CHESTERFIELD PEDIATRICS

REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____

Address: _____ Suite/Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

May leave message at: □ Home □ Work □ Cell Email address (age 18 and up): _____

Gender: □ F □ M DOB: ___/___/_____ Preferred Language: _____ Hospital Born: _____

Race/Ethnicity: □ American Indian | □ Black/African American | □ Hispanic/Latino | □ Native Hawaiian | □ White | □ Asian | □ Other

Pharmacy Name and Address: _____ Phone #:_____

Siblings & DOB: _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Mother's Name or Guardian : _____ Social Security or DL#: _____

DOB: ___/___/_____ Address: _____ City/State: _____/____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Mother's Employer: _____ Employer's Address: _____

Father's Name or Guardian : _____ Social Security or DL#: _____

DOB: ___/___/_____ Address: _____ City/State: _____/____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Father's Employer: _____ Employer's Address: _____

Email Address for Electronic Communications- Mother: _____ Father: _____

INSURANCE INFORMATION

Insurance Company: _____ Policy #: _____

Group #: _____ Insured's Name: _____ DOB: _____

Secondary Insurance: _____ Policy #: _____

Group #: _____ Insured's Name: _____ DOB: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

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

Home #: _____ Work #: _____ Cell #: _____

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

Our Notice of Privacy Practices (available upon arrival to our office) provides information about how we may use and disclose protected health information (PHI) about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have received a copy of Chesterfield Pediatrics' Notice of Privacy Practices. I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____

Patient or Parent/ Legal Guardian Signature **Date**

DISCLOSURES OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS

Disclosures may be made to family and friends related to the patient's health or as needed for payment of health care services. We will only disclose information relevant to current treatment.
I authorize Chesterfield Pediatrics to disclose my health care information to:

_____

Name Phone Number Relationship

_____

Name Phone Number Relationship

_____ _____

Patient or Parent/ Legal Guardian Signature **Date**

FINANCIAL POLICY AND RELEASE

All copayments are due at the time of service. Coinsurance and deductible balances will be billed and are due upon receipt. It is your responsibility to notify us of any changes in your policy information. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all, of the services provided may be non-covered and/or not considered reasonable and necessary under your medical plan; we are not responsible for knowing what it covered and noncovered by your individual plan. Additionally, it is your responsibility to obtain and track referrals and/or prior authorizations required for your care.

Release: I hereby authorize direct payment of insurance benefits that are otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or other persons to whom disclosure is necessary to establish or collect a fee for services provided.

Returned Checks and Collection Fees: There will be a $35 returned check fee on all returned checks. In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees whether or not the attorney files suit. Additionally, you will be assessed a finance charge of 1.5% per month on balances over thirty (30) days past due, which is an APR of 18%.

Missed Appointments: We reserve the right to charge $25 for missed appointments. Please help us serve you better by keeping your scheduled appointments.

I have read, understand and agree to this Financial Policy:

_____ _____ _____

Patient or Parent/ Legal Guardian Signature **Print Name** **Date**

CHESTERFIELD PEDIATRICS

NEW PATIENT HEALTH HISTORY

Patient Name: _____

DOB: _____

Form completed by:_____ **Date:**_____

HOUSEHOLD

Please list all those living in the child's home:

Name	Relation to patient	Age

Are there any siblings not listed? If so, please list names, ages, and where they reside:

_____

Please indicate the patient's legal custody status:

☐ Lives with both mother and father ☐ Lives with mother only ☐ Lives with father only

☐ Lives with legal guardian ☐ Lives with foster family ☐ Other _____

Do we have a copy of the child's most recent custody order? ☐ Yes ☐ No ☐ N/A

BIRTH HISTORY

Birth weight: _____ **Method of delivery:** ☐ vaginal ☐ cesarean

If applicable, reason for cesarean section: _____

Gestational age at delivery: _____ weeks

Did baby have any problems right after birth? ☐ Yes ☐ No

If yes, please elaborate: _____

{This form should be used for all new patient appointments and new patient initial behavioral assessments}

CHESTERFIELD PEDIATRICS

NEW PATIENT HEALTH HISTORY

Did mother have any illness or problems with her pregnancy? ☐ Yes ☐ No

If yes, explain: _____

Feedings: ☐ breast fed ☐ bottle fed

During pregnancy, was there exposure to any of the following:

