INITIAL HISTORY QUESTIONNAIRE *(CUESTIONARIO INICIAL)*

Form Completed By: _____ **Date:** _____
(Forma completada por) *(fecha)*

Name of Patient _____ **SS#** _____
(Nombre del paciente) *(seguro social)*

Birth Date: _____ **Age** ___ _____ **Male** _____ **Female** _____
(Fecha de nacimiento) *(Edad)* *(Hombre)* *(Mujer)*

HOUSEHOLD*(HOGAR)*
List all persons that live in your home at this time. *(Lista de todas las personas que viven en su hogar en este momento)*

NAME*(NOMBRE)*	**RELATION TO PATIENT** *(Relación con paciente)*	**BIRTH DATE** *(fecha de naciemiento)*	**HEALTH PROBLEMS** *(problemas de salud)*

Are there siblings not listed? If so, please list their names and ages and where they live
(Algún otro familiar o allegado que no esté en la lista? No Si , escriba la edad y lugar donde vive)

_____
_____

If mother and father are not living together or if the child does not live with parents. What is the child's custody status?
(Si los padres del niño(a) no viven juntos o si el niño(a) no vive con los padres, por favor, escriba quien tiene custodia de niño(a))

_____
_____

If one or both parents are not living in the home, how often does he/she see the parent not in the home?
(Si uno o ambos padres no viven en el hogar, ¿con qué frecuencia no se ve el padre en el hogar?)

_____
_____

BIRTH HISTORY OF PATIENT *(HISTORIA DE NACIMIENTO DE PACIENTE)*
Birth weight *(Peso al nacer)* _____ Was the baby born at term? *(Nació el bebé a término?)* □Yes *(Si)* □No

Was baby born *(Fue recién nacido)* : Early *(temprano)* _____ Late *(tarde)*____

If born early or late why? *(Si nacio temprano o tarde por que?)* _____

Was the birth *(como fue el parto)*: Normal C-section *(Cesarea)*
If C-section, explain why? *(si fue cesarea explique por qué)* _____

If early, how many weeks' gestation? *(Si fue prematuro, ¿cuántas semanas de gestación?)*

_____

Did mother have any illness or problem with her pregnancy? *(¿La madre tuvo alguna enfermedad o problema con su embarazo?)* □Yes (Si) □No Explain *(explique)*:_____

During pregnancy, did mother *(Durante el embarazo,hizo la madre lo siguiente)*:

Smoke*(fumó)*: □Yes *(Si)* □No ***Drink Alcohol*** *(Beber licor)*: □Yes *(Si)* □No

Drugs *(drogas)*: □Yes *(Si)* □No ***Medications*** *(medicamentos)*: □Yes *(Si)* □No

If yes, to any of these (*En caso afirmativo, a cualquiera de estas)*: What *(qué)*: _____

When *(cuándo)*: _____

Did your baby have any problems right after birth? *(¿Su bebé tiene algún problema inmediatamente después del nacimiento)*
□Yes *(Si)* □No Explain *(explique)*: _____

Was Initial feeding*(¿Cuál fue la alimentación inicial)* □ Breast? *(Pecho)* □ Bottle? *(Botella)*

Did your baby go home with mother from the hospital? *(¿Su bebé fue a casa con la madre desde el hospital)*
□Yes *(Si)* □No Explain *(explique)*:_____

GENERAL

Do you consider your child to be in good health? *(¿Considera usted que su hijo esté en buen estado de salud)*
□Yes *(Si)* □No Explain *(explique)*:_____

Does your child have any serious illness or medical condition?
(¿Su hijo tiene alguna enfermedad grave o una enfermedad médica)
□Yes *(Si)* □No Explain *(explique)*:_____

Has your child had serious injuries or accidents? *(Su hijo ha tenido lesiones graves o accidentes)*
□Yes *(Si)* □No Explain *(explique)*:_____

Has your child had any surgery? *(Ha tenido su hijo alguna cirugía)*
□Yes *(Si)* □No Explain *(explique)*:_____

