Email Address ___________________________

Preferred Pharmacy ___________________________

PATIENT INFORMATION

Patient First Name ______________ Middle __________ Last __________

Billing Address ______________ City/State/Zip ______________

Home Address ______________ City/State/Zip ______________

Phone *(home)* ______________ Cell __________ DOB __________

Patient Soc. Sec. # ______________ ☐ Male ☐ Female

Please check below the racial category or categories with which you most closely identify. Circle as many as apply.

☐ Decline ☐ Hispanic/Latino ☐ American Indian/Alaska Native ☐ Asian

☐ African American ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian

Primary language spoken at home ______________

Do you need an interpreter or sign language helper? ☐ Yes ☐ No

Mother's Name ______________ Marital Status __________ DOB __________

Father's Name ______________ Marital Status __________ DOB __________

Stepmother's Name *(if applicable)* ______________ Stepfather's Name *(if applicable)* ______________

Siblings First Name *(and last name if different than patient)* ______________ DOB __________

First Name *(and last name if different than patient)* ______________ DOB __________

First Name *(and last name if different than patient)* ______________ DOB __________

Primary Insurance Company ______________ Policy # __________ Group # __________

Insured Name ______________ Insured DOB __________

Secondary Insurance Company ______________ Policy # __________ Group # __________

Insured Name ______________ Insured DOB __________

Responsible Party *(parent or legal guardian)* ______________

Address ______________ City/State/Zip ______________

Soc. Sec. # ______________ DOB __________

Employer ______________ Work Phone __________ *(cell)* __________

Emergency Contact ______________ Phone __________ Relationship __________

<u>Important</u> — The emergency contact phone number needs to be different than the home number. By signing below I give permission for the clinic to call this number if needed.

How did you hear of us? ☐ Friend ______________ ☐ Newspaper ☐ Phone Book

(who can we thank for the referral?)

Release of benefits and medical information

I authorize my insurance benefits to be paid directly to Pediatric TLC P.C. I am financially responsible for any balance due. I authorize Pediatric TLC P.C. or the insurance company to release information required for this claim. Even though an insurance claim may be pending you will receive a statement each month if your account has any balance. The responsible party is obligated for payment in full of this account. In the event of nonpayment, responsible party shall bear the cost of collections, and/or court cost and reasonable legal fees, should this be required.

<u>Please note: There will be a $5 statement fee added to your bill each month after 60 days.</u>

Parent/Guardian Signature ______________ Date __________

Pediatric TLC
Complete health care for tots and teens
P.C.

INITIAL HISTORY QUESTIONNAIRE

Patient's Name ______________________ DOB ________ Age ________ ☐ Male ☐ Female

Form Completed By ______________________ Date Completed ________

Household

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

Name ________ Relationship to Child ________ Health Problems ________ DOB ________

Name ________ Relationship to Child ________ Health Problems ________ DOB ________

Name ________ Relationship to Child ________ Health Problems ________ DOB ________

Name ________ Relationship to Child ________ Health Problems ________ DOB ________

Name ________ Relationship to Child ________ Health Problems ________ DOB ________

Are there siblings not listed? If so, please list their where they live, name, and ages.

Where They Live ________ Name ________ Age ________

Where They Live ________ Name ________ Age ________

Where They Live ________ Name ________ Age ________

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Lives with foster family ☐ Joint custody ☐ Single custody

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

____

Birth History

☐ Don't know birth history

Birth weight ________ Was the baby born at term? ________ OR ________ weeks ________

Where there any prenatal or neonatel complications? ☐ Yes ☐ No Explain ________

Was a NICU stay required? ☐ Yes ☐ No Explain ________

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink Alcohol ☐ Yes ☐ No Use drugs of medications ☐ Yes ☐

No Use prenatal vitamins ☐ Yes ☐ No

What ________ When ________

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? ________

Was initial feeding ☐ Formula ☐ Breast Milk How long breastfed? ________

Did your baby go home with mother from the hospital? ☐ Yes ☐ No Explain ________

GENERAL

DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK

Explain ________

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK

Explain ________

Has your child had any surgery? ☐ Yes ☐ No ☐ DK

Explain ________

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK

Explain ________

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Pediatric TLC
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INITIAL HISTORY QUESTIONNAIRE

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK
Explain ______________________

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK
Explain ______________________

Biological Family History

DK = don't know

Have any family members had the following?

