Patient Information / Demographic form (Please print)

Date_____

Patient Name_____

Primary Language_____ **Date of Birth**_____ Sex M F

Ethnicity: Culture/Origin

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race: Choose one or more

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Island
- ☐ White
- ☐ Prefers not to answer

Pharmacy Name_____

Pharmacy #_____

Father's Name_____ **Mother's Name**_____

Father's SS#_____ **DOB**_____ **Mother's SS#**_____**DOB**_____

Father's Occupation_____ **Mother's Occupation**_____

Home #_____ Work #_____ Home #_____ Work #_____

Cell #_____ Cell #_____

E-mail_____ E-mail_____

Do you have other children? Yes No

<u>Responsible Party Information</u>

Custodian (**patient lives with**):

Name_____

Address_____Apt_____

City_____State_____Zip_____

Guarantor (**bills sent to**):

Name_____

Address_____Apt_____

City_____State_____Zip_____

<u>Primary Insurance Information</u>

Cardholder Name_____

Insurance Carrier_____

ID Number_____

Group Number_____

Effective Date_____

Employer_____

Patient's relationship to Insured

Son ☐ Daughter ☐ Other _____

Referred by_____

Emergency Contact

(In the event the parents cannot be reached)

Name _____

Phone #_____Cell#_____

Relationship to patient_____

Permission to treat

In case of emergency, I give permission for the Providers of Coral Square Pediatrics to treat my child/children.

Name _____Date _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE INCLUDING COPAYMENTS, DEDUCTIBLES, AND NON COVERED SERVICES.

I certify that my dependent(s) have insurance coverage as indicated and assign Coral Square Pediatrics to receive payment directly for services rendered. I authorize the use of this signature on all insurance submission to release information necessary for the payment of claims. I understand I am responsible for all charges not covered by my insurance.

Print name _____Signature _____ Date _____

What Parents should know before scheduling their child's appointment!

Parents are urged to schedule well exams visits in advance and to call as early as possible for same day sick appointments. Please come in at least 10 minutes early to allow the front desk to process your visit. Insurance updates must be provided 48 hours before your visit for verification and to avoid the possibility of being rescheduled.

Co-payment: Your co-payment is required at time of service.

Deductible payment: Your payment will be collected before each visit; additional charges may apply depending on tests performed and or the severity of the evaluation and management of care given.

Well Visits: This visit is a routine physical exam which addresses preventative care and health maintenance and is billed as such. All parents must agree to the administration of Childhood vaccinations and follow the recommended guidelines. Additionally, the American Academy of Pediatrics recommends Behavioral and Developmental testing be administered at selected Well visits. These important tests may not be covered fully by your Insurance plan and may become the "Guarantor's responsibility." Please ask your Insurance carrier for details.

Sick Visits: This visit will address 1 to 2 specified illnesses mentioned upon scheduling. Non-urgent concerns such as behavioral issues, attention problems, or worsening chronic conditions will require much more time and a separate office visit.

Sick/Well Visit: This is a *combination visit* of a routine physical exam where an acute or chronic issue is addressed as well. For example, if you presented today for a well visit and you have an acute or chronic issue you would like addressed, it is considered a *combination visit* and must be billed differently than just a well visit or just a sick visit.

WHY IT IS BILLED DIFFERENTLY: It is billed differently to account for the additional work, expertise and time required for a combination visit (additional lab work, x-ray, referrals and/or prescription medications). It involves additional documentation as well.

HOW THIS AFFECTS ME: Although many insurance companies acknowledge the sick/well visit combination, some of them still require the patient to have additional costs applied to his/her annual deductible or pay a co-pay.

Walk-in: Our appointments are given based on a schedule. Patients' whom walk in will be triaged and seen for urgent care if necessary. If deemed non-urgent, the next available appointment time will be offered, "not squeezed in." Walk-in appointments may incur additional fees depending on your individual Insurance plan.

Add-on: Please call before your child's scheduled visit to request additional time needed to add-on a sibling visit. An Add-on visit should be for urgent care only. We may need to adjust your appointment time to allow enough time for both children. If an Add-on child is seen **without prior notice**, it will be considered a Walk-in appointment and may incur additional fees depending on your individual Insurance plan.