Has your child ever been hospitalized? *(Su niño ha sido hospitalizado)*
□Yes *(Si)* □No Explain *(explique)*:_____

Is your child allergic to any medicines or drugs? *(Es su niño alérgico a algún medicamento o drogas)*
□Yes *(Si)* □No Explain *(explique)*:_____

DEVELOPMENT *(DESARROLLO)*

Are you concerned about your child's physical development?*(¿Está preocupado por el desarrollo físico de su hijo)*
□Yes *(Si)* □No Explain *(explique)*::_____

Are you concerned about your child's mental or emotional development?*(¿Está preocupado por el desarrollo mental o emocional de su hijo)*
□Yes *(Si)* □No Explain *(explique)*:: _____

Are you concerned about your child's attention span? *(Le preocupa la capacidad de atención de su hijo)*
□Yes *(Si)* □No Explain *(explique)*:: _____

IF YOUR CHILD IS IN SCHOOL (SI SU HIJO ESTÁ EN LA ESCUELA) :

How is your child behavior in school? *(¿Cómo es el comportamiento del niño en la escuela)*
Explain *(Explicque)*:: _____

Has your child failed or repeated a grade in school? *(¿Su niño ha fallado o repetido un grado en la escuela?)*
□Yes *(Si)* □No Explain *(explique)*:: _____

How is your child doing in academic subjects? *(¿Cómo es su hijo haciendo en las materias académicas?)*
Explain *(explique)*: _____

Is your child in special or resource classes? *(¿Está su hijo en clases especiales o de recursos?)*
□Yes *(Si)* □No Explain *(explique)*:: _____

_____

PAST HISTORY ***(HISTORIA DEL PASADO)***
*Does your **child** have or had (¿Su hijo tiene o ha tenido):*

Chickenpox *(Varicela)* □Yes *(Si)* □No Explain*(explique)*: _____

Frequent ear infections *(Infecciones frecuentes del oído)* □Yes *(Si)* □No Explain*(explique)*: _____

Problems with ears or hearing *(Problemas con las orejas o el oído)*
□Yes *(Si)* □No Explain*(explique)*: _____

Nasal allergies *(Alergias nasales)* □Yes *(Si)* □No Explain*(explique)*: _____

Problems with eyes or vision *(Problemas con los ojos o la visión)*
□Yes *(Si)* □No Explain*(explique)*: _____

Asthma, bronchitis, bronchiolitis, or pneumonia *(Asma, bronquitis, bronquiolitis o pulmonía)*
□Yes *(Si)* □No Explain*(explique)*: _____

Any heart problem or heart murmur *(Cualquier enfermedad del corazón o soplo cardíaco)*
□Yes *(Si)* □No Explain*(explique)*: _____

Anemia or bleeding problem *(La anemia o sangrado)* □Yes *(Si)* □No Explain*(explique)*: _____

Blood transfusion *(Transfusión de sangre)* □Yes *(Si)* □No Explain*(explique)*: _____

Frequent abdominal pain *(dolor abdominal frecuente)* □Yes *(Si)* □No Explain*(explique)*: _____

Constipation requiring doctor visits *(Estreñimiento que requieren visitas al medico)*
□Yes *(Si)* □No Explain*(explique)*: _____

Bladder or kidney infection *(La vejiga o infección en los riñones)*
□Yes *(Si)* □No Explain*(explique)*: _____

Bed-wetting (after 5 years old) *(Mojar la cama (después de 5 años de edad)*
□Yes *(Si)* □No Explain*(explique)*: _____

(For girls) has she started her menstrual periods? *((Para niñas) ha inició su período menstrual?)*
□Yes *(Si)* □No Explain*(explique)*: _____

(For girls) are there problems with her periods? *((Para niñas) hay problemas con sus períodos menstruales)*
□Yes *(Si)* □No Explain*(explique)*: _____

Any chronic or recurrent skin problems(acne, eczema, etc)*(Cualquier crónicos o recurrentes problemas de la piel (acné, eczema, etc)*
□Yes *(Si)* □No Explain*(explique)*: _____