Condition	Yes	No	DK	Who	Comments
Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Nasal allergies	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Asthma	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Tuberculosis	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Heart Disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
High Cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Anemia	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Dental decay	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Liver disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Kidney disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Bed wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Obesity	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Developmental disability	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Tobacco use	☐ Yes	☐ No	☐ DK	Who ______	Comments ______

Additional family history ______________________

Past History

DK = don't know

Does your child have or has your child ever had:

Condition	Yes	No	DK	Details
Chickenpox	☐ Yes	☐ No	☐ DK	When ______
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain ______
Problems with ears of hearing	☐ Yes	☐ No	☐ DK	Explain ______
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain ______
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain ______
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain ______

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Pediatric TLC
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INITIAL HISTORY QUESTIONNAIRE

Condition	Yes	No	DK	Explain
Any heart problems or heart murmur	☐ Yes	☐ No	☐ DK	Explain ________
Anemia or bleeding problems	☐ Yes	☐ No	☐ DK	Explain ________
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain ________
HIV	☐ Yes	☐ No	☐ DK	Explain ________
Organ transplant	☐ Yes	☐ No	☐ DK	Explain ________
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain ________
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain ________
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain ________
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain ________
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain ________
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain ________
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain ________
Cancer	☐ Yes	☐ No	☐ DK	Explain ________
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain ________
Bed wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain ________
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain ________
Chronic or recurrent skin problems (eg. acne, eczema)	☐ Yes	☐ No	☐ DK	Explain ________
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain ________
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain ________
Obesity	☐ Yes	☐ No	☐ DK	Explain ________
Diabetes	☐ Yes	☐ No	☐ DK	Explain ________
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain ________
High blood pressure	☐ Yes	☐ No	☐ DK	Explain ________
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain ________
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain ________
Tobacco use	☐ Yes	☐ No	☐ DK	Explain ________
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain ________
Developmental delay	☐ Yes	☐ No	☐ DK	Explain ________
Dental decay	☐ Yes	☐ No	☐ DK	Explain ________
History of family violence	☐ Yes	☐ No	☐ DK	Explain ________
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain ________
Pregnancy	☐ Yes	☐ No	☐ DK	Explain ________
Problems with her periods (for girls)	☐ Yes	☐ No	☐ DK	Explain ________

Has had first period ☐ Yes ☐ No Age of first period ________

Any other significant problems

____

Pediatric TLC
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P.C.

PARENTAL CONSENT

It is strongly recommended by Pediatric TLC P.C. that a parent or legal guardian be present at all office visits, not just routine exams. If this is not possible, the consent form below may be signed by the parent or guardian.

I, ______________________________ (parent/guardian name), agree and understand that by signing below, I am giving authorization to the person(s) listed to make any medical decisions regarding my child, ______________________________ (child's name), on my behalf. This includes, but is not limited to immunizations, procedures, etc.

Parent/Guardian Printed Name ______________________________ Date ______________

Parent/Guardian Signature ______________________________

Name of Authorized Person ______________________________ Relationship to Patient ______________

Name of Authorized Person ______________________________ Relationship to Patient ______________

Name of Authorized Person ______________________________ Relationship to Patient ______________

This permission is valid until parent terminates

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FINANCIAL POLICY

The following disclosures are made in compliance with the Federal Truth in Lending Law. Pediatric TLC P.C. will extend credit to a patient with the understanding that:

Parent/Child The adult accompanying the child is responsible for payment at the time of service including co-payment. The parent/guardian with whom the child resides is the person who will be billed for services rendered. We will not be involved in mediating financial arrangements between parents/guardians. We will bill insurance as stated below.