After Hours Visit: This appointment is offered after 5:00 p.m. or on Saturday. These appointments are available for added convenience or emergencies and are billed as such. You may incur an additional fee for this appointment depending on your individual Insurance plan.

We encourage you to check with your insurance company to confirm your coverage for all types of doctor visits.

Please acknowledge your understanding of the various Physician visits and possible fees associated with them.

Patient Name_____ Date of Birth_____

Parent Name_____ Parent Signature_____ Today's Date_____

New Patient Handout

Patients Name: _____ **Date:** _____
Date of Birth: _____

Demographics

Father's Name:_____ Birthdate:_____
Mother's Name: _____ Birthdate:_____
Child is: Biological _____ Adopted _____ Fostered_____

Birth History

Hospital: _____ **Hearing Screening:** Pass / Fail

Delivery: Vaginal / C-section **Pregnancy: Term** YES / NO

Complications: (During pregnancy, Labor, delivery) : YES / NO
Explain: _____

PATIENTS PAST MEDICAL HISTORY:
Hospitalizations *(List)*: _____

Surgeries *(List)*: _____

Allergies: Medicine _____ Food _____ Environmental _____

Immunizations: Up to Date: YES / NO

PATIENTS PAST MEDICAL ILLNESSES:

ADD/ADHD	Celiac	Ear Infection	Heart	Strep Throat
Allergies	Chicken Pox	Eczema	Hep A, B, C	Thyroid Disease
Anemia	Concussion	Elevated Chol/Trig	High BP	Tuberculosis
Anxiety	Constipation	Fainting w/exercise	Learning Disorder	Ulcerative Colitis
Arthritis	Crohn's	Genetic Disorder	Migraines	Urinary Problems
Asthma	Cystic Fibrosis	GERD	Meningitis	UTI
Behavioral Issues	Depression	Growth Disorder	Menses Problem	Vision Problems
Broken Bones	Developmental Delay	Headaches	Pneumonia	Wheezing
Bronchitis	Diabetes	Head Trauma	Seizures	
Cancer	Diarrhea	Hearing Problems	Sinus Infections	OTHER _____

Medicines Taken Daily *(List):* _____

Social History:

Lives with _____

Parents: Married ____ Divorced ___ Separated ___ Never Married ___ Remarried____

(NEXT PAGE)

Medical Condition	Parent	Sibling	Grandparent
Alcoholism			
Anxiety Disorder			
Depression			
Drug Dependency			
Bipolar Disorder			
Schizophrenia			
Stroke			
Anemia			
Blood Disorder			
Hemophilia			
Sickle cell anemia/trait			
Thalassemia			
Arthritis			
Autoimmune disease			
Crohn's disease			
Lupus			
Asthma			
Cystic fibrosis			
Celiac disease			
Diabetes mellitus			
Thyroid disorder			
Ulcerative colitis			
Familial hypercholesterolemia/ high cholesterol			
Ischemic heart disease/ Cardiovascular disease			
Hypertension			
Gastrointestinal disease			
Hepatitis			
Allergy			
Eczema			
Psoriasis			
ADD/ADHD			
Dyslexia/ Learning Disability			
Mental retardation			
HIV			
Tuberculosis			
Chromosomal anomaly			
Epilepsy			
Migraine			
Multiple sclerosis			
Deafness			
Cancer			
Kidney disease			
Kidney stone			

CORAL SQUARE PEDIATRICS, P.A.

FINANCIAL AGREEMENT:

The undersigned agrees he/she is herby obligated and agrees to pay **Coral Square Pediatrics, P.A.'s** charges for services rendered by said Doctors. I further agree that payment is due upon receipt of invoice/statement. I understand that unpaid accounts will be considered in default after sixty (60) days, after which time interest will be imposed at the rate of 1-1/2%per month on unpaid balances (ANNUAL PERCENTAGE RATE OF 18%) or the legal interest rate, which ever is lower. In the event a legal suit or outside collections are necessary to enforce payment of this account. I agree to pay such attorney's fees and court costs as may be deemed reasonable or collection fees. The patient/guarantor waives venue jurisdiction and submits itself to the jurisdiction and venue of the State Courts of Broward County, Florida.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment to be made directly to **Coral Square Pediatrics, P.A.** for benefits which may be due and payable under insurance coverage for the above named patient. Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct, and request that said payment of authorized benefits be made payable on my behalf to **Coral Square Pediatrics, P.A.**. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to **Coral Square Pediatrics P.A.**.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION:

Coral Square Pediatrics, P.A. is hereby authorized to disclose all or any part of the medical record on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by **Coral Square Pediatrics, P.A.**. Likewise my insurance company(s), organizations, or agencies responsible for payment is hereby authorized to disclose all or any medical records to **Coral Square Pediatrics, P.A.**, which includes treatment for Drug and Alcohol Abuse, Mental Health, HIV Virus and Sexual Assault. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by **Coral Square Pediatrics, P.A.**.

