

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 individuals: _____

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: _____

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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: _____

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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: _____

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NOTICE OF PRIVACY PRACTICES

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

Updated January 13, 2026

OUR COMMITMENT TO YOUR PRIVACY

Thank you for visiting a division of Florida Pediatric Associates, LLC (collectively referred to as "Florida Pediatric Associates", "we," or "us"). Florida Pediatric Associates is dedicated to maintaining the privacy of your/your child's health information. We are required by law to maintain the confidentiality of your/your child's health information, provide you with this Notice of our legal duties and the privacy practices that we maintain concerning your/your child's health information, and to notify you of a breach of your unsecured health information. We are required to follow the terms of this Notice that are in effect at the time.

Applicability and Changes to this Notice. The terms of this Notice apply to all records containing your/your child's health information that are created or retained by us. This Notice will be followed by all divisions of Florida Pediatric Associates, health care professionals, employees, medical staff, and other individuals providing services at Florida Pediatric Associates. A complete list of our current division locations at the following website address: <https://floridapediatrics.com/associates/>. We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will be effective for all of your medical records that we have created or maintained in the past, and for any of your records that we may create or maintain in the future. We will post a current copy of this Notice on our website. You may also request a copy of the current Notice at any time by reaching out to us at the contact information provided at the end of this Notice.

YOUR RIGHTS

When it comes to your/your child's health information, you have certain rights. This section explains your rights and some of our responsibilities to help you exercise those rights.

Right to Inspection and Copies. You have the right to get an electronic or paper copy of your/your child's medical records, billing records, and other records maintained by us that are used to make decisions about you/your child. This right does not include psychotherapy notes or health information that is not part of your designated record set. To obtain copies or request inspection of your/your child's health information, or request that we send such records to a third party, we require that you submit your request in writing to the manager or administrator at the Florida Pediatric Associates location where you/your child is receiving treatment (unless a reasonable accommodation is needed). We may charge a reasonable fee that will be in compliance with applicable law. We may deny your request to inspect and/or copy your/your child's medical records only in limited circumstances. If your request is denied, in some instances you may request a review of our denial. Another licensed health care professional chosen by us will conduct such reviews and we will follow their findings.

Right to Request an Amendment. You can ask us to correct your/your child's health information if you believe it is incorrect or incomplete for as long as we have the information. To request an amendment, your request must be made in writing and submitted to the Privacy Officer whose contact information is included at the end of this Notice. Please provide us with a reason that supports your request for amendment. If we agree to the amendment request, we will notify you and amend your/your child's health information. Please note that we cannot delete information contained in medical records and the change requested by you will be made as an addendum to the existing record. In certain circumstances, we may deny your request. If your request is denied, we will inform you in writing and explain your rights.

Right to an Accounting. You can ask for a list ("accounting") of the times we've shared your/your child's health information for six years prior to the date of your request, 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 will provide one accounting per calendar year for free but may charge a reasonable, cost-based fee if you ask for another

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one before the next calendar year. To request an accounting, submit your request in writing to the Privacy Officer whose information is contained at the end of this Notice.

Right to Request Restrictions. 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 we agree to your request, our agreement will be in writing, and we will comply with the restriction unless the information is needed to provide you with emergency care or we are required or permitted by law to disclose it. 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.

Right to 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 agree to all reasonable requests. To request a type of confidential communication, you must make a written request to the Privacy Officer (see contact information at the bottom of this Notice) specifying the requested method of contact for billing purposes, or the location where you wish to be contacted. You do not need to give a reason for your request.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of this Notice at any time, even if you agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us by contacting the Privacy Officer whose contact information is included at the end of this Notice. All complaints must be submitted in writing, unless a reasonable accommodation is needed. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

Right to a Personal Representative. Personal Representatives (including parents and legal guardians) can exercise the rights described in this Notice. If you have given someone the legal authority to exercise your rights and choices covered by this Notice, we will honor such requests once we verify their authority. This Notice also applies to minors, disabled adults, or others that are not able to make health care decisions for themselves and individuals that choose to designate someone to act on their behalf. There are also some situations under State Law where prior authorization of a minor patient is required before certain actions can be taken related to their health information. We comply with applicable State Laws related to the confidentiality of information related to minors.

YOUR CHOICES

In some cases, you can tell us your choices about what health information we share, and who we share it with.

Family Members & Friends. We may disclose you/your child's health information to individuals who you have chosen to involve in your/your child's medical care unless you object. For example, if you have involved your child's caretaker in your child's medical appointments, the caretaker may have access to your child's health information unless you object. We may also share your/your child's information when needed to lessen a serious and imminent threat to health or safety.

Disaster Relief. Subject to any additional limitations under State Law, in the event of a disaster we may disclose your/your child's health information to organizations assisting in disaster relief efforts unless you tell us not to, and that decision will not interfere with our ability to respond in emergency circumstances.

Disclosures Requiring Your Authorization. Uses and disclosures that are not identified by this Notice will be made only with your written authorization. Certain types of sensitive information are afforded additional protections under Federal and State Laws and with limited exceptions, will be made only with your written authorization. We will never sell or use your/your child's health information for marketing purposes without your authorization. Most uses and disclosures of psychotherapy notes require your prior authorization. Any authorization you provide to us regarding the use and disclosure of your/your child's health information may be revoked at any time by notifying us in writing. After you revoke your authorization, we will no longer

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use or disclose your/your child's health information for the reasons described in the authorization. However, uses and disclosures made before we receive the revocation will not be affected as we cannot take back any disclosures already made.

