TAMPA CHILDREN'S EYE CLINIC

A DIVISION OF FLORIDA PEDIATRIC ASSOCIATES, LLC

AUTHORIZATION AND CONSENT FOR TREATMENT

PLEASE REVIEW CAREFULLY AND ASK STAFF TO EXPLAIN TERMS THAT ARE UNFAMILIAR OR CONFUSING.
THEN, INITIAL APPLICABLE CONSENTS AND SIGN AT BOTTOM OF FORM

_____General Consent for Treatment

I consent for the medical care and treatment that includes a routine medical examination, diagnostic testing, immunizations (when indicated and provided by this office) and other medical services deemed necessary or advisable in the judgment of the physician or other practitioners providing care. I understand that certain aspects of care may be offered at a facility owned by the practice or treating physician, and if so, this information will be disclosed and alternative facilities identified. I understand that health care professional students may participate in my care under the supervision of an attending physician or other health care professional. I am aware that the practice of medicine (including surgery) is not an exact science and I acknowledge that neither the provider nor office staff has made any guarantee or assurance as to the results that may be obtained. I understand that the practice may refuse to provide care if I refuse to sign this consent or if, at any time, I choose to revoke this consent.

_____Consent for Electronic Prescriptions (E-Prescribing)

I voluntarily authorize E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a physician/patient relationship exists.

_____Consent for Identification Photograph *(applicable only if this office is using an electronic medical record).*

I consent to a patient photograph that will only be used for identification purposes and will be securely stored. Medical care will not be affected if I refuse to provide consent or withdraw my consent in the future.

_____Consent to Call

I understand and agree that the practice may need to contact me regarding appointments, preventative care, test results, treatment recommendations, outstanding balances, or any other communications from the medical group. These communications may include automated calls, emails, and text messaging sent to my landline and/or mobile device. I understand that I must voluntarily "opt-in" to receive automated text message communications from the practice and agreeing to additional Terms and Conditions as set forth by my mobile carrier.

_____Consent Testing in the Event of Healthcare Worker Exposure

I understand that in the event that a healthcare worker is accidentally exposed to a patient's blood or bodily fluids, the patient will be required to undergo a blood test to determine the presence of Hepatitis B or C surface antigen and/or Human Immunodeficiency Syndrome (HIV) antibodies. I understand that these tests are performed by withdrawing and testing a small amount of the patient's blood. I acknowledge that these tests may, in some instances, indicate that a person has been exposed to these viruses when the person has not (false positive) or may fail to detect that a person has been exposed to these viruses when the person actually has been exposed (false negative). If any test is positive, the practice will provide counseling about the meaning of these tests as it relates to patient healthcare. I understand that these test results will be kept confidential to the extent allowed by law and that unauthorized distribution of these test results is a criminal offense under state law.

The undersigned certifies that he/she read and understand this document and has the legal right and is duly authorized to provide consent for the initialed provisions as the patient or the parent or legal guardian of the patient.

Patient (print name): _____

Signature of patient or authorized person: _____

Relationship: _____ Date: _____

Tampa Children's Eye Clinic
A division of Florida Pediatric Associates, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES &

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that as part of my healthcare, the practice creates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment. I understand that this information serves as a:

- Basis for planning my care and treatment
- Means for communication among health professionals who contribute to my care, such as referrals
- Source of information for applying my diagnosis and treatment information to my bill
- Means by which a third-party payer can verify that services billed were actually rendered
- Tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I acknowledge that I have been provided with a "*Notice of Patient Privacy Practices"* that provides a more complete description of information uses and disclosures and of my privacy rights. I understand that I have the right to:

- Review the "*Notice*' prior to acknowledging this consent
- Restrict or revoke the use or disclosure of my health information for other uses or purposes
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, of healthcare operations.

I understand that as part of treatment, payment or health care operations, it may become necessary to disclose health information to another entity, e.g. referrals to other health care providers. I understand that my information may be used or disclosed, without an authorization, as permitted or required by law.