Regarding Insurance It is the **responsibility of the patient** to know what is covered and excluded from his/her plan. You will be asked to **present your insurance at each visit**. If this information is not provided, the balance will be the patient's responsibility. We ask that you **pay your copay at the time of service**. If this payment is not made by closing of the next business day a charge of $10.00 will be assessed. We accept all payments made from the insurance. If there is overpayment made from either the patient or insurance, there will be a refund generated.

Secondary Insurance We will submit claims to your secondary carrier as a courtesy. You are responsible for deductibles, co-pays, and any non-covered services provided. You are responsible for any balance after insurance(s) has cleared.

Usual and Customary Rates Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Private Pay We ask that our patients without insurance pay in full at the time of service. We offer a 30% discount if full payment is made on the day of the visit. All charges are due and payable within 30 days form the date of the closing statement. If there is no payment made at that time, the patient has 60 days to pay off the debt until a monthly billing charge of $5.00 is charged.

Monthly Payments on Outstanding Balances If you are not able to pay your account in full at the time of service and need to make monthly payments, you will need to make a payment arrangement with our office. After this arrangement is made, the account will be turned over to our collection agency if it is not met.

Divorce Decrees This office is **NOT** a party to your divorce decree. The responsibility for minors rests with the accompanying adult.

Service Charges We reserve the right to apply a billing charge of $5.00 per month to your account for balances after 60 days. A fee of $25.00 will be assessed to your account for any checks returned due to non-sufficient funds. We will charge the patient $5.00 for forms filled out by the physician if not done at the time of service. This is to cover additional administrative costs. These amounts will not be billed to the insurance company. **We accept personal checks, money orders, VISA, MasterCard, and cash**.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read, understand and agree to the Financial Policy for Pediatric TLC P.C.

Signature of Responsible Party ______________________________ Date ____________________

ACKNOWLEDGMENT AND CONSENT

I understand that Pediatric TLC P.C. *(referred to below as "This Practice")* will use and disclose **health information** about me.

I understand that my health information may include information both created an received by the practice, may be in the form of written or electronic records or spoken words and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that **This Practice may use and disclose my health information in order to**:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written descriptions of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I m entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By ______________________________ Date ______________
(patient)

OR

By ______________________________ Date ______________
(patient representative)

Description of Representative's Authority ______________________________

1819 SW Nebraska Avenue, Grants Pass, Oregon 97527 541-479-2411 fax: 541-479-2236

POLICY AND PROCEDURE
AFTER HOURS/EMERGENCY FACILITIES/NO-SHOW

There is someone on call 24 hours a day. You must call our office before going to an Emergency Room, Urgent Care or Valley Immediate Care. We always try to get you in our office the same day or the next. You can go to the above-named places to receive care in the event of a true emergency.

To reach the on-call nurse line call **(541) 479-2411 ext. 8**.

What's an emergency?

An emergency is a serious injury or sudden illness, including severe pain that you believe might **cause death** or **serious bodily harm if not treated**.

Here are a few health care conditions that **are** considered emergencies:

- Chest pain or pressure
- Seizures
- Loss of consciousness *(blacking out)*
- Major burns
- Bleeding that does not stop
- Broken bones
- Trouble breathing
- Dehydration *(which is uncontrollable vomiting and/or diarrhea)*

Here are a few health care conditions that **are not** considered emergencies:

- Sore throat
- Ear pain
- Back pain
- Flu
- Colds
- Dental Pain

(The conditions shown above are examples and not a complete list of emergency and nonemergency conditions).

No Showing Appointment

We have had to make this policy regarding missed *(also known as "no show")* appointments, as this makes it difficult for our office to schedule **sick visits for children whom may need to be seen**.

