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.

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record
- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other dis closures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 2.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- Sale of your information

In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.
We can use your health information and share it with other professionals who are treating you.
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. Your information may be shared w/ other providers, labs and radiology groups through our EHR system as listed:

1) Lab Corp 2) Quest Diagnostics 3) CAN/IPA Network

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Preventing or reducing a serious threat to anyone's health or safety
- Reporting suspected abuse, neglect, or domestic violence

Do research
Comply with the law
Respond to organ and tissue donation requests
Work with a medical examiner or funeral director
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

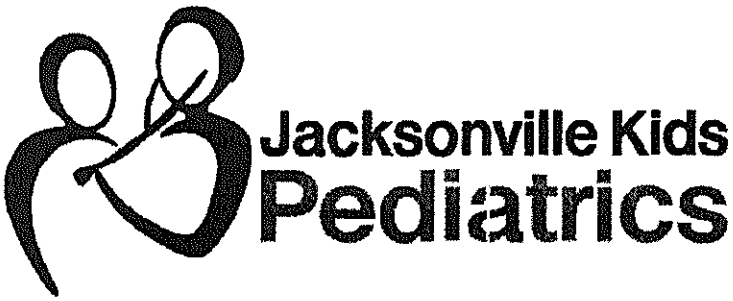
Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.



I _____ (parent/guardian name) hereby acknowledge that I have reviewed and received a copy of this practice's Notice of Privacy Practices, which has been updated for the new Omnibus Rule and has an effective date of July 16,2015.

The notice describes:

- the ways that the Privacy Rule allows our practice to use and disclose protected health information. How our practice will get your permission, or authorization, before using your health records for any other reason.
- the practice's duties to protect health information privacy.
- the patient's privacy rights, including the right to complain to HHS and to the covered entity if you believe your privacy rights have been violated.
- how to contact our practice for more information and to make a complaint.

I understand that the Notice of Privacy Practices may be revised from time to time and that I have a right to receive an updated copy upon request.

_____

PARENT/GUARDIAN SIGNATURE

_____

RELATIONSHIP TO PATIENT

_____

PATIENT NAME PATIENT DOB

_____

DATE

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH			

TO: (Name, Address, Phone of **Recipient** of Records)							
Name	Jacksonville Kids Pediatrics, P.L.L.C.				Phone	(904) 446-9991	
Address	7807 Baymeadows Road East Suite 207				**Fax**	**(904) 446-9992**	
City/State Zip		Jacksonville		FL			32256

RECORDS FROM: (Who is **Releasing** the Records)						
Name					Phone	
Address	Fax:					
City/State Zip	City		State		Zip	

For the Following Purposes:

	Continued Medical Care		Personal Information		Legal Follow-up
	Disability Insurance		Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

	Please send the entire Medical Record (all information) to the above named recipient.				
	Office Notes and Reports		Diagnostic Reports		Laboratory Reports
	Rx History		Transcribed Hospital Reports		Vaccine Records
	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases
_____ Mental Health Information and/or Records
_____ Domestic Violence
_____ Genetic Testing Information and/or records
_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

_____ Other: _____

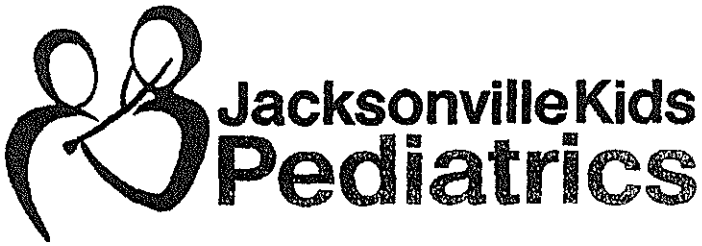
I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____



AUTHORIZATION FOR TREATMENT

Date:_____

Patient Name:_____ **Date of Birth:**_____

Patient Name:_____ **Date of Birth:**_____

Patient Name:_____ **Date of Birth:**_____

Patient Name:_____ **Date of Birth:**_____

Patient Name:_____ **Date of Birth:**_____

Patient Name:_____ **Date of Birth:**_____

In the event that I am unable to bring my child(ren) to the office, I consent for the following persons to authorize medical care that is recommended by any of the Jacksonville Kids Pediatrics physicians.

