PEDIATRIC PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name	Social Security #	Gender Preference ☐ M ☐ F ☐ Transgender (M to F) ☐ Transgender (F to M)	Date of Birth (MM/DD/YY)
Preferred Language		Interpreter Needed? ☐ Yes ☐ No	U.S. Citizen? ☐ Yes ☐ No
Patient Race/Ethnicity – Select all that apply. ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ Other Is the patient Hispanic? ☐ Yes ☐ No		Type of Housing ☐ Own ☐ Subsidized ☐ Other Shelter ☐ Rent ☐ Transitional Housing ☐ Homeless ☐ Staying with Friends/Family	
Emergency Contact Name	Relationship to Patient	Emergency Contact Phone	

PARENT/GUARDIAN INFORMATION

Mother/Guardian Name		Mother/Guardian Email Address		
Mother/Guardian Address		City	State	ZIP
Mother/Guardian Primary Phone	Secondary Phone	Preferred Contact Method ☐ Mail ☐ Primary Phone ☐ Secondary Phone ☐ EZAccess Portal		
Father/Guardian Name		Father/Guardian Email Address		
Father/Guardian Address		City	State	ZIP
Father/Guardian Primary Phone	Secondary Phone	Preferred Contact Method ☐ Mail ☐ Primary Phone ☐ Secondary Phone ☐ EZAccess Portal		

INSURANCE & GUARANTOR INFORMATION

Primary Insurance	Policy #	Group #
Subscriber Name	Relationship to Patient	
Secondary Insurance (if applicable)	Policy #	Group #
Subscriber Name	Relationship to Patient	
Guarantor/Name of Person Responsible for Payment (if different from Subscriber)		
Address	City	State ZIP
Phone	Relationship to Patient	

Parent/Guardian Signature	Relationship to Patient	Date

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PEDIATRIC MEDICAL HISTORY

Patient Name	Date of Birth (MM/DD/YY)

MEDICAL HISTORY

Patient (Child)		Family	
Strep Throat	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Heart	☐ Yes ☐ No
Measles	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Ear Infections	☐ Yes ☐ No	Kidney	☐ Yes ☐ No
RSV	☐ Yes ☐ No	Liver	☐ Yes ☐ No
Croup	☐ Yes ☐ No	Mental Illness	☐ Yes ☐ No
Stomach Problems	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Mental Illness	☐ Yes ☐ No	Cataracts	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Headaches/Migraines	☐ Yes ☐ No
Cancer (Type: _____)	☐ Yes ☐ No	Cancer (Type: _____)	☐ Yes ☐ No
Other: _____	☐ Yes ☐ No	Other: _____	☐ Yes ☐ No

NUTRITION

Breast Fed?	☐ Yes ☐ No
Formula?	☐ Yes ☐ No Type: _____
Take Vitamins?	☐ Yes ☐ No
Taking Iron?	☐ Yes ☐ No

MEDICATIONS

Name of Medicine	Dosage	Times per Day

PREVENTIVE CARE

Date of last doctor visit: _____

Date of last dental visit: _____

Dentist's Name: _____

FAMILY HISTORY

Father: ☐ Living ☐ Deceased Age: _____
Cause of Death _____

Mother: ☐ Living ☐ Deceased Age: _____
Cause of Death _____

Siblings, How Many: ☐ Living _____ ☐ Deceased _____
Cause of Death _____

BIRTH HISTORY

☐ Vaginal Birth ☐ C-Section

Birth Weight _____ Birth Length _____

Place of Birth? _____

Pregnancy History: _____

Problems at Birth: _____

ALLERGIES

SURGERIES

Parent/Guardian Signature	Relationship to Patient	Date

List of Authorized Persons for Medical Purposes

I, _____, the parent or legal guardian of
Parent/Legal Guardian Name

_____, hereby authorize the individual(s)
Child's Name and Date of Birth

listed below to act as temporary guardian(s) for the purpose of bringing my child to True Health. These individuals have permission to bring my child into the clinic and consent to healthcare treatments and examinations in my absence. This authorization is valid for one year from the effective date unless otherwise specified in writing.

Name of Authorized Person	Relationship to Child

Parent/Guardian Signature	Relationship to Patient	Date

For Health Center Use Only		
Employee Signature	**Employee Title**	**Date**

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Sliding Fee Scale Agreement

Patient Name	Date of Birth (MM/DD/YY)

Uninsured patients may qualify for the sliding fee scale discount program at True Health. Eligibility for the sliding fee scale discount program is based on household income and family size. We require documentation to determine eligibility.