Smoke: ☐ Yes ☐ No **Alcohol:** ☐ Yes ☐ No **Illegal drugs:** ☐ Yes ☐ No

Take prescription medications: ☐ Yes ☐ No **If yes, what?** _____

Was the baby discharged home with the mother? ☐ Yes ☐ No

If no, please explain: _____

DEVELOPMENT

Are you concerned about your child's physical development? ☐ Yes ☐ No

Explain: _____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No

Explain: _____

Are you concerned about your child's attention span? ☐ Yes ☐ No

Explain: _____

SCHOOL AGE CHILDREN ONLY

How is behavior in school? _____

Repeated any grade(s)? ☐ Yes ☐ No **If yes, which grade(s)?** _____

How are grades in school? _____

Any special resources or classes? _____

ANY OTHER CONCERNS

_____

{This form should be used for all new patient appointments and new patient initial behavioral assessments}

CHESTERFIELD PEDIATRICS

Prescription Refill Policies and Procedures

Patient Name: _____ DOB: _____ Acct #: _____

In order to clarify our medical partnership with patients who are using prescription medications, we have compiled a list of procedures for how our office will handle refilling medications. A parent/ legal guardian should initial and sign below.

● Patients should contact their pharmacy first when needing a medication refill. Usually the pharmacist can refill a patient's medication on the spot or they will submit a refill request to our office.

● Before your regular appointments, please check your medications and note which need to be refilled. It is the patient's responsibility to ask for refills during appointments.

I understand it is my responsibility to request prescription(s) refills: _____

● We require regular office visits for all patients who are taking prescription medications. The interval will vary based on the medication prescribed.

I understand that regular office visits are required to have prescription(s) refilled: _____

● We require regular blood work for all patients on prescription medication, which is necessary for monitoring the safety and effectiveness of a medication. Patients who do not schedule for their regular intervals of bloodwork will not have their prescriptions refilled.

I understand that regular blood work is required to have prescription(s) refilled: _____

● Patients should be responsible and submit their request for refills and/or schedule their regular office visit at least 2 week prior to running out of their medication. Fulfilling a refill request takes at least 24 hours to process, so please plan ahead.

I will be responsible to know when my medication(s) need to be refilled and I will schedule my office visits early: _____

● All new patients must have an office visit before any prescription medication is prescribed.

I understand: _____

Chesterfield Pediatrics provides multiple ways for patients to request the medication refills they need. These include the following:

1. Calling your pharmacy first when ordering refills. They will send a refill request to our office.
2. Ask for refills during your regular office visits with a provider.
3. Call our office and leave a voicemail on the nurse's line.

I understand the available options to request a medication refill: _____

I have read Chesterfield Pediatrics' **Prescription Refills Policies and Procedures** and by initialing above and signing below, I agree to abide by them in full.

_____ _____

Parent/ Legal Guardian Signature Date

Chesterfield Pediatrics, P.C. 5955 Harbour Park Drive, Midlothian, VA 23112
Phone: 804.744.4495, **Fax:** 804-744.0751, www.chesterfieldpediatrics.com

E-prescribing Medication History Consent

I understand that Chesterfield Pediatrics has implemented ePrescribing for its patients. I also understand that ePrescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need for a more time consuming, and sometimes more costly, approach to prescribing through paper, phone, and fax. ePrescriptions are fast, convenient, legible, secure, cost-effective and safe. The ePrescribing process also allows the health care provider to access critically important information about their patient's current and past medications from pharmacy benefit managers and community pharmacies. This information helps alert the provider to other potential medication issues with their patients and can improve safety and quality.

I have been given an opportunity to ask questions about the ePrescribing process and have had those questions answered to my satisfaction. I hereby consent to the practice requesting and using my medication history from other health care providers or third party pharmacy benefit payers for treatment purposes in connection with the ePrescribing process.

_____ _____

Patient or Parent/ Legal Guardian Signature **Date**

CHESTERFIELD PEDIATRICS

Notice of Privacy Practices

This Notice is provided to you pursuant to the privacy regulations enacted as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This joint notice of privacy practices describes how your medical information may be used and disclosed and how you can get access to your information. This Notice applies to all your medical information created or maintained by Chesterfield Pediatrics. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Chesterfield Pediatrics is committed to maintaining the privacy of your health information. We are required by law to (i) maintain the privacy of your health information; (ii) provide you with this notice of our legal duties and privacy practices with respect to your health information; (iii) follow the terms of the notice of privacy practices currently in effect; and (iv) notify you if there is a breach of your health information. We must also provide you with the following important information: (a) how we may use and disclose your health information; (b) your privacy rights; and (c) our obligations concerning the use and disclosure of your health information.

This Notice of Privacy Practices is NOT an authorization. Rather it describes how we, our Business Associates, and their subcontractors may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes as permitted or required by law. It also describes your rights to access and control your Protected Health Information.

“Protected Health Information” (“PHI”) means information that identifies you individually; including demographic information, and information that relates to your past, present, or future physical or mental health condition and/or related health care services.