Frequent headaches *(Dolores de cabeza frecuentes)* □Yes *(Si)* □No Explain*(explique)*: _____

Convulsions or other neurological problems *(Convulsiones u otros problemas neurológicos)*
□Yes *(Si)* □No Explain*(explique)*: _____

Diabetes *(Diabetes)* □Yes *(Si)* □No Explain*(explique)*: _____

Thyroid or other endocrine problems *(La tiroides u otros problemas endocrinos)*
□Yes *(Si)* □No Explain*(explique)*: _____

Any other significant problems *(Cualquier otro problems significantes)*
□Yes *(Si)* □No Explain*(explica)*: _____

Use of alcohol or drugs *(El uso de alcohol o drogas)* □Yes *(Si)* □No Explain*(explique)*: _____

FAMILY HISTORY *(HISTORIA DE LA FAMILIA)*

Have any family members had the following: *(¿Alguien en su familia tuvo o tiene la siguiente)*

Deafness*(Sordera)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

Nasal allergies*(Alergias nasales)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

Asthma*(Asma)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

Tuberculosis*(Tuberculosis)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

Heart disease (before 50 years old) *(Las enfermedades del corazón (antes de los 50 años de edad)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

High blood pressure (before 50 years old)*(Presión arterial alta (antes de los 50 años de edad)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

High cholesterol*(Niveles altos de colesterol)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

Anemia □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

Bleeding disorder*(Sangrado trastorno)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

Liver disease*(Enfermedad hepática)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

Kidney disease*(Enfermedad de los riñones)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

Diabetes (before 50 years old) *(Diabetes (antes de los 50 años de edad)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

Bed-wetting (after 10 years old)*(Mojar la cama (después de 10 años de edad)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios)*: _____

Epilepsy or convulsions *(La epilepsia o convulsiones)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios):* _____

Alcohol abuse *(Abuso del alcohol)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios):* _____

Drug abuse *(Abuso de drogas)* □Yes *(Si)* □No
Who*(Quién)*/Comments*(Comentarios):* _____

Mental Illness*(Enfermedad Mental)* □Yes *(Si)* □No
Who*(Quién)*/Comments*(Comentarios):* _____

Mental Retardation *(Retraso Mental)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios):* _____

Immune problems, HIV or AIDS *(Inmune problemas, el VIH o el SIDA)* □Yes *(Si)* □No
Who *(Quién)*/Comments*(Comentarios):* _____

Additional family History *(Historial de la familia adicional):*

_____

_____

PEDIATRIC CARE CENTER
4505 Hospital Road Suite C
Pascagoula, MS 39581
228-762-9595/fax 228-762-9494

Date (*Fecha*): _____

Patient Information (*Informacion de paciente*)

*Name: _____
Nombre: Last (*Apellido*) First (*Nombre*) Middle (*Medio*)

SS# (*Seguro social*) _____ Sex (*Sexo*) M F

Date of Birth (*Fecha de Nacimiento*): _____

Street Address (*Dirección*): _____

City (*Ciudad*): _____ State (*Estado*): _____

Zip (*Código Postal*): _____ Martial Status (*Estado martial*): S M D W

Home Ph (*número de teléfono casa*): _____

Cell Ph # (*nurmero de celular*) : _____

Emergency Contact (*Contacto de Emergencia*)

Please list the name of a relative or friend that does not live with you and can be contacted in the case of an emergency. (Por favor escriba el nombre de un pariente que no viva con usted y pueda ser contactado.)