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Parent/Guardian Signature:_____

Patient Name

Medical History

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Medical History

Check all diseases and conditions that apply.

- ☐ ADD or ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Bedwetting
- ☐ Bladder or Kidney Problems
- ☐ Blood Diseases
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Congenital Anomalies
- ☐ Constipation
- ☐ Depression
- ☐ Developmental or Behavioral Disorders
- ☐ Diabetes
- ☐ Ear or Hearing Problems
- ☐ Eczema, Hives or other skin conditions
- ☐ Heart Problems
- ☐ Hospital Admission other than birth
- ☐ Muscle, Joint, or Bone Problems
- ☐ Reflux/GI
- ☐ Seizures/Epilepsy
- ☐ Serious Illness or Injuries
- ☐ Skin Problems
- ☐ Thyroid Problems
- ☐ Vision or Eye Problems

Patient Name

Surgical History

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Surgical History

Check all surgeries that apply.

- ☐ Adenoid Surgery
- ☐ Appendectomy
- ☐ Cardiac Surgery
- ☐ Circumcision
- ☐ Cleft Palate/Lip Repair
- ☐ Frenulectomy
- ☐ Gastric Surgery
- ☐ Gastrostomy Tube Placement
- ☐ Hernia Repair
- ☐ Hydrocele Repair
- ☐ Hypospadias Repair
- ☐ Myringotomy Tube Placement
- ☐ Neurosurgery
- ☐ Nissen Fundoplication
- ☐ Orthopaedic Surgery
- ☐ Other
- ☐ PE Tubes
- ☐ Pyloric Stenosis Repair
- ☐ Strabismus Surgery
- ☐ Tonsillectomy
- ☐ Tracheostomy
- ☐ VP Shunt Placement

Patient Name

Medication History

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Medication History

List all current medications. Include prescribed and over-the-counter drugs, such as vitamins and inhalers.

Medication	Dosage	Frequency

Drug/Food Allergies

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Allergies

List all known allergies.

Allergy	Reaction(s)	Date of First Reaction (approx.)
		___ / ___
		___ / ___
		___ / ___
		___ / ___

Patient Name

Family History

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Family History

Check all diseases and conditions that apply.

- ☐ Allergy — Family member(s): _____
- ☐ Anemia — Family member(s): _____
- ☐ Anxiety disorder — Family member(s): _____
- ☐ Arthritis — Family member(s): _____
- ☐ Asthma — Family member(s): _____
- ☐ Blood coagulation disorder — Family member(s): _____
- ☐ Depressive disorder — Family member(s): _____
- ☐ Developmental disorder — Family member(s): _____
- ☐ Diabetes mellitus — Family member(s): _____
- ☐ Disease of liver — Family member(s): _____
- ☐ Disorder of thyroid gland — Family member(s): _____
- ☐ Family history of alcoholism — Family member(s): _____
- ☐ Heart disease — Family member(s): _____
- ☐ Hypercholesterolemia — Family member(s): _____
- ☐ Hypertensive disorder — Family member(s): _____
- ☐ Immunodeficiency disorder — Family member(s): _____
- ☐ Kidney disease — Family member(s): _____

☐ Malignant neoplastic disease	Family member(s): _____
☐ Mental disorder	Family member(s): _____
☐ Migraine	Family member(s): _____
☐ Seizure disorder	Family member(s): _____
☐ Substance abuse	Family member(s): _____
☐ Tuberculosis	Family member(s): _____