The terms of this notice apply to all your PHI created or maintained by Chesterfield Pediatrics. We reserve the right to revise or amend this Notice at any time. Any revision or amendment to this notice will be effective for all of your records that we 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 copy of our current Notice online at: www.chesterfieldpediatrics.com and you may request a copy of our most current Notice at any time.

B. SUMMARY OF THIS NOTICE

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

    For more information see Section E below.

2. You may have certain choices about how we use and share information when we:
    - Tell family and friends about your condition
    - Provide disaster relief
    - Include you in a hospital directory
    - Provide mental health care
    - Market our services or sell your information
    - Raise funds

    For more information see Section F below.

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

    For more information see Section G below.

C. CONTACT FOR QUESTIONS

For more information or questions about Chesterfield Pediatrics' privacy policies, please contact:

Eve Pugh, Privacy Officer
5955 Harbour Park Drive
Midlothian, VA 23112
804.744.4495
epugh@chesterfieldpediatrics.com

E. USE AND DISCLOSURE OF YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI)

1. **Treatment.** Chesterfield Pediatrics may use or share your PHI to provide medical treatment or services for you and in order to manage and coordinate your medical care. Chesterfield Pediatrics may disclose medical information about you to physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that your medical providers have the necessary information to diagnose and provide treatment to you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may affect the healing process. Chesterfield Pediatrics also may disclose your PHI to individuals who are involved in your care, including family members or other care providers.
2. **Payment.** Chesterfield Pediatrics may use and disclose your PHI in order to bill and collect payment from health plans or other entities. For example, we may disclose PHI to your health insurance plan so it will pay for your services, determine your eligibility for coverage, or to obtain

prior approval from the insurer to cover payment for treatment. Chesterfield Pediatrics also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, including family members. Chesterfield Pediatrics may disclose your information to a collection agency to obtain overdue payment. Chesterfield Pediatrics may also disclose your PHI to a regulatory agency or other entity to determine whether the services we provided were medically necessary or appropriately billed.

3. **Health Care Operations.** Chesterfield Pediatrics may use and disclose your PHI to run our practices, improve your care, and contact you when necessary. For example: We may use or disclose your PHI: (1) to conduct quality or patient safety activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination, and contacting your health care providers and you with information about treatment alternatives; (2) when conducting training programs or performing accreditation, licensing, or credentialing activities; (3) when conducting or arranging for medical review, legal services, and auditing functions; and (4) for our proper management and administration, including customer service, resolving complaints, strategic planning, etc. In addition, we may use or disclose de-identified information or a limited data set for certain healthcare operations purposes.
4. **Appointment Reminders, Check-In and Results.** Chesterfield Pediatrics may use and disclose your PHI to contact you and remind you of an appointment. Chesterfield Pediatrics may use a sign-in sheet at the registration desk and call you by name in the waiting room when your provider is ready to see you. Chesterfield Pediatrics may also use your PHI to contact you about test results. Chesterfield Pediatrics may leave a message reminding you of an appointment or the results of certain tests, but will leave the minimum amount of information necessary to communicate this information.
5. **Treatment Options and Health-Related Benefits and Services.** Chesterfield Pediatrics may use and disclose your PHI to inform you of treatment options or alternatives as well as certain health-related benefits or services that may be of interest to you. Chesterfield Pediatrics may also use and disclose your PHI to describe health-related products or services (or payment for such products or services) provided through your benefit plan or to offer information on other providers participating in a healthcare network that we participate in.
6. **Disclosures to Family or Friends.** Chesterfield Pediatrics may disclose your PHI to individuals involved in your care or treatment or responsible for payment of your care or treatment. If you are incapacitated, we may disclose your PHI to the person named in your Durable Power of Attorney for Health Care or your personal representative (the individual authorized by law to make health-related decisions for you). In the event of a disaster, your PHI may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition.
7. **Required By Law.** Chesterfield Pediatrics will use and disclose your PHI when we are required to do so by federal, state or local law. For example, Chesterfield Pediatrics may disclose PHI to comply with child and elder abuse reporting laws or to report certain diseases, injuries or deaths to state or federal agencies.

F. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. **Public Health Reporting.** Chesterfield Pediatrics may disclose and may be required by law to disclose your PHI for certain public health purposes. For example, Chesterfield Pediatrics may disclose your PHI to the Food and Drug Administration (FDA) regarding the quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; to report child abuse and/or neglect; to report reactions to medications or problems with health products; to provide notification of recalls of products; or report a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition. In addition,

Chesterfield Pediatrics may provide proof of immunizations to a school that requires a patient's immunization record prior to enrollment or admittance of a student if you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.