*Name: _____
Nombre: Last (*Apellido*) First (*Nombre*) Middle (*Medio*)

SS# (*Seguro social*) _____ Sex (*Sexo*) M F

Date of Birth (*Fecha de Nacimiento*): _____

Street Address (*Dirección*): _____

City (*Ciudad*): _____ State (*Estado*): _____

Zip (*Código Postal*): _____ Martial Status (*Estado marital*): S M D W

Home Ph (*número de teléfono casa*): _____

Cell Ph # (*número de celular*) : _____

Parent's Information (Información de Padres)

*Name: _____
Nombre: Last (*Apellido*) First (*Nombre*) Middle (*Medio*)

SS# (*Seguro social*) _____ Sex (*Sexo*) M F

Date of Birth (*Fecha de Nacimiento*): _____

Street Address (*Dirección*): _____

City (*Ciudad*): _____ State (*Estado*): _____

Zip (*Código Postal*): _____ Martial Status (*Estado martial*): S M D W

Home Ph (*número de teléfono casa*): _____

Cell Ph # (*nurmero de celular*) : _____

Occupation (*ocupación*) : _____ Employer (*Empleador*): _____

Work Phone (*número de teléfono del trabajo*:) _____

*Name: _____
Nombre: Last (*Apellido*) First (*Nombre*) Middle (*Medio*)

SS# (*Seguro social*) _____ Sex (*Sexo*) M F

Date of Birth (*Fecha de Nacimiento*): _____

Street Address (*Dirección*): _____

City (*Ciudad*): _____ State (*Estado*): _____

Zip (*Código Postal*): _____ Martial Status (*Estado marital*): S M D W

Home Ph (*número de telúfono casa*): Cell Ph # (*número de celular*) :

_____

Work Phone (*numero de telefono del trabajo*) _____
Occupation (*ocupacion*) : _____ Employer (*Empleador*): _____

Person Responsible for Bill (Persona Responsible de la Cuenta)

Financial responsibility ultimately falls to the person that brings the child to the office and signs our financial policy.
La responsabilidad financiera en última instancia corresponde a la persona que trae el niño a la oficina y los signos de nuestra política financiera.

*Name: _____
Nombre: Last (*Apellido*) First (*Nombre*) Middle (*Medio*)

SS# (*Seguro social*) _____ Sex (*Sexo*) M F

Date of Birth (*Fecha de Nacimiento*): _____

Street Address (*Dirección*): _____

City (*Ciudad*): _____ State (*Estado*): _____

Zip (*Código Postal*): _____ Martial Status (*Estado marital*): S M D W

Home Ph (*número de telúfono casa*): _____

Cell Ph # (*número de celular*) : _____

Occupation (*ocupación*) : _____ Employer (*Empleador*): _____

Work Phone (*número de teléfono del trabajo*:) _____

Insurance Information *(Información de Seguro)*

1. Name of Insurance *(nombre de seguro)* _____
   Policy# *(# de Póliza)* _____
2. Name of Insurance *(nombre del seguro)* _____
   Policy# *(# de Póliza)* _____

Permission to Treat by Parents/Legal Guardian for Minor Children

(El permiso para tratar parte de los Padres o tutor legal para hijos menores de edad)

I hereby authorize consent for medical examination and treatment, to include but not limited to, obtaining blood samples, medication administration, patient education, and immunizations by the healthcare providers of this facility.
(Por la presente autorizo el consentimiento para el examen y tratamiento médico, que incluye pero no está limitado a, la obtención de muestras de sangre, administración de medicamentos, educación del paciente, y las vacunas por los proveedores de asistencia médica de este servicio).

The consent of a parent or guardian is required for the treatment of minors. This consent gives us permission to treat the patient. This consent will remain in effect for one (1) year, or until you notify us otherwise.
(Se requiere el consentimiento de un padre o tutor para el tratamiento de los menores. Este consentimiento nos da permiso para tratar al paciente. Este consentimiento permanecerá efectivo durante un (1) año o hasta que usted nos notifique lo contrario.)