Patient Name

Social History

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Social History

1. Diet (Circle one)

Regular Vegetarian Vegan Gluten free

Specific Carbohydrate Cardiac Diabetic

2. Caffeine intake (Circle one)

None Occasional Moderate Heavy

3. Exercise level (Circle one)

None Occasional Moderate Heavy

4. Sporting activities _____

5. Parents' marital status (Circle one)

Married Unmarried Separated Divorced

Widowed

6. Home situation (Circle one)

Both parents Mother Father Relatives

Adoptive parents Foster parents Other

7. Siblings _____

8. Childcare? (Circle one)

None Relative Private sitter Daycare/preschool

9. Animal exposure? (Circle one)

Yes No

10. Passive smoke exposure? (Circle one)

Yes No

11. Smoke/CO detectors in home? (Circle one)

Yes No

12. Seat belt/car seat used routinely? (Circle one)

Yes No

13. Sunscreen used routinely (Circle one)

Yes No

14. Insect repellent used routinely? (Circle one)

Yes No

15. Year in school (Circle one)

Pre-K	Kindergarten	1	2
3	4	5	6
7	8	9	10
11	12	HS Grad	College

16. School name _____

17. Smoking Status (Circle one)

Never smoker	Former smoker	Current every day smoker	Current some day smoker
Smoker - current status unknown	Unknown if ever smoked		

JACKSONVILLE KIDS PEDIATRICS
FINANCIAL POLICY

Thank you for choosing Jacksonville Kids Pediatrics (JK Peds) as your primary care provider. We are committed to providing you with the highest quality of care at a fair and reasonable cost. In order to accomplish this goal, we are requesting your help in avoiding unnecessary billing issues that may happen as a result of incorrect insurance information.

The following is a summary of our payment policy. ***Acknowledgement and understanding of this Financial Policy must be signed. Patients cannot see the providers unless this statement is signed.*** It may not be altered in any way, it must be signed as is.

PAYMENT IN FULL IS DUE AND EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered. This includes applicable coinsurance, co-payments, and payments for services not covered or denied by your insurance company. If you participate in a high deductible plan, we reserve the right to request payment in full or in part for charges incurred at time of service as allowable by your insurance carrier. If you do not have insurance, please come prepared to pay for your visit in full. JK Peds offers a 20% discount for all self- pay services paid in full on the day of the visit. If your balance cannot be paid in full at the time of service, we may be able to create a budget plan/agreement to have the outstanding bill/service paid within 90 days, with the first payment due the day the service is rendered.

Jacksonville Kids Pediatrics accepts cash, debit cards, credit cards including Visa, Master Card, Discover, and American Express. We do not accept personal checks at this time.

Missed Copay Fee: We are required by our insurance contracts to collect all co-pays at the time of service. Failure to collect copays puts the responsible party and JK Peds in default of the insurance contract. Any co-payments that are not paid at the time of the office visit will be charged a "Missed Co-pay processing fee" of $10.

Missed Appointment Fee: Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time that we set aside for you. Cancellations are requested **24 hours prior** to the appointment. The first time that a patient **does not show up for a scheduled ILL visit appointment, there will be a $25 fee charged. The first time that a patient does not show up for a scheduled WELL visit appointment, there will be a $50 fee charged.** This fee must be paid before a new appointment is scheduled. Patients with four missed appointments will be asked to transfer their records to another doctor.

BRING YOUR CURRENT INSURANCE CARD TO EVERY VISIT

The Financial Policy Continues on page 2.

INSURANCE FILING AND ASSIGNMENT OF BENEFITS

Regarding Insurance: As a courtesy to our patients, JK Peds will file claims to any insurance carrier with whom we are participating providers. It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to their appointment date. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance. If the insurance company has not processed and paid the claim within a timely manner or has denied the claim, payment of the account in full becomes the responsibility of the person bringing the child to our office for the treatment.

Change of Insurance/Change of Address: Please notify the office ASAP of all insurance and address changes. The guarantor is responsible for all charges not paid as a result of the change of insurance coverage.

Payments: Unless other arrangements are approved by us in writing, the balance of your statement is due and payable when the statement is issued. Payment is due within (30) days from the statement date. If you feel that your claim was unfairly denied by your insurance company, it is the parent/guardian responsibility to pursue the insurance company on their child's behalf.