I hereby permit and authorize the practice to discuss my/the patient's protected health information (PHI) with the individuals listed below including that may accompany me/the patient to this office for medical evaluation or treatment. Authorized individuals must present positive identification in person or state my passcode if communicating by phone. I understand that I may contact this office to edit or rescind this authorization at any time.

Passcode to be used by authorized indiviuals:_____

Name:_____Relation:_____ Phone:_____

Name:_____Relation:_____ Phone:_____

The undersigned certifies that he/she read and understand this document and has the legal right and is duly authorized to execute this document and accepts its terms as the patient or the parent or legal guardian of the patient.

Patient (print name): _____

Signature of patient or authorized person: _____

Relationship: _____ Date: _____

TAMPA CHILDREN'S EYE CLINIC

A DIVISION OF FLORIDA PEDIATRIC ASSOCIATES, LLC

NOTICE OF PATIENT FINANCIAL RESPONSIBILITY & RELEASE OF INFORMATION

PLEASE REVIEW CAREFULLY AND ASK STAFF TO EXPLAIN TERMS THAT ARE UNFAMILIAR OR CONFUSING. SIGNATURE IS REQUIRED.

Statement of Financial Responsibility
I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. In consideration of services rendered to the patient named herein, I agree to be financially responsible and to pay charges for all services ordered by the provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account may be referred to a collection agent and/or attorney, and I agree to pay all collection related charges. I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plans provisions. I understand that failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

Assignment of Benefits
I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Florida Pediatric Associates for any medical services provided to me by that organization.

Release of Medical Information
I understand that Florida Pediatric Associates, its business associates, any treating physician/surgeon and/or my insurance company may obtain, use and/or disclose information for the purposes of treatment, payment and normal health care operations. This use and disclosure may include collection agencies and credit bureaus. Information may include psychiatric, drug abuse, alcohol and/or HIV status. I understand that if I do not consent to release of information for payment purposes, the Florida Pediatric Associates and other health care providers will be unable to bill my insurance company or other party which is or may be responsible for payment for the services documented by the withheld information, and I will be billed directly for these services. Patients with implantable devices consent to the release of their Social Security numbers to the device manufacturer to comply with the Safe Medical Devices Act. For a more detailed description of uses and disclosures for treatment, payment or normal health care operations, review Florida Pediatric Associates Notice of Privacy Practices. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization. I acknowledge that I have received information regarding my rights to privacy of information under HIPAA regulations, as described in the Florida Pediatric Associates Notice of Privacy Practices.

Notice of Unauthorized, Non-Covered, or Out of Plan Services
I am aware that some services performed by Florida Pediatric Associates may be considered "non-covered" by my insurance carrier or Medicare. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that if my insurance plan does not consider any service rendered a covered service or if my insurance plan has not authorized this service, they will not pay for the service rendered during this outpatient visit. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge. I am responsible for the entire bill or balance of the bill as determined by the practice and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Waiver of "Usual, Customary and Reasonable" Clauses - (*For patients with "Out-of-Network" coverage).*
I acknowledge that the fee charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable," due to specialized services and staff. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

For Medicare Recipients Only
I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Practice for any services furnished to me by Practice physician or other provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

The undersigned certifies that he/she read and understand this document and has the legal right and is duly authorized to execute this document and accepts its terms as the patient or the parent or legal guardian of the patient.

Patient (print name): _____

Signature of patient or authorized person: _____
Relationship: _____ Date: _____

TAMPA CHILDREN'S EYE CLINIC

A DIVISION OF FLORIDA PEDIATRIC ASSOCIATES, LLC

PAYMENT POLICY

PLEASE REVIEW CAREFULLY AND ASK STAFF TO EXPLAIN TERMS THAT ARE UNFAMILIAR OR CONFUSING. SIGNATURE IS REQUIRED.

Thank you for choosing us for your healthcare needs. Our relationship is best served when expectations are clearly understood. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we developed this payment policy to help you better understand your financial responsibilities in relation to the medical care we provide. We ask that you read the policy, ask any questions you may have and sign your name in the Acknowledgement section. A copy will be provided to you upon request.