As parent or guardian, I _____ give permission
(Como padre o tutor, Yo) ***(doy permiso)***

For _____
(por)
To be seen at Pediatric Care Center according to the guidelines below:
(Para ser visto en el Centro de Cuidado Pediátrico de acuerdo con las siguientes directrices:

□ May come to the Doctor's office with the following persons:
(Puede venir a la oficina del médico con las siguientes personas):

_____ Relation: _____
(Relación)
_____ Relation: _____
(Relación)
_____ Relation: _____
(Relación)

I give permission for the following (***Doy permiso para lo siguiente):***
□ Well Child checks/Routine physical examinations
(Bueno controles del Niño/exámenes físicos de rutina)
□ Immunizations
(Vacunas)
□ Allergy Shots
(Vacunas para alérgias)
□ Sick visits and all treatments related to said visit
(Visitas por enfermedad y todos los tratamientos relacionados con la visita)
□ Breathing treatments and medication administration
(Tratamientos respiratorios y la administración de medicamentos)

My contact number is _____ if any problems arise.
(Mi número de contacto es) ***(en caso de problemas.)***

_____ _____
Parent/Legal Signature (***Firma del padre/Tutor)*** Date(***Fecha)***

_____ _____
Witness (***Testigo)*** Date (***Fecha)***

PEDIATRIC CARE CENTER
FINANCIAL POLICY

Thank you for choosing us as our health care provider. We are committed to making health care less stressful and more effective by clarifying financial responsibilities in advance. The following is a statement of our financial policy which we ask that you read and sign prior to your office visit.

Your insurance policy is a contract between you and your insurance company. We are not party of that contract. Remember filling your insurance is a Courtesy Only, and that the patient remains solely responsible for services rendered. Should any account be 45 days following the date of service, and we have not heard from your insurance company, we ask that the patient contact their insurance company to help expedite payment.

All patients' payments, co-pays, deductibles, etc., are due at the time services are rendered, and will be collected before seeing the doctor. Any portion not collected in advance will be collected at check out. Please come prepared to pay all monies due. We accept cash, check, MasterCard, and Visa.

(Choose one)
I WILL BE PAYING TODAY: CASH_____ CHECK#_____ CREDIT/DEBIT_____

(Please initial each one)

_____ *AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION*:
I authorize *Pediatric Care Center* to disclose any personal health information necessary to process health insurance claims, coordinate, or manage treatment, and for the purpose of our healthcare operations. I also authorize payment DIRECTLY to the undersigned physician or supplier for services rendered.

_____ *ACKNOWLEDGEMENT OF RESPONSIBILITY*:
I understand that I am financially responsible to *Pediatric Care Center* for all professional services rendered, including but not limited to, those services which are not covered by my insurance programs (Co-payments and/or deductibles). I also understand that if I have an HMO or PPO insurance and I do not obtain the proper referral authorization prior to my visit, or verify the physician is a preferred provider that I am financially responsible for any charges incurred. I understand the payments for these charges are due at the time of service. In the event of default, I agree to pay all collection cost, including a reasonable attorney fee.

_____ *ACKNOWLEDGEMENT YOU RECEIVED "NOTICE OF UR PRIVACY PRACTICE"*:
We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to our form, please ask to speak with our HIPPA COMPLIANCE OFFICER in person or by phone at our main phone number.

PEDIATRIC CARE CENTER
RESPONSABILIDAD FINANCIERA

Gracias por escogernos como su proveedor de asistencia médica. Estamos comprometidos a hacer de la asistencia médica una menos estresante y más efectiva; clarificando responsabilidades financieras por adelantado. Lo siguiente es una declaración de nuestra política financiera, le pedimos que usted lea y firma antes de su visita en la oficina.

Su póliza de seguros es un contrato entre usted y su compañía de seguros. Nosotros no somos el partidos de ese contrato. Recuerde archivando su seguro es una Cortesía Sólo, y que el paciente se queda únicamente responsable de servicios rendidos. Deba ninguna cuenta es 45 días que siguen la fecha del servicio, y de nosotros no hemos oído de su compañía de seguros, nosotros preguntamos que el paciente contacta su compañía de seguros para ayudar a facilitar el pago.

Todos los pagos pacientes, la co-pago, deducible, etc., deben ser pagados cuando el servicio es provisto, y serán antes de ver al Médico. Si alguna porción no se colectó de antemano, se colectará después de ver al médico. Venga por favor preparado para pagar todo dinero debido. Aceptamos el dinero efectivo, cheque, tarjetas de Crédito/ débito Mastercard y Visa.