True Health reserves the right to review your tax return and/or wage statements upon request. Eligibility will be updated periodically depending on the type of documentation provided. If there are any changes in your income status or insurance eligibility prior to your scheduled update, please notify True Health immediately.

Please initial each statement in the space provided.

_____ *(initials)* I certify that the income and family information supplied on this form is true and correct to the best of my knowledge. I understand that if any of the information provided in this form has been falsified, this agreement will be canceled, and I will be responsible for the **FULL** cost of services. I understand this document will be maintained in my permanent medical record and that falsification of information may constitute a federal offense.

_____ *(initials)* I understand that the sliding fee scale is subject to change. I understand fees are subject to change depending on the level of service and/or procedures performed during the visit.

_____ *(initials)* I understand that payment is expected upon receipt of services.

_____ *(initials)* (If applicable) I have been informed and understand that if I do not supply proof of my income at my next visit, my category will be changed to a higher fee scale.

Patient/Guardian Signature	Relationship to Patient	Date

For Health Center Use Only

Income Verification	Income Source	Amount – Self	Amount – Spouse	Frequency
	☐ Paycheck Stubs – 3 Most Recent			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Social Security Benefits Determination			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Last Year's Income Tax Return			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Unemployment Compensation Statement			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Notarized Letter of Support			☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually
	☐ Other Income			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

Total Members in Household*: _____ **For 3 or more household members, please produce last year's tax return.*

☐ Your documented annual income is $_____. Your documented family size is _____.

Therefore, you qualify for the Sliding Fee Schedule noted below until _____.

☐ No proof of income presented – One-time exemption used. Indicate appropriate Sliding Fee Schedule below.

☐ SLIDE A	☐ SLIDE B	☐ SLIDE C	☐ SLIDE D	☐ SLIDE E	☐ SLIDE F

Employee Signature	Employee Title	Date

Authorization and Agreement for Treatment

Patient Name	Date of Birth (MM/DD/YY)

The undersigned hereby makes the acknowledgements and agreements regarding the treatment to be provided to the patient whose name appears on the Registration Form. The patient, guardian, or patient representative must initial all applicable items.

Consent for Treatment

_____ *(initials)* I certify that I am requesting examination and medical treatment of the patient by the physicians and employees of True Health via face-to-face visit and/or telehealth services. I give permission for evaluation and treatment and certify that no guarantee or assurance has been made as to the results that may be obtained. If the patient is a minor, I understand that a parent, legal guardian, or responsible adult must accompany the patient to the health center and stay with the patient throughout the entire examination.

Financial Agreement and Assignment of Benefits

_____ *(initials)* I acknowledge that I have received a copy of the True Health Financial Policy and that I agree to abide by its terms.

Patient's Bill of Rights and Responsibilities

_____ *(initials)* I acknowledge that I have received a copy of the True Health Patient's Bill of Rights and Responsibilities and that I agree to abide by its terms.

Notice of Privacy Practices

_____ *(initials)* I acknowledge that I have received a copy of True Health's Notice of Privacy Practices.

Release of Medical Information

_____ *(initials)* (If applicable) In addition to the use and/or disclosure of my protected health information (PHI) as stated above, I authorize my information to be released to the following individual(s). Please provide full name(s) of authorized individual(s) below. I understand that this request will not restrict the normal use or disclosure of PHI as stated above.

Name of Authorized Person	Relationship to Patient

_____ *(initials)* I understand that I may amend or revoke my consent to use and/or disclosure of PHI at any time, if submitted in writing. Use or disclosure that occurs prior to the date on which the revocation of consent is received will not be affected.

I have read and fully understand the above acknowledgments and agreements.

Patient/Guardian Signature	Relationship to Patient	Date

For Health Center Use Only		
Employee Signature	**Employee Title**	**Date**

Financial Policy

True Health is dedicated to providing high quality, comprehensive healthcare at a reasonable cost to everyone.

Financial Responsibility

Patients have financial responsibility to True Health for 100% of the charges for professional services rendered. True Health accepts Visa, MasterCard, Discover, and American Express, as well as personal checks, money orders, and cash. True Health will work with patients to ensure their medical care is the finest available and this care does not become a financial burden. This includes the use of payment plans to resolve medical bills from True Health.