All patients must provide us with valid identification (driver's license) and a current and valid copy of your primary (and secondary if applicable) insurance card(s) to provide proof of insurance. We do our best to confirm your insurance eligibility and determine what amounts you will owe prior to your visit, but sometimes that amount changes depending on the scope of services actually provided.

Our policy is to collect amounts due from patients, including co-payments, deductibles and co-insurance amounts on the same day that services are rendered unless other arrangements have been made in advance. The practice accepts cash, personal checks, debit and credit card payments although additional fees will apply if a personal check is denied for insufficient funds**.** The practice reserves the right to deny non-urgent care to patients that refuse to manage his or her responsibility.

Insurance
Our practice is contracted with most insurance companies including Medicaid and Medicare and we will submit claims to those companies on your behalf. Insurance plans may restrict the type and/or number of services covered and/or the number or type of eligible providers. Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you may have regarding your coverage and confirm that our doctors participate with your insurance plan, whether or not a primary care referral or insurance authorization is required, and that the services you require are actually covered by your health plan. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.
If we are not contracted with your insurance company, payment for all services is expected at the time of service. As a courtesy, we will submit claims to your insurance company. If you do not have insurance coverage, payment for all services is expected at the time of service.

Co-payments and deductibles
All co-payments deductibles and co-insurance amounts required by your insurance company must be paid at the time of service without exception.

Non-covered services.
Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance plan. You must pay for these services in full at the time of visit. Refractions are not covered by insurance. If a refraction is done at the date of service, the fee is $50.00 will be due same day.

Claims submission.
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes.
If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Nonpayment.
Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and may be discharged from this practice.

Missed appointments.
You may be charged a fee for missed appointments not canceled at least one day in advance. These charges will be your responsibility and billed directly to you. Please verify what this office charges for missed appointments fee with the Front Desk or office manager. Please help us to serve you better by keeping your regularly scheduled appointment. Excessive missed appointments will result in discharge from the practice.

Minor Patients
The adult accompanying a minor and/or the parent(s) (or guardian(s) of the minor) is responsible for payment at the time of service. Non-emergency treatment for unaccompanied minors will be denied unless payment arrangements have been made in advance.

Medical Records
We do not charge for sending medical records to another health care provider. If you request a hard copy of your medical record there will be $1.00 per page charge for the first 25 pages, and $.25 for each additional page.

Billing Questions
If you have a billing related question please contact Fountainhead Practice Management Solutions, LLC,727-456-3288.

The undersigned certifies that he/she read and understand this document and has the legal right and is duly authorized to execute this document and accepts its terms as the patient or the parent or legal guardian of the patient.

Patient (print name): _____
Signature of patient or authorized person: _____
Relationship: _____ Date: _____

FLORIDA PEDIATRIC ASSOCIATES, LLC

Tampa Children's Eye Clinic and Surgery

a Division of Florida Pediatric Associates

NOTICE OF PRIVACY PRACTICES - EFFECTIVE DATE JANUARY 1, 2024

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will remain in effect until it is amended or replaced by us.

We reserve the right to revise or amend this Notice of Privacy Practices provided law permits the changes. Any revision or amendment to this notice will be effective for all health information maintained, created and/or received by us before the date changes were made and for any health information 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, and you may request a copy of our most current Notice at any time. You may request a copy of our Privacy Notice at any time by contacting the manager of this office or by contacting our Compliance Office.

For questions regarding this notice, please contact the Florida Pediatric Associates Compliance Office at:
1800 Dr. Martin Luther King Jr. Street North
St. Petersburg, FL 33704
Phone: (866) 635-8765
E-mail: icomply@floridapediatrics.com

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of:

- Florida Pediatric Associates, LLC (FPA).
- Any health care professional authorized to enter information into your medical record maintained by FPA.
- Any persons or companies with whom FPA does business, e.g., "Business Associates."
- All these persons, entities, sites, and locations follow the terms of this notice. In addition, these persons, entities, sites, and locations may share medical information with each other for treatment, payment, or health care operations purposes and other purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from FPA. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the paper and/or electronic records of your care and billing for that care (collectively your Protected Health Information or PHI) generated or maintained by FPA, whether made by FPA personnel or other health care providers. Other health care providers may have different policies or notices about confidentiality and disclosure that apply to your PHI that is created in their offices or at locations other than FPA.