EMERGENCY CARE AUTHORIZATION:

I authorize **Coral Square Pediatrics, P.A.** to perform any necessary emergency care for my child (children), if I am unable to be located at the time of need for such emergency medical care.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS EACH OF THE ABOVE PARAGRAPHS AND IS THE PATIENT OR RESPONSIBLE PARTY WITH THE POWER TO EXECUTE THIS DOCUMENT AND ACCEPT THESE TERMS.

_____ _____ / /

Signature of Witness *Signature of Patient or Responsible Party & Date*

Financial Policy

Know Your Insurance Plan

Now that you have chosen Coral Square Pediatrics as your Health care providers, you must have your child assigned to our practice. Please have your current insurance card present for every office visit. You will be asked to verify and sign the printed account information. This is your verification of insurance and consent to bill. If the insurance company that you designate is incorrect, you will be responsible for payment of that visit.

It is your responsibility to understand your benefit plan. Not all services provided by our office are covered by every plan. Any service that is not covered by your plan will be your responsibility. Your remittance is due within ten business days after receiving the bill.

Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.

Co-pays and Deductibles are due at the time of the service. Outstanding account balances are to be collected prior to your visit. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits.

Private Paying Patients: Payment for the office visit will be collected prior to being seen.

Divorced Parents: For services rendered to the patient, the adult accompanying the patient is responsible for payment. We will not become involved in your legal agreement.

Returned Checks will incur a $25.00 fee plus any bank fees incurred. If a second check is returned on your account, then checks will no longer be accepted as payment.

Past Due Accounts: Balances over 90 days old will be forwarded to a collection agency.

Office Policy

Please call for appointments: Office visits are scheduled by appointment only. Walk-in appointments are triaged by our nurse and scheduled accordingly.

True medical emergencies are seen promptly; this may add delays in office scheduling. Please be understanding if this situation should arise as this may cause delays in office scheduling.

Schedule your next office visit (well visits, follow-up visits etc.) before leaving the office so you may get a time that is convenient for you.

After Hours Appointments : For your convenience, we offer after hours appointments.
Additional fees may be incurred for these appointments depending on individual insurance policies.

Reminder appointment calls are courtesy calls made by our staff. Please give a phone number where you may be reached during the day, 24 hrs before your visit.

Missed appointments that are not canceled with in **2 hours** of your scheduled time will result in a **$25.00 no show charge**.

Payment is expected at time of service for all deductible, copayment, and private pay patients. We do ask for credit card information to be kept on file, only to be used for missed payments. Checks or cash are also accepted for payment.

Divorced parents: The **parent** who brings the child for the office visit is **responsible** for any co-payment and / or deductible payments at the time of service. Receipts will be provided upon request. Legal agreements are not our concern.

Patients are encouraged to see all the Providers at least once. This allows the providers and the patients to get to know one another.

Pharmacy telephone numbers: Please have your pharmacy number available to our staff when a prescription may be needed (at **all times**). We do not keep numbers on file.

After office hours: Calls are returned promptly, by one of our Providers 7 days a week. The Providers can be reached by calling **(954)-753-7870** and leaving a message on our answering machine. Please defer all non-medical questions (i.e.; billing, appointments, and insurance questions) for normal office hours. We ask that you **remove all call blocks** from your phone to allow a return call. **Caller ID** is not an appropriate means to contact our Providers.

Cell phones: Please **turn off** your cell phone when in the exam room.

Billing Department calls or questions may be received between the hours of **9:00 to 5:00** Monday through Friday. Diagnosis cannot be altered for insurance purposes.

The Referral Department is available between the hours of **9:00 to 5:00** Monday through Friday. Please pick-up your referrals during those hours only. Non-emergent referrals will be processed within **5 business days**.
Administrative fees: Sport, camp and School yellow/ blue forms will incur a $5.00 processing fee. Medical necessity letters may cost up to $25.00 depending on the content.