ESTARE PAGANDO HOY POR: *EFFECTIVO_____ CHEQUE _____ CREDITO/DEBITO_____*

_____ *LA AUTORIZACION para REVELAR INFORMACION PERSONAL de SALUD*: Autorizo a "*Pediatric Care Center*" a revelar información personal de la salud necesaria para procesar los reclamos de seguro de enfermedad, coordinar, o manejar el tratamiento, y para el propósito de nuestras operaciones de asistencia sanitaria. Autorizo también el pago DIRECTAMENTE al médico o el suministrador abajofirmantes para servicios rendidos.

_____ *El RECONOCIMIENTO DE RESPONSABILIDAD*:
Entiendo que soy financieramente responsible con "Pediatric Care Center" por todos servicios profesionales rendidos, inclusive pero no limitados a, esos servicios que no son cubiertos por mis programas del seguro (los Co-Pagos y/o deducibles). Entiendo también que si tengo un SEGURO MEDICO GLOBAL o el seguro de PPO y yo no obtengo la autorización apropiada de la referencia antes de mi visita, o verifico que el médico es un proveedor preferido que soy financieramente responsable de cualquier cargo contraído. Entiendo que los pagos por estos cargos son pagaderos al tiempo del servicio. En caso de incumplimiento con el pago, yo acuerdo en pagar todo el costo del proceso de colección del dinero, inclusive el honorario razonable de abogado.

_____ *El RECONOCIMIENTO que USTED RECIBIO "NOTA DE NUESTRAS PRACTICAS de la PRIVACIDAD*: Somos requeridos por la ley a mantener la privacidad de, y proporcionar a individuos con esta nota de nuestras prácticas legales de deberes y privacidad con respecto a información protegida de salud. Si usted tiene cualquier objeción a nuestra forma, pide por favor para hablar con nuestro OFICIAL de la CONFORMIDAD de HIPAA en la persona o por teléfono en nuestro número de teléfono principal.

Signature (*Firma*)_____**Date (*Fecha*)**_____

HIPAA Notice of Privacy Practices

PEDIATRIC CARE CENTER
4505 Hospital Road Ste C
Pascagoula, Ms 39581
(228 762-9595

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information
Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature_____
Date:_____

Patient's Name: _____ **Date:** _____

Attendance Policy effective April 2010

In order to provide all our patients with effective medical care, we ask you to respect our attendance policy.

Our scheduled appointments are intended to try and work with variable time constraints, yet we cannot accommodate everyone's needs for each visit. Please understand that some appointments will take longer than others, depending on the needs of each child.

Late Appointments:

If you are going to be late for your appointment, please call us ahead of time so that we can adjust the schedule accordingly, so not to inconvenience our other patients. If you sign in for your appointment over **15 minutes** past your appointment time, you will be seen but a patient that was on time for their appointment might be seen first.

Cancellations Versus No Shows

We understand that circumstances arise that hinders you from being able to make each scheduled appointment. We ask that you cancel or reschedule any appointment you may have **before** your scheduled appointment time. If you do not show up to the appointment and you have not contacted us, this will be marked as a No Show appointment. No Show appointments prevent us from seeing sick children when they need to be evaluated by the doctor. We want to keep the schedule available to all patients and not waste time waiting on appointments that will not show for their allotted time. After **three consistent no show** appointments, we will no longer be able to see your child in our clinic.

Work in Appointments:

Works in Appointments are same day appointments that are for sick children only and are seen as an urgent need for physician care. These appointments are fit into our booked work days and are scheduled for specific times. We take works in from **9:30 to 10:30** and **2:30 to 3:30.** If you are unable to be here during those times or do not have time to wait, you will need to schedule an appointment time on another day. We cannot guarantee a wait time for work in appointments, but we will see your child as soon as possible.

**Small babies will take priority over well patients or older children when it comes to a work in appointments. We hope that you would understand this policy. **

Parent Signature: _____