

Four Seasons Pediatrics

532 Moe Road
Clifton Park, NY 12065
Phone: (518)383-2425
Fax: (518) 383-3255



Welcome

Thank you for contacting us. We appreciate the privilege of caring for your child and helping your family through the exciting years that are ahead of you. We are a small practice and our family will get to know your family well.

Enclosed are some registration forms and history forms. **It will save time if you fill these out ahead of your appointment and send or fax to us.** Please note, the following:

- Tab between fields to fill in information
- Please fill out forms completely
- You will see some fields that have a drop-down list available to choose. Please choose the appropriate selection by mouse or you can use the down arrow button on your computer
- **Please note, the PDF file is the preferred method of doing paperwork** and will save you a lot of time, as some fields are duplicates and the form will fill in other areas of the document where the same information is required.
- For siblings, please print out first child. Go back and change info for the new child and **just fill out and print information. Pages 5, 6 and 11 –14 are for you to keep (they are labeled “THIS PAGE FOR YOU TO KEEP”)**
- As the form requires a signature, please print it out, fax it (518) 383-3255 or mail it.

Directions to Four Seasons Pediatrics:

From the North:

Route 87 South to Exit 9 West. Take a right on to Route 146. Proceed to the intersection of Moe Road where there is a traffic light. Take a left onto Moe Road. Take the first driveway on the right into Pine Brook Office Park.

From the South:

Route 87 North to Exit 9. Take a left on to Route 146. Proceed to the intersection of Moe Road where there is a traffic light. Take a left onto Moe Road. Take the first driveway on the right into Pine Brook Office Park.

From the West:

Take Route 146 East to the first light AFTER Shenendehowa High School. Proceed to the intersection of Moe Road where there is a traffic light. Take a right onto Moe Road. Take the first driveway on the right into Pine Brook Office Park.

Thanks again and we look forward to seeing you soon.

Harry S. Miller, MD * Kimberly K. Elmer MD * Sara L. McCaffrey, MD * Carrie L. Roglieri, DO
Joyce Gillespie, RPA * Julianne Ashcroft, RPA

Patient Name: _____

Date of Birth: _____

Allergies: _____

Pediatric History Questionnaire

List Family:	Name	Birth	Date	Occupation	Employer
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
& Sisters	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Are the natural parents living together? _____

Birth History:

Delivery: _____ If Cesarean delivery, describe reason: _____

Birth Weight: _____ lbs _____ oz Group B Strep Cervical Culture: _____

Mothers Hepatitis B test was: _____ Mothers Rubella Status was: _____

Was your baby full term? _____ Discharge weight from hospital: _____ lbs _____ oz

What hospital was your baby born at? _____ Was the hearing test passed in the hospital? _____

Please list any problems in the nursery:

Past Medical History - please list all medical problems (place comma after each problem) and age of onset:

Past Surgeries – please list type and year:

Medications – please describe all medications currently taken:

Allergies – any allergy to food or medication; if yes please list medication and what reaction occurred:

Development – please list any developmental problems your child has had.

Family History – please check those that are positive and list relationship to PATIENT (e.g. paternal grandfather)

Alcoholism _____

Allergies (environmental, hay fever etc) _____

Anemia _____

Asthma _____

ADHD _____

Cancer _____

Cystic Fibrosis _____

Diabetes _____

Eczema _____

High Cholesterol _____

Hypertension _____

Kidney Disease _____

Mental Retardation _____

Heart attack, stroke (under 55 years of age) _____

Obesity _____

Seizures _____

Tuberculosis _____

Patient Name: _____

Date of Birth: _____

Allergies: _____

Other History:

Do you anticipate or are you currently using daycare for your child? _____

Was your house built before 1960? _____

Has anyone in the home ever smoked? _____

Does anyone currently smoke in (or outside) the home? _____

Please list your water district (e.g. Clifton Park Water Authority): _____

Provider Signature – Info reviewed and transferred into EMR

Date

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**PATIENT CONSENT FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS
Four Seasons Pediatrics**

Privacy Use: Patient Consent for Use and Disclosure of Protected Health Information

With this consent, Four Seasons Pediatrics may use and disclose protected health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (TPO). Please refer to Four Seasons Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent and acknowledge I have received a copy. Four Seasons Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Four Seasons Pediatrics Privacy Officer at 532 Moe Road, Clifton Park, NY 12065.

With this consent, Four Seasons Pediatrics may call my home, mail to my home, email me, or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to me/my child's clinical care, including test results and medical information.

Financial Policy: Agreement for Payment

Listing Four Seasons Pediatrics as Primary Care Provider (PCP): I understand that if Four Seasons Pediatrics is not listed as my/my child's PCP, that I am responsible to notify my insurance company to change to Four Seasons Pediatrics as my/my child's PCP. Failure to do so within the time frame required by my insurance company will make me responsible for the services rendered during any visits to Four Seasons Pediatrics.

Co-Payment is due at the time of the office visit. Failure to pay co-payment is subject to a co-pay surcharge (currently \$5, subject to change).

Monthly Statements will reflect the amount I owe to Four Seasons Pediatrics. Unpaid balances will have a **finance charge** (currently \$5 per month, subject to change).