In order to bill the patient's insurance company for healthcare costs, it is important that we obtain complete and accurate information about the patient's primary and supplementary insurance companies; including phone numbers, addresses, and a copy of the insurance card. If this information is not provided, the patient may be required to pay charges in full at the time of service. True Health may perform insurance verification at any time to obtain preauthorization for services or to determine eligibility for services rendered. Although we bill the patient's insurance company for services rendered, we are obligated to collect co-pays and deductibles from the patient at the time of service. It is the patient's responsibility to notify True Health when their insurance coverage information changes promptly. Any reimbursement from insurances that True Health is unable to obtain due to not having accurate insurance information at the time of the visit, the payment for the charges for services provides will become the responsibility of the patient.

Sliding Fee Scale Program

Uninsured patients may qualify for the sliding fee scale discount program at True Health. Eligibility for the program is based on household income and family size. Services are not denied due to inability to pay. In order to qualify for the discounted services, we require the following:

- One of the following documents for income verification: last 3 consecutive paycheck stubs, unemployment compensation statement, Social Security benefits determination, last year's income tax return (including 1099 or W-2), and/or a typed, notarized statement of income from employer or verification of other support.
- Photo ID

If the patient is unable to supply proof of income or has no income, a self-declaration is available. The Center Manager/Office Coordinator will counsel with the patient before using the self-declaration form to determine patient eligibility. Additional fees will be assessed for labs and/or other services provided during the office visit. If the patient fails to produce the required documents to qualify for the reduced-rate services according to the federal guidelines, the patient will not be placed on the slide scale and will be expected to pay full price.

Medicaid

We accept assignment from Medicaid so all payment from Medicaid will be made directly to True Health. We bill Medicaid directly.

Medicare

We accept assignment from Medicare so all payment from Medicare will be made directly to True Health. We bill Medicare and supplementary insurances directly. Because we are a Federally Qualified Health Center, the Medicare deductible is reduced for services obtained at our facilities.

Contracted Insurance

We contract directly with insurance companies through the physicians employed by our organization. All payment from insurance companies will be made directly to True Health. Patients enrolled in one of these companies will pay the co-pay and deductible fees that are predetermined by their insurance carrier. Some services may be deemed non-covered or medically unnecessary by the patient's insurance company. If so, the patient is directly responsible for the charges incurred. Any balance that remains unpaid after the insurance payment is received is due to True Health within 30 days.

Worker's Compensation

Worker's compensation cases are not accepted at any of our facilities. We ask that patients contact their employer for guidance regarding these services.

Non-Contracted Insurance

Patients who have policies with non-contracted insurance companies will be responsible for all office visits at the time of service. Such patients will be responsible for payment of all fees. Our fees are calculated based on the Medicare fee schedule.

Patient's Bill of Rights and Responsibilities

True Health believes the Patient's Bill of Rights and Responsibilities will contribute to more effective patient care. True Health recognizes service providers and clinical staff have certain responsibilities toward the patient and the patient has certain rights and responsibilities toward True Health.

Patient's Rights

1. *Information Disclosure:* Patients have the right to receive accurate and easily understood information to make informed decisions about their health plans and medical providers. Patients have the right to be informed of services available and their respective fees, as well as related charges for non-covered services for which the patient will be responsible. Patients have the right to be informed of the accreditation status of the health center, certification and years of practice of the medical providers, results of patient satisfaction surveys and quality of care studies, and complaints and appeal processes. Patients have the right to be informed about the organization's rules and regulations that apply to them. Patients have the right to be informed of any existing or potential relationship between True Health and other health/educational agencies or individuals participating in their health care.
2. *Choice of Providers and Plans:* Patients have the right to choose their healthcare provider to ensure access to high quality medical care. Patients have the right to access qualified specialists through our referral network. Patients have the right to choose health plans.
3. *Access to Emergency Services:* Patients have the right to access emergency services when and where the need arises. The health center will inform patients of the provisions for after-hours access to the medical providers and emergency coverage.
4. *Participation in Treatment Decisions:* Patients have the right to be informed by their medical provider of their diagnosis, treatment, and prognosis in easily understood terms; to be offered the opportunity to participate in planning their medical treatment and any specialist referrals; and to refuse participation in experimental research. Patients have the right to give informed consent prior to procedures.
5. *Respect and Non-Discrimination:* Patients have the right to be treated with consideration, respect, and full recognition of their dignity and individuality; to be free from mental and physical abuse; and to be free from physical restraints except as authorized in writing by a medical provider for a specific and limited period of time, or when necessary to protect the patient from injury to themselves or others. Patients have the right to receive the best available medical care regardless of age, sex, race, color, religion, language, economic status, disability, sexual orientation, or national origin.
6. *Confidentiality:* Patients have the right to privacy and confidentiality in all interactions with staff members and in their medical records. Medical records will only be released to other individuals or organizations with the patient's consent, except in cases required by law or third-party payment contracts.
7. *Complaints and Appeals:* Patients have the right to a fair and efficient process for resolving differences with their medical providers or True Health staff free from restraint, interference, coercion, discrimination, or reprisal. Complaints may be presented in person or in writing. Complaints that are clinical in nature will be handled by the Clinical Manager and/or Lead on site. Complaints concerning the pharmacy will be handled by the Pharmacist in charge. Complaints concerning the clerical or demographic staff will be handled by the Center Manager or Office Coordinator. A follow-up response will be given to the patient in a timely manner, either in person or via phone or written communication, from the Patient Service Coordinator or appropriate Director.
8. Patients have the right to receive information to assist them in preparing a document called an "Advance Directive." Patients have a right to have this Directive included in their electronic health record and any appropriate record releases per the patient's signed consent. True Health does not honor DNR (Do Not Resuscitate) Orders.