Fundraising. We may contact you for fundraising efforts, but you will be given an opportunity to opt-out of further fundraising communications. You may also notify us your intent to opt-out at any time by contacting the Privacy Officer whose information is included at the bottom of this Notice.

USES & DISCLOSURES OF YOUR INFORMATION

We may use or share your/your child's health information in the following ways.

Treatment. We may use your/your child's health information as needed to provide you with medical treatment and share it with other health care professionals who are treating you/your child. For example, we may use and disclose your/your child's health information to order laboratory tests or prescriptions, to assist other health care providers in their treatment of you/your child, or to inform you of potential treatment alternatives or programs.

Payment. We may use and disclose health information to bill and collect payment for the services and items provided by us. For example, we may share your/your child's health information with your health insurance plan so it will pay for the services provided. We may also disclose your/your child's health information with other health care providers to assist in their billing and collection efforts.

Health Care Operations. We may use and disclose your/your child's health information to operate our practice, improve your/your child's care, and contact you when necessary. For example, we may use or disclose your/your child's health information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities. In some circumstances, and subject to any additional restrictions under State Law, we may also share health information with other health care providers for their health care operations.

Health Information Exchanges. We may participate in one or more Health Information Exchanges ("HIE"). HIEs allow health care entities participating in the same HIE to quickly share health information as necessary to support timely care coordination and quality health care. For example, your/your child's health information related to a recent hospital visit may be shared via a HIE with us so that we can promptly coordinate necessary follow-up treatment with you. If we participate in a HIE, we will follow applicable State Law related to consent and/or opt-out requirements.

Research. If the location where you/your child receives health care services from us participates in clinical research, we may use or share your/your child's health information for research purposes and medical records may be reviewed to determine whether you/your child may be eligible to participate in certain research studies, subject to the requirements of applicable laws. We have to meet many conditions under applicable law before we can use or share your/your child's information for research purposes, including for example, ensuring your/your child's identity is protected, obtaining approval from an institutional review board, maintaining appropriate security controls, and/or obtaining prior authorization from you, as applicable.

OTHER USES & DISCLOSURES

Public Health & Safety. Subject to certain conditions and requirements under applicable law, we can share your/your child's health information for preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

Compliance with Law. We will share your/your child's health information if state or federal laws require it, including with the Department of Health and Human Services for the purpose of confirming our compliance with federal privacy laws.

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Organ & Tissue Donation Requests. Subject to applicable State Law and where applicable, we may share your/your child's health information with organ procurement organizations.

Medical Examiners and Funeral Directors. We may share health information with a coroner, medical examiner, or funeral director when an individual dies when needed to fulfill their legal obligations under State Law.

Workers' Compensation. We may release your/your child's health information for workers' compensation and similar programs subject to the requirements of State Law.

Law Enforcement & Other Government Requests. We may share health information for law enforcement purposes or with law enforcement officials when permitted by law. We may also share health information with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

Court Orders and Subpoenas. We can share your/your child's health information in response to a court or administrative order, or in response to a subpoena. We will comply with applicable State Laws when certain information is afforded additional protections.

Redisclosure. Health information disclosed pursuant to the HIPAA Privacy Rule may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.

Substance Use Disorder ("SUD Records"). SUD Records are afforded additional protection under state and federal laws and may be subject to stricter limitations than those described in this Notice. If we receive SUD Records, we will not use or disclose SUD Records in civil, criminal, administrative, or legislative proceedings against you/your child unless we have your written consent, or a court order after notice and an opportunity to be heard is provided to the you or the holder of the record. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the SUD Record is used or disclosed.

Electronic Communications Not Secure. We provide mechanisms that can be used by you to communicate with us via secure electronic messaging platforms. Using any unsecure electronic communication methods (such as regular email) to communicate with us can present risks to the security of information. These risks include possible interception of information by unauthorized parties, misdirected emails, shared accounts, message forwarding, or storage of the information on unsecured platforms and/or devices. We do not recommend communicating with us via unsecured email or text message. We recognize, however, that there may be times when you choose to communicate with us using unsecure email or standard text messaging for convenience purposes. If you provide us with an email address or mobile phone number, we may communicate with you using unsecured text or email related to general information or reminders. You will be provided with an opportunity to opt-out of these communications and can also opt-out at any time by notifying us at the contact information included below, but acknowledge that it may take systems time to apply the update (and you agree to disregard any messages received prior to the completion of your opt-out request). By choosing to correspond with us via unsecure electronic communication platforms, you acknowledge and accept the risks involved with unsecure electronic communications and understand that you are responsible for any charges applied by your telecommunications carrier. The use of any form of electronic messaging is not appropriate for medical emergencies.

Question & Concerns. If you have any questions about this Notice or would like to notify us of a privacy concern, please contact:

Compliance Officer
Florida Pediatric Associates, LLC
1800 Dr. Martin Luther King Jr. Street North
St. Petersburg, FL 33704

Email: icomply@floridapediatrics.com
Phone: (866)-635-8765