This notice will tell you about the ways in which we may use and disclose PHI about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your PHI. We are required by law to:

- Make sure that PHI that identifies you is kept private
- Give you this notice of our legal duties and privacy practices of FPA, and your legal rights, with respect to PHI about you
- Follow the terms of the notice that is currently in effect

HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU

The following categories describe different ways that we use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

- **For Treatment**. We may use PHI about you to provide you with medical treatment or services. We may disclose PHI about you to doctors, nurses, technicians, medical students, volunteers, or other personnel who are involved in taking care of you at FPA. For example, a doctor treating you for a broken hip may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose PHI about you to people outside FPA who may be involved in your medical care after you have been treated by FPA, such as friends, family members, or employees or medical staff members of any hospital or skilled

nursing facility to which you are transferred or subsequently admitted.

- **For Payment**. We may use and disclose PHI about you so that the treatment and services you receive from FPA may be billed by FPA and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment you received from FPA so your health plan will pay us or reimburse you for the treatment. We also may disclose information about you to another health care provider, such as a hospital or skilled nursing facility to which you are admitted, for their billing activities concerning you.
- **For Health Care Operations**. We and our business associates may use and disclose PHI about you for health care operations. These uses and disclosure are necessary to operate FPA and make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine PHI about many patients to decide what additional services FPA should offer, and what services are not needed. We may also disclose information to doctors, nurses, technicians, and other personnel affiliated with FPA for review and learning purposes. We may also combine the PHI we have with PHI from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of PHI so others may use it to study health care and health care delivery without learning the identities of specific patients. We also may disclose information about you to another health care provider for its health care operations purposes if you also have received care from that provider.
- **Treatment Alternatives**. We may use and disclose PHI to inform you of potential treatment options or alternatives; or communicate with you regarding the scheduling, ordering or results of tests.
- **Appointment Reminders.** We may use and disclose your PHI to contact you and remind you of an appointment.
- **Health Related Benefits and Services.** Most uses and disclosures of for marketing purposes, and disclosures that constitute sale of protected health information require authorization.
- **Individuals Involved in Your Care or Payment for Your Care**. We may release PHI about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for some or all of your care. In addition, we may disclose PHI about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.
- **Individuals that Assist with Your Child's Care**. We may disclose PHI to individuals that assist with your child's care (e.g. a babysitter, family friend, or relative) provided that the parent has provided us the names of those individuals that we are permitted to disclose PHI and provided that the individual accompanying your child presents a valid picture identification upon arrival to our office.
- **As Required or Permitted by Law**. We may disclose PHI about you when required or permitted to do so by federal, state, or local law such as for law enforcement purposes, suspected abuse or neglect reporting, health oversights or audits, funeral arrangements, organ donation, public health purposes or in the case of a medical emergency.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose PHI about you when it appears necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone who appears able to help prevent the threat and will be limited to the information needed.

SPECIAL SITUATIONS

- **Organ and Tissue Donation**. If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- **Active Duty Military Personnel and Veterans**. If you are an active duty member of the armed forces or Coast Guard, we must give certain information about you to your commanding officer or other command authority so that your fitness for duty or for a particular mission may be determined. We may also release PHI about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Department of Veterans Affairs PHI about you to determine whether you are eligible for certain benefits.
- **Workers' Compensation**. In accordance with state law, we may release without your consent PHI about your treatment for a work-related injury or illness or for which you claim workers' compensation through your employer, insurer, or care manager paying for that treatment under a workers' compensation program that provides benefits for work-related injuries or illness.
- **Public Health Risks**. We may disclose, without your consent, PHI to public health authorities that are authorized by law to collect information for the purpose of activities that generally include but are not limited to the following:
    - To report, prevent, or control disease, injury, or disability
    - To report births and deaths
    - To report reactions to medications or problems with products
    - To notify people of recalls of products they may be using

- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To report suspected abuse or neglect as required by law
- To report child abuse or neglect
- To prevent or control disease, injury or disability
- To notify a person regarding potential exposure to a communicable disease
- To notify a person regarding a potential risk for spreading or contracting a disease or condition
- To report reactions to drugs or problems with products or devices
- To notify individuals if a product or device they may be using has been recalled

- **Health Oversight Activities**. We may disclose, without your consent, PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. The government uses these activities to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we must disclose PHI about you in response to a court or administrative order. We also may disclose PHI about you in response to a subpoena or other lawful process from someone involved in a civil dispute.
- **Law Enforcement**. We may release, without your consent, PHI to a law enforcement official:
    - In response to a court order, warrant, summons, grand jury demand, or similar process
    - To comply with mandatory reporting requirements for violent injuries, such as gunshot wounds, stab wounds, and poisonings
    - In response to a request from law enforcement for certain information to help locate a fugitive, material witness, suspect, or missing person
    - To report a death or injury we believe may be the result of criminal conduct
    - To report suspected criminal conduct committed at FPA facilities

- **Coroners and Medical Examiners**. We may release, without your consent, PHI to a coroner or medical examiner. This may be done, for example, to identify a deceased person or determine the cause of death. We may also release PHI about deceased patients of FPA to funeral directors to carry out their duties.
- **National Security and Intelligence Activities**. We may release, without your consent, PHI about you as required by applicable law to authorized federal or state officials for intelligence, counterintelligence, or other governmental activities prescribed by law to protect our national security.
- **Protective Services for the President and Others**. We may disclose PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.
- **Psychotherapy Notes**. Regardless of the other parts of this Notice, psychotherapy notes will not be disclosed outside FPA except as authorized by you in writing or pursuant to a court order, or as required by law. Psychotherapy notes about you will not be disclosed to personnel working within FPA, except for training purposes or to defend a legal action brought against FPA, unless you have properly authorized such disclosure in writing.
- **Inmates**. If you are an inmate of a correctional institution or in the custody of law enforcement, we may release PHI about you to the correctional institution or law enforcement official who has custody of you, if the correctional institution or law enforcement official represents to FPA that such PHI is necessary: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) to protect the safety and security of officers, employees, or others at the correctional institution or involved in transporting you; (4) for law enforcement to maintain safety and good order at the correctional institution; or (5) to obtain payment for services provided to you. If you are in the custody of the [Name of State] Department of Corrections (DOC) and the DOC requests your medical records, we are required to provide the DOC with access to your records.

YOUR RIGHTS REGARDING PHI ABOUT YOU

You have the following rights regarding PHI we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and receive a copy of your medical records, unless your attending physician determines that information in those records, if disclosed to you, would be harmful to your mental or physical health. If we deny your request to inspect and receive a copy of your PHI on this basis, you may request that the denial be reviewed. Another licensed health care professional chosen by FPA will review your request and the denial. The person conducting the review will not be the person who denied your request. We will do what this reviewer decides.

  If we have all or any portion of your PHI in an electronic format, you may request an electronic copy of those records or request that we send an electronic copy to any person or entity you designate in writing.

  Your PHI is contained in records that are the property of FPA. To inspect or receive a copy of PHI that may be used to make decisions about you, you must submit your request in writing to the manager or administrator of the applicable FPA office. If you

request the copy of the information, **we may charge a fee** for the costs of copying, mailing, or other supplies associated with your request, and we may collect the fee before providing the copy to you. If you agree, we may provide you with a summary of the information instead of providing you with access to it, or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay and will collect the fees, if any, for preparing the summary or explanation.