No Show/Late Cancellation Charges: Four Seasons Pediatrics cannot bill the insurance for these charges, but are permitted by insurance companies to bill for them. We kindly ask for 24 hours notice if you are unable to come to an appointment previously made. Notifying us 24 hours in advance allows an appointment to be offered to others. Failure to give 24 hours notice to cancel an appointment previously made is subject to a **Late Cancellation** charge (currently **\$25**). Failure to show up for an appointment without notification is subject to a **No Show** charge (currently \$50). I understand that if I miss appointments, I will be asked to transfer records to another doctor and am still responsible for the balance owed.

Past Due Accounts: Accounts that are past due greater than 60 days are subject to being referred to a collection agency. Four Seasons Pediatrics will make every effort to inform me of this action. It is my responsibility to inform Four Seasons Pediatrics of any change in insurance, address, phone numbers or other information important to medical payments. Failure to notify Four Seasons Pediatrics of changes in

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address or insurance information; does not relieve my responsibility of any charges incurred that are not received by me due to wrong information that I have not updated with Four Seasons Pediatrics. Once accounts are turned over to collections, I understand that I will be responsible for late fees, and any collection costs incurred. If the account is turned over for legal action, I agree to pay all lawyers fees and court costs incurred by Four Seasons Pediatrics as a result of such action.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's (the parent who brings the child) responsibility to collect from the other parent.

Returned Checks: There is a fee (currently Four Seasons Pediatrics is charged \$32) that will be passed on to me for any checks returned by the bank for insufficient funds.

Transferring of Records: I will need to request, in writing, and pay a reasonable fee (currently \$0.75 per page or \$15 per family) if I want to have copies of my/my child's records sent to me, another doctor or organization. If I request a summary of my/my child's records, there is no charge for the first request made.

Waiver of Confidentiality: I understand that if this account is submitted to an attorney or collection agency, if Four Seasons Pediatrics has to litigate in court, or if my past due status is reported to a credit reporting agency, the fact that I received treatment at your office may become a matter of public record.

Fees: I understand that Four Seasons Pediatrics may reasonably adjust the above fees, from time to time based on fees incurred by Four Seasons Pediatrics, and that these fees are re-assessed on an annual basis.

I have received a copy of the Four Seasons Pediatrics **Patient Consent for Treatment, Payment and Healthcare Operations**, and understand the responsibilities of for me and Four Seasons Pediatrics.

I may revoke my consent in writing except to the extent that the practice has already made disclosures or provided services in reliance upon my prior consent. If I do not sign this consent, I understand that Four Seasons Pediatrics is under no obligation to provide treatment to me/my child.

I authorize the use of my signature for all my insurance submissions and to carry out activities related to treatment, payment and healthcare operations with all my insurance companies. I understand that I am responsible for any fees not covered by my insurance company, unless my insurance company prohibits billing for such services. I authorize payment directly to my doctor. I permit a copy of this authorization to be used in place of the original.

Please list all your children:

Please list both parents:

Patient Name

DOB

Mother Name

DOB

Patient Name

DOB

Father Name

DOB

Patient Name

DOB

Patient Name

DOB

Patient Name

DOB

Patient Name

DOB

Print Name of Responsible Person

Signature of Responsible Person

Date

IF MANAGED MEDICAID/CHILD HEALTH PLUS; PLEASE ALSO SIGN BELOW:

Managed Medicaid/Child Health Plus: Failure to name Four Seasons Pediatrics as PCP for any visit will make Me/My childrens' care to be viewed as an uncovered service delivered on a fee-for-service basis. As a Private Pay Patient, this and all other uncovered services are delivered on a fee-for-service basis. I will be responsible for the cost of these and all other uncovered services. I further understand that I may obtain medical care at no cost from another Provider that participates in my Managed Care Plan.

Print Name of Responsible Person

Signature of Responsible Person

Date

CONSENT BY PROXY FOR NON-EMERGENT PEDIATRIC CARE

For families who are ongoing patients of Four Seasons Pediatrics

THIS FORM IS TO AUTHORIZE SPECIFIC PEOPLE TO BRING YOUR CHILD FOR CARE – IT IS OPTIONAL

I (we) appoint the following people:

_____,
who is (are) my (our) child(ren)'s [please state relationship]:

as my (our) proxy decision maker for consenting to non-emergent medical care for my (our) children listed below. I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. I am advised that protected patient health information may be shared with the proxy to facilitate informed decision-making.

_____ Patient Name	_____ DOB
_____ Patient Name	_____ DOB
_____ Patient Name	_____ DOB
_____ Patient Name	_____ DOB
_____ Patient Name	_____ DOB
_____ Patient Name	_____ DOB

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "none."

Identify any limitations on the time frame for which this authorization is given. If none, state "none."