Patient's Responsibilities

1. Patients have the responsibility to follow the organization's rules and regulations.
2. Patients have the responsibility to report any changes in their medical condition.
3. Patients have the responsibility to let their medical provider know if they do not understand any aspect of their medical care.
4. Patients have the responsibility to participate in the decision-making processes regarding their medical care and to follow the treatment plans set up for them. This includes keeping appointments and/or cancelling in advance when necessary.
5. Patients have the responsibility to give truthful financial information, and to pay their bills in a timely manner.
6. Patients have the responsibility to advise us if they are dissatisfied with their care.
7. Patients have the responsibility to treat other patients and our staff with respect, consideration, and full recognition of their dignity and individuality.
8. Patients have the responsibility to respect and care for True Health property and facilities.

Patient-Centered Medical Home (PCMH)

The medical home encompasses five functions and attributes:

1. Comprehensive Care

The patient-centered medical home is accountable for meeting:

- A majority of each patient's physical and mental health care needs
- Prevention and wellness
- Acute care
- Chronic care

Providing comprehensive care requires a team of care providers. This team might include physicians, physician assistants, nurses, pharmacists, and care coordinators.

2. Patient-Centered

The patient-centered medical home provides health care that is relationship-based with an orientation toward the whole person.

- Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences.
- The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses.
- Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.

3. Coordinated Care

- The patient-centered medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports.
- Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital.
- Medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.

4. Accessible Services

The patient-centered medical home delivers accessible services with shorter waiting times for:

- Urgent needs
- Enhanced in-person hours
- Around-the-clock telephone or electronic access to a member of the care team
- Alternative methods of communication such as email and telephone care.

The medical home practice is responsive to patients' preferences regarding access.

5. Quality and Safety

The patient-centered medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as:

- Using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families
- Engaging in performance measurement and improvement
- Measuring and responding to patient experiences and patient satisfaction
- Practicing population health management

Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

Patient/Guardian Signature _____ Date _____

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: _____ Phone: (____) _____

Address: _____ Fax: (____) _____

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed**.

X_____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form**.

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

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Notice of Privacy Practices

HIPAA Officer: Anthony Diaz
(407) 322-8645 ext. 1149
Anthony.Diaz@mytruehealth.org
4930 E. Lake Mary Blvd.
Sanford, FL 32771

Your Information. Your Rights. Our Responsibilities.

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.**

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

➤ ***See page 2*** *for more information on these rights and how to exercise them*

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

➤ ***See page 3*** *for more information on these choices and how to exercise them*

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

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

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 correct your medical record	• You can ask us to correct 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 disclosures (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, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
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 make sure the person has this authority and can act for you 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 1. • 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 • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, 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 • Sale of your information • Most sharing of psychotherapy notes
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

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

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 the spread of communicable disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing serious threat to yourself and/or others' health and safety

Do research	• We can use or share your information for health research.
Comply with the law	• 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.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• 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	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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.

HIPAA Officer: Anthony Diaz • (407)322-8645 ext. 1149 • Anthony.Diaz@mytruehealth.org