Divorce: In the case of divorce or separation, the parent authorizing treatment for a child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all of part of the treatment costs, it is the **AUTHORIZING PARENT'S** responsibility to collect from the other parent.

Insurance Release: This is to certify that I have been informed prior to receiving treatment today that my health plan may not be liable for services rendered if any of the following conditions apply: Provider not participating in my health plan; Unmet deductibles under my health plan; Services not covered under my particular health plan including the recommended preventative care such as well visits, immunizations, vision and hearing screening, depression or developmental screening, any in house labs or EKGs/any other services that may be performed during well visits or during ill visits. Please check with your insurance carrier if you are not sure if routine services are covered.

Outstanding Balances: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account and payment or credits applied to your account during the month. If your account becomes past due, we will take the necessary steps to collect this debt.

JK Peds understands that full payment may not be possible in certain circumstances. As a courtesy, JK Peds offers a binding contract referred to as a "Payment plan". In order for services to be rendered, patients with payment plans must be in full compliance with all conditions of the budget agreement. Failure to make scheduled payments on the budget agreement or not paying off a balance in full may result in your account being turned over to a collection agency.

Waiver of Confidentiality: You understand that if the account is submitted to a collection agency or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transfer of Records: Should you wish to transfer care to another physician, you will need to complete the authorization to release records form, which can be obtained from our office, or your new physician may have their own compliant form. This form needs to be completed in its entirety in order for us to process the request. All balances should be paid before records are transferred.

Effective Dates: Once you have signed this agreement, you agree to all of the terms and conditions contained herein, and the agreement will be in full force and effect.

Billing Inquiries: Questions about a bill should be directed to our **Billing Manager at 904-446-9991.**

Therefore, knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency, the undersigned shall pay all collection agency fees, court costs, and attorney fees, and risk being dismissed from the provider care of Jacksonville Kids Pediatrics.

I have read this Financial Policy at outlined above and on page 2, and understand that I am ultimately responsible for the charges incurred by my child/children as their legal parent or guardian.

Patient's Name (s) _____

Parent/Guardian Signature _____ Date: _____

Jacksonville Kids Pediatrics

Vaccination/Well Visit Schedule

3-5 day Newborn Well visit: No vaccines due unless **Hep B#1** (Hepatitis B vaccine) not given at birth

2 week: No vaccines due

1 month: Hep B#2 (assuming Hep B#1 was given at birth hospital)

2 months: Pentacel #1 (DTap/IPV/HIB) which is the Diptheria/Tetanus/Pertussis (Whooping Cough)/Polio and HIB vaccine combo; **Prevnar #1** (strep pneumo vaccine), **Rotateq #1** (rotavirus oral vaccine)

4 months: Pentacel #2 (DTap/IPV/HIB), **Prevnar #2, Rotateq #2**

6 months: Pentacel #3 (DTap/IPV/HIB), **Prevnar #3, Rotateq #3**

9 months: Hep B #3, Hemoglobin (anemia check)

12 months: MMR# 1 (measles/mumps/rubella vaccine), **Varicella #1** (chicken pox vaccine), **Hep A #1** (Hepatitis A vaccine)

15 months: Prevnar #4, HIB #4, Hemoglobin check

18 months: Dtap #4, Hep A#2

2-3 years: No vaccines due unless needs to "catch up"

4 years: Quadracel (Dtap #5, IPV #4), Proquad (MMR#2/VZV#2), Hemoglobin check

5 years: No vaccines due

6 years-10 years: No vaccines due, yearly well visit recommended

11 years: Tdap (Tetanus booster with Pertussis booster vaccine), **Menactra** (meningococcal meningitis vaccine)

12 years: Gardasil (Human Papilloma Virus Vaccine) is a 2 or 3-series vaccine recommended now for both females and males

13-15 years: Yearly well visit recommended, no vaccines due unless needs to "catch up" or start Gardasil series

16 years: Menactra #2

17-18 years: Yearly well visit recommended

****We recommend every child 6 months and older receive a yearly flu vaccine****