2. **Health Oversight Activities.** Chesterfield Pediatrics may disclose your PHI to a health oversight agency for investigations, inspections, audits, surveys, licensure and disciplinary actions, and in certain civil, administrative, and criminal procedures or actions, or other health oversight activities as authorized by law.
3. **Lawsuits and Disputes.** Chesterfield Pediatrics may disclose your PHI in response to a court or administrative order, subpoena, request for discovery, or other legal processes. However, absent a court order, Chesterfield Pediatrics will generally disclose your PHI if you have authorized the disclosure or efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.
4. **Law Enforcement.** Chesterfield Pediatrics may disclose your PHI if requested by a law enforcement official: (a) regarding a crime victim in certain situations, if we are unable to obtain the person's agreement; (b) about a death we believe resulted from criminal conduct; (c) regarding criminal conduct on our premises; (d) in response to a warrant, summons, court order, subpoena or similar legal process; (e) to identify/locate a suspect, material witness, fugitive or missing person; or (f) 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.** Chesterfield Pediatrics may disclose your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. In addition, we may disclose PHI necessary for funeral directors to fulfill their responsibilities.
6. **Organ and Tissue Donation.** Chesterfield Pediatrics may disclose your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation or blood banks, as necessary to facilitate donation and transplantation if you are a donor.
7. **Research.** Chesterfield Pediatrics may use and disclose your PHI to researchers for the purpose of conducting research with your written authorization or when the research has been approved by an Institutional Review or Privacy Board and is in compliance with law governing research.
8. **Serious Threats to Health or Safety.** Chesterfield Pediatrics may use and disclose your PHI 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, National Security, and other Specialized Government Functions.** If you are in the military or involved in national security or intelligence, Chesterfield Pediatrics may disclose your PHI to authorized officials. Chesterfield Pediatrics also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct certain investigations.
10. **Workers' Compensation.** Chesterfield Pediatrics will disclose only the PHI necessary for worker's compensation in compliance with worker's compensation laws. This information may be reported to your employer and/or your employer's representative in the case of an occupational injury or illness.
11. **Inmates.** If you are an inmate or in the custody of a law enforcement official, Chesterfield Pediatrics may disclose your PHI to correctional institutions or law enforcement officials as necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the law enforcement officer or the correctional institution; and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Minors.** If you are a minor (generally an individual under 18 years old), we may disclose your PHI to your parent or guardian unless otherwise prohibited by law.

G. YOUR PRIVACY RIGHTS REGARDING YOUR PHI

1. **Inspection and Copies.** You may request a copy of or inspect the PHI that is used to make decisions about you, including medical and billing records and laboratory and imaging reports. You have the right to obtain an electronic copy if it is readily producible by us in the form and format requested. We will provide a copy or a summary of your health information, to you or whomever you designate to receive it, usually within thirty (30) days of your request. Chesterfield Pediatrics may charge a reasonable cost-based fee to cover the costs of copying, mailing, labor and supplies associated with your request. Chesterfield Pediatrics may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. There may be times that your provider, in his or her professional judgment may not think it is in your best interest to have access to your medical record. Depending on the reason for the decision to deny a request, we may ask another licensed provider chosen by us to conduct a review of your request and its denial.
2. **Confidential Communications.** You may request in writing that we communicate with you in a specific way or send mail to a different address. For example, you may request that we contact you at home, rather than work or by mail. Chesterfield Pediatrics will accommodate all reasonable requests. You do not need to give a reason for your request.
3. **Amendment.** You may request a correction or amendment of your PHI if you believe it is incorrect or incomplete. You may make a written request for a correction or amendment for as long as your PHI is maintained by or for Chesterfield Pediatrics. Requests must provide a reason or explanation that supports the request. Chesterfield Pediatrics will deny your request if it is not in writing or if, in the provider's opinion, the information is: (a) accurate and complete; (b) not part of the PHI maintained by or for Chesterfield Pediatrics; (c) not part of the PHI that you have the right to inspect and copy; or (d) not created by Chesterfield Pediatrics, unless the individual or entity that created the information is not available to amend the information. Chesterfield Pediatrics will notify you in writing within sixty (60) days if we cannot fulfill your request.
4. **Accounting of Disclosures.** You may request an accounting of certain disclosures that Chesterfield Pediatrics has made of your PHI. This accounting will list the disclosures that we have made of your PHI but will not include disclosures made for the purposes of treatment, payment, health care operations, disclosures required by law, and certain other disclosures (such as any you asked us to make). Your request must be in writing and state the time period for which you want the accounting (not to exceed six (6) years prior to the date you make the request). Chesterfield Pediatrics will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months. Chesterfield Pediatrics will notify you of the costs involved with any additional request and you may withdraw your request before you incur any costs.
5. **Requests for Restrictions.** You have the right to request that Chesterfield Pediatrics not use or share your PHI for treatment, payment, or health care operations. We are not required to agree to your request, and we may say "no" if we believe it might affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. In that case, we will approve your request unless a law requires us to