Medical Records: The preparation fee for medical records is $ 1.00 per page. A signed Medical record release is required before records can be released. All outstanding balances are expected to be paid at time of transfer. If your child is ≥18 years old, the request must come from them directly.

Immunization Policy

Coral Square Pediatrics, P.A. is dedicated to providing the highest quality of evidence-based medical care to our patients. We adhere to the vaccine schedule recommended by the American Academy of Pediatrics (AAP) and the Advisory Committee on immunizations Practices (ACIP).

These well-respected organizations play a major role in setting the standard of care in both pediatrics and infectious disease. Together, they strive to eradicate or minimize the incidence of serious preventable disease, thereby promoting the healthcare of all children. National experts routinely analyze research information, monitor the prevalence of vaccine-preventable diseases, and monitor reported adverse events following vaccine administration. This information is used to create the best vaccine schedule to protect all children.

Coral Square Pediatrics serves as an advocate for our patients, while making every effort to respect the wishes of our parents. Should a family desire to alter the vaccine schedule or withhold recommended vaccines, Coral Square Pediatrics believes this decision not only puts your child at risk of serious preventable diseases, but also contributes to the health risk of others.

Please be advised that if you desire an “alternate” vaccine schedule or intend to refuse vaccines, you do so against the advice of Coral square Pediatrics, P.A. the AAP and the ACIP. Because we believe that this decision puts your child at risk for vaccine preventable diseases and increases the health risks for others, Coral Square Pediatrics respectfully declines to accept you into our practice.

Thank you,
Coral Square Pediatrics

Exhibit 3

Coral Square Pediatrics

Notice Of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO *YOUR* INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

• How we may use and disclose your IIHI

• Your privacy rights in your IIHI

• Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. 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 our practice has created or maintained in the past, and for any of your records that 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 at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Coral Square Pediatrics, 700 Riverside Drive, Coral Springs, FL 33071, 954-753-7870C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose

your IIHI to others who may assist in your care, such as your spouse, children or parents.

Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI 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 details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

OPTIONAL:

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

OPTIONAL:

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL:

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

C. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI 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

• notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
• notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI 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.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:
• Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
• Concerning a death we believe has resulted from criminal conduct
• Regarding criminal conduct at our offices
• In response to a warrant, summons, court order, subpoena or similar legal process
• To identify/locate a suspect, material witness, fugitive or missing person
• In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL:

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL:

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL:

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the

following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice 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 to [insert name, or title, and telephone number of a person or office to contact for further information] specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Coral Square Pediatrics, 700 Riverside Drive, Coral Springs, FL 33071, 954-753-7870. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;

(b) whether you are requesting to limit our practice's use, disclosure or both; and

(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Coral Square Pediatrics, 700 Riverside Drive, Coral Springs, FL 33071, 954-753-7870 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies

associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Coral Square Pediatrics, 700 Riverside Drive, Coral Springs, FL 33071, 954-753-7870. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Coral Square Pediatrics, 700 Riverside Drive, Coral Springs, FL 33071, 954-753-7870. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Coral Square Pediatrics, 700 Riverside Drive, Coral Springs, FL 33071, 954-753-7870.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Coral Square Pediatrics, 700 Riverside Drive, Coral Springs, FL 33071, 954-753-7870. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Coral Square Pediatrics, 700 Riverside Drive, Coral Springs, FL 33071, 954-753-7870.

CORAL SQUARE PEDIATRICS, P.A

Joel D. Cheresnick, M.D. Jennifer Y. Liang, M.D.

Notice of Privacy Practices
Acknowledgement Form

This notice describes how your child's health information may be used and disclosed and how you can get access to your child's health information, as required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I, _____, (Parent/Guardian) of _____
(Patient's name)
have received a copy of Coral Square Pediatrics' Notice of Privacy Practice / HIPPA pamphlet.

_____ Date_____
Signature of Parent / Guardian

Office use only: As a privacy office, I did not obtain the Parent / Guardian signature on this acknowledgement Because:
_____ It was emergency treatment
_____ The Parent / Guardian refused to sign
_____ Other
_____

Signature of the Privacy officer: _____ Date_____