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health of my (our) children at the following telephone number (s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Contact Information:

Parent's Name: _____
Relationship: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

Parent's Name: _____
Relationship: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

Signed Parent or Legal Guardian Date

Signed Parent or Legal Guardian Date

Four Seasons Pediatrics, LLC * 532 Moe Road * Clifton Park, NY 12065

Today's Date: _____ **Family Last Name:** _____

Please list all children:

Name: _____ Middle Initial _____ DOB: _____ Sex: _____ Allergies: _____

Name: _____ Middle Initial _____ DOB: _____ Sex: _____ Allergies: _____

Name: _____ Middle Initial _____ DOB: _____ Sex: _____ Allergies: _____

Name: _____ Middle Initial _____ DOB: _____ Sex: _____ Allergies: _____

Name: _____ Middle Initial _____ DOB: _____ Sex: _____ Allergies: _____

Name: _____ Middle Initial _____ DOB: _____ Sex: _____ Allergies: _____

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

Main Phone #: _____ Is this # cell or home ? _____

Patients Primary Care Physician (as listed with Insurance company): _____

Mother's Maiden Name (**the child's/children's biological mother**): _____ Mother's DOB _____

Is English your family's primary spoken language? _____ If no list primary language _____

Race or Ethnicity: _____

Please list any vision or hearing issues (related to communication) _____

Please list your primary pharmacy (Location and/or phone number) _____

Parent contact numbers: (or legal guardian)

Name: _____ Relationship: _____

Work phone: _____ Cell: _____

Name: _____ Relationship: _____

Work phone _____ cell _____

E-mail address _____

Emergency Contact (other than parent) _____ Relationship to patient _____

Home # _____ Cell # _____

Insurance Information: Enter policy holder / subscriber information. If the patient is the policy holder (e.g. Fidelis - CHP) please list responsible party (parent/legal guardian) information here:

Policy Holder (or responsible party):

Last name: _____ First name: _____ Middle initial _____

DOB: _____ / _____ / _____ Sex: _____ SS#: _____

Address: **If address & phone is the same as patient just write 'same'**

Street: _____ City: _____ State: _____ Zip: _____

Home phone: _____

Employer: _____ Occupation: _____

Work phone: _____

Name of insurance: _____ Effective date: _____

Patient's policy #: _____ Group number: _____

Does your insurance require a copay? _____ If so what is the copay amount: \$ _____

Is there a secondary insurance? If yes, please provide information about 2nd policyholder:

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Street: _____

City: _____ State: _____ Zip: _____

Home Phone # _____

Email: _____

Employer: _____ Work Phone _____

Name of Insurance: _____ Policy Number: _____

Group Number: _____ Policy Effective Date: _____

Does your insurance require a copay? _____ If yes, what is your copay amount? _____

Please bring insurance Card(s) with you to all appointments, thank you.

THIS PAGE FOR YOU TO KEEP**FOUR SEASONS PEDIATRICS**
NOTICE OF PRIVACY PRACTICES
THIS IS YOUR FORM TO KEEP

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

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

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

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

- How we may use and disclose your IIHI
- Your privacy rights in regard to your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

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

Kimberly Elmer, MD; Privacy Officer
532 Moe Road
Clifton Park, NY 12065
518-383-2425

C. We may use and disclose your individually identifiable health information (IIHI) in the following ways:

1. Treatment. We might use your IIHI in order to order laboratory tests or write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

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

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- 4. Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
- 5. Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
- 6. Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
- 7. Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information, if you have consented to allow that person to seek care.
- 8. Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

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

- 1. Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
 - maintaining vital records, such as births and deaths
 - reporting child abuse or neglect
 - preventing or controlling disease, injury or disability
 - notifying a person regarding potential exposure to a communicable disease
 - notifying a person regarding a potential risk for spreading or contracting a disease or condition
 - reporting reactions to drugs or problems with products or devices
 - notifying individuals if a product or device they may be using has been recalled
 - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
 - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- 2. Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- 3. Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
- 4. Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
 - Concerning a death we believe has resulted from criminal conduct
 - Regarding criminal conduct at our offices
 - In response to a warrant, summons, court order, subpoena or similar legal process
 - To identify/locate a suspect, material witness, fugitive or missing person
 - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
- 5. Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
- 6. Organ and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

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- 7. Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.
- 8. Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- 9. Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- 10. National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
- 11. Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
- 12. Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

- 1. Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Dr. Kimberly Elmer, the Four Seasons Pediatrics Privacy Officer**; specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
- 2. Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Dr. Kimberly Elmer, the Four Seasons Pediatrics Privacy Officer**. Your request must describe in a clear and concise fashion:
- (a) the information you wish restricted;
 - (b) whether you are requesting to limit our practice's use, disclosure or both; and
 - (c) to whom you want the limits to apply.
- 3. Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Dr. Kimberly Elmer, the Four Seasons Pediatrics Privacy Officer**, in order to inspect and/or obtain a copy of your IIHI. Our practice will charge a fee of \$0.75 cents per page for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
- 4. Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Dr. Kimberly Elmer, the Four Seasons Pediatrics Privacy Officer**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and

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complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

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

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Dr. Kimberly Elmer, the Four Seasons Pediatrics Privacy Officer**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Dr. Kimberly Elmer, the Four Seasons Pediatrics Privacy Officer**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

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

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Dr. Kimberly Elmer, the Four Seasons Pediatrics Privacy Officer**.