspected abuse or neglect reporting, health oversights or audits, funeral arrangements, organ donation, public health purposes or in the case of a medical emergency.

PUBLIC HEALTH: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled

HEALTH OVERSIGHT ACTIVITIES: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

LAWSUIT OR SIMILAR PROCEEDING: Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

NATIONAL SECURITY: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

NOTICE OF PRIVACY PRACTICES

YOUR PRIVACY RIGHTS AS OUR PATIENT

You have the following rights regarding the PHI we maintain about you:

CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. At our discretion, we will accommodate all reasonable requests. You are not required to give a reason for your request.

ACCESS: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit the completed request form. You may contact our Privacy Officer for a copy of this form. Once approved an appointment can be made to review your records, during the process of review no records may be removed from the office. Copies, if requested, *will be $1.00 per page for the first 25 pages and $0.25 per page for every page over 25*. The individual office *may* choose to waive this fee at the discretion of the physician. We will try to accommodate all reasonable requests, however if we deny your request to inspect and/or copy your record you may request a written reason for the denial. You have a right to obtain a copy of your health information within the designated record set maintained in electronic form in electronic format. We will send the electronic form of your health information to you via unencrypted email if you acknowledge the risk of the sending of unencrypted emails.

AMENDMENT: You may ask us to amend your health information if you believe it is inaccurate or incomplete, and you may request that the amendment be in effect for as long as it is maintained by our practice. Your request for an amendment, must be in writing (the appropriate form can be requested from office staff) and must include an explanation of why the information should be amended. We will deny your request if you fail to submit your request with supporting explanation in writing. Also, we may deny your request if you ask us to amend information that is not created by us, or is not part of the medical information maintained by us, or if we find that the information we possess is accurate and complete. If we deny your request you will receive the denial in writing; you have a right to appeal the decision – but it must be done in writing.

RESTRICTIONS: You have the right to request that we restrict the uses or disclosure of your health information for treatment, payment or healthcare operations purposes. We are not required to comply with any other requests for restrictions, but if we do, we will abide by the written agreement (except in the case of a medical emergency). Additionally, you have a right to request that we place additional restrictions on our use or disclosure of your health information to a health plan. Specifically you have the right to request that we restrict the use or disclosure of health information to a health plan (insurance company) for purposes of payment or operations, IF you pay for the service out-of-pocket IN FULL at the time the service is provided. This request MUST be made in writing (the appropriate form can be requested from office staff). This requirement does not apply to disclosures for treatment, such as disclosures to a referring physician for continuation of care. This office is required to comply with any requests that limit disclosures to a health plan when the service has been paid out-of-pocket and in full by the patient. Such restrictions do not override disclosures that are otherwise required by law. Additionally if initial payment for services, that have a request for restriction applied to them, is returned or invalid; our office will make a good faith attempt to collect payment – if this is unsuccessful we have the right to then submit a claim for these services to the health plan.

ACCOUNTING OF DISCLOSURES: All of our patients have the right to request an accounting of all disclosures made. All requests for an accounting of disclosures must be submitted in writing (the appropriate form can be requested from office staff) and include: a time period, that must not exceed 6 years prior to the date of the request and/or be dated prior to April 14, 2003 – as information prior to that date was not required to be tracked. The first list you request within a 12-month period is free of charge. We may charge you for any additional lists requested within the same 12-month period. We will notify you of the costs involved with any additional requests prior to their completion, allowing you to withdraw your request before you incur any costs.

BREACH NOTIFICATION REQUIREMENTS: In the event that unsecured protected information about you is "breached", we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform The Department of Health and Human Services and take any other steps that are required by law.

RIGHT TO FILE A COMPLAINT: If you believe your privacy rights have been violated, you may file a complaint with our practice and/or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please submit it in writing and to the attention of the Privacy Officer (the appropriate form can be requested from office staff). We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the Department of Health and Human Services.

RIGHT TO A PAPER COPY OF THIS NOTICE: You are entitled to receive a paper copy of our Notice of Privacy Practices. To obtain a paper copy of this Notice, contact our Privacy Officer in writing.

MINORS AND PERSONS WITH LEGAL GUARDIANS:

Minors and certain disabled adults are entitled to the privacy protection of their health information. Because, by law, they cannot make health decisions for themselves, a parent or guardian can make medical decisions on their behalf. Therefore parents and guardians can authorize the use and release of PHI and also hold all rights listed in this notice or the behalf of the minor child or disabled adult.

Under certain situations defined by law, minors can make independent healthcare decisions without parent or guardian knowledge or consent. In those situations, the minor may hold all rights listed in this notice. If the minor chooses to inform the parent or guardian, then all privacy rights regarding PHI may transfer to the parent or guardian. There are also certain situations where access, use or release of a minor's PHI may occur without the consent of the parent or guardian, i.e. when the health or safety of the minor is in danger and PHI is necessary to protect the minor.

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we have created or maintained in the past, and for any we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

HOW TO CONTACT US:

Please direct any questions about this Notice to our Privacy Officer at 727-456-4244

Privacy Officer address:
Florida Pediatric Associates, LLC
Attn: Privacy Officer
1033 Dr. Martin Luther King Jr. St. N, Ste 108
St. Petersburg, FL 33701

Medical Information Department address:
Florida Pediatric Associates, LLC
Attn: Medical Information Department
1033 Dr. Martin Luther King Jr. St. N, Ste 108
St. Petersburg, FL 33701

FLORIDA PEDIATRIC ASSOCIATES, LLC
FOUNTAINHEAD PRACTICE MANAGEMENT SOLUTIONS, LLC
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