- **Right to Amend**. If you feel that PHI we have about you in your record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for FPA.
  To request an amendment, you must submit your request in writing to the manager or administrator of the applicable FPA office. Your written request must include a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
  - Is not part of the PHI created or maintained by FPA
  - Is not part of the information that you would be permitted to inspect and copy
  - Has been determined to be accurate and complete

  If we deny your request for an amendment, you may submit a written statement of disagreement and ask that it be included in your medical record.
- **Right to an Accounting of Disclosures**. You have the right to request a list of certain disclosures we have made of PHI about you during the past six years. To request this list or accounting of disclosures, you must submit your request in writing to the manager or administrator of the applicable FPA office and state whether you want the list delivered on paper or electronically. Your requested time period may not be longer than six years. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We may collect the fee before providing the list to you.
- **Right to Request Restrictions**. Except where we are required to disclose the information by law, you have the right to request a restriction or limitation on the PHI we use or disclose about you. For example, you could revoke any and all authorizations you previously gave us relating to disclosure of your PHI. **We are not required to agree to your request,** with the exception of restrictions on disclosures to your health plan, as described below. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
  To request restrictions, you must submit your request in writing to the manager or administrator of the applicable FPA office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

  You may request that we do not disclose your PHI to your health insurance plan for some or all of the services you receive during a visit to any FPA location. If you pay the charges for those services you do not want disclosed **in full at the time of such service**, we are required to agree to your request. "In full" means the amount we charge for the service, not your copay, coinsurance, or deductible responsibility when your insurer pays for your care. Please note that once information about a service has been submitted to your health plan, we cannot agree to your request. If you think you may wish to restrict the disclosure of your PHI for a certain service, please let us know as early in your visit as possible. This requirement does not apply to disclosures for treatment, such as disclosures to a referring physician for continuation of care. This office is required to comply with any requests that limit disclosures to a health plan when the service has been paid out-of-pocket and in full by the patient. Such restrictions do not override disclosures that are otherwise required by law. Additionally, if initial payment for services, that have a request for restriction applied to them, is returned or invalid; our office will make a good faith attempt to collect payment – if this is unsuccessful we have the right to then submit a claim for these services to the health plan.
- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, or at another mailing address other than your home address. We will accommodate all reasonable requests. We will not ask you the reason for your request. To request confidential communications, make your request in writing to the Privacy Officer and specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice or any revised notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may request a copy of our Privacy Notice at any time by contacting the manager of this office or by contacting our Compliance Office.

MINORS AND PERSONS WITH LEGAL GUARDIANS:
Minors and certain disabled adults are entitled to the privacy protection of their health information. Because, by law, they cannot make health decisions for themselves, a parent or guardian can make medical decisions on their behalf. Therefore, parents and guardians can authorize the use and release of PHI and also hold all rights listed in this notice or the behalf of the minor child or disabled adult.

Under certain situations defined by law, minors can make independent healthcare decisions without parent or guardian knowledge or consent. In those situations, the minor may hold all rights listed in this notice. If the minor chooses to inform the parent or guardian, then all privacy rights regarding PHI may transfer to the parent or guardian. There are also certain situations where access, use or release of a minor's PHI may occur without the consent of the parent or guardian, i.e. when the health or safety of the minor is in danger and PHI is necessary to protect the minor.

OTHER USES OF PHI

Other uses and disclosures of PHI not covered by this notice may be made only with your written authorization or as required by law. If you authorize us to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. Your revocation will be effective as of the end of the day on which you provide it in writing to the administrator or manager of this office. If you revoke your permission, we will no longer use or disclose PHI about you for the purposes that you previously had authorized in writing. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current notice at each FPA office. The notice will contain the effective date on the first page, in the top right-hand corner. If the notice changes, a copy will be available to you upon request.

INVESTIGATIONS OF BREACH OF PRIVACY

We will investigate any discovered unauthorized use or disclosure of your PHI to determine if it constitutes a breach of the federal privacy or security regulations addressing such information. If we determine that such a breach has occurred, we will provide you with notice of the breach and advise you what we intend to do to mitigate the damage (if any) caused by the breach, and about the steps you should take to protect yourself from potential harm resulting from the breach.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with FPA or with the Secretary of the United Stated Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

To file a complaint with FPA, contact the Florida Pediatric Associates Compliance Office at:
1800 Dr. Martin Luther King Jr. Street North
St. Petersburg, FL 33704
Phone: (866) 635-8765
E-mail: icomply@floridapediatrics.com