- After **2 No-Shows** the front desk will send a "Failed Appointment Letter".
- If patient is on Allcare letter will be faxed to them.
- **On the next No-Show the provider will Discharge the family**.
- If patient is on Allcare a letter will be faxed to them notifying of the family's Discharge.
- **Front desk will cancel any upcoming appointments. The provider will see patient for emergency visits only for 30 days.**

Late Arrival Policy

Arriving 5 or more minutes past your scheduled arrival time is considered a late arrival, and we will have to reschedule you on most days. We do understand that unexpected situations can occur which can cause you to be late. **Please call us as soon as possible** to see if you are still able to keep your appointment or if it will need to be rescheduled.

Child's Name ______________________________

Patient Signature ______________________________ Date ______________

Pediatric TLC
Complete health care for tots and teens
P.C.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please Review it Carefully

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT ERIN PIPGRAS, OUR PRIVACY OFFICER, AT OUR OFFICE:

1819 SW Nebraska Avenue
Grants Pass, OR 97527

Who Will Follow This Notice

This notice describes the information privacy practices followed by Pediatric TLC P.C., which includes physicians and all employees hereinafter referred to as "we."

Your Health Information

This notice applies to the information and pediatric records we have about you/your child's health, health status, and the health care and service you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

How We May Use and Disclose Health Information About You

We may use and disclose health information for the following purposes:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. The physician may use your medical history to decide what treatment is best for you. The physician may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, or how we can become more efficient.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff, and comply with the law.

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NOTICE OF PRIVACY PRACTICES

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at our office. A message may be left on your answering machine or voice mail.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive communications, we will not use or disclose your information for these purposes.

Special Situations

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law: We will disclose health information about you when required to do so by federal, state or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directions: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identity a deceased person or determine the cause of death.

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NOTICE OF PRIVACY PRACTICES

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you are being admitted for surgery and provide updates on your progress. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays.

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially protected information such as HIV, substance abuse, mental health, and genetic testing information.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Erin Pipgras, privacy officer, in order to inspect and/or copy records of your health information. If you request a copy of the information, we will charge for the costs of copying, mailing or other associated supplies. Please allow us 30 days to meet your request.

We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as this office keeps the information. To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to Erin Pipgras, privacy officer. We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the health information that we keep.
- You would not be permitted to inspect and copy
- Is accurate and complete

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NOTICE OF PRIVACY PRACTICES

Right to an Accountant of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization. To obtain this list, you must submit your request in writing to Erin Pipgras, our privacy officer. It must state a time period, which may not be longer than six years and may not include dates before April 1, 2007. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information. To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to Erin Pipgras, our Privacy Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATIONS to Erin Pipgras, our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain such a copy, contact, Erin Pipgras, Privacy Officer.

Changes to This Notice

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Erin Pipgras, Privacy Officer at 1819 SW Nebraska Avenue, Grants Pass, OR 97527. **<u>You will not be penalized for filing a complaint</u>**.

ACKNOWLEDGMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have been offered a copy of Pediatric TLC's Notice of Privacy Practices.

Patient's Name ____

Patient's Signature ____ Date ____________

OR

Parent/Legal Representative's Name ______________________________________

Parent/Legal Representative's Signature _____________________________ Date ____________

CONSENT TO ELECTRONIC APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

I, ________________________________, consent to receive text messages, email and/or phone call reminders. These reminders will be sent to the phone number and email address on the account. I understand this request will apply to all future appointment reminders and other healthcare communications unless I request a change in writing.

Patient's Name ____

Patient's Signature ____ Date ____________

OR

Parent/Legal Representative's Name ______________________________________

Parent/Legal Representative's Signature _____________________________ Date ____________

☐ By checking this box, I am choosing to OPT-OUT of electronic reminders and other electronic healthcare communications.

For Pediatric TLC use only:

Pediatric TLC made the following good faith efforts to obtain the above referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices and Consent to Electronic Appointment Reminders: ____________ (initials).

1819 SW Nebraska Avenue, Grants Pass, Oregon 97527 541-479-2411 fax: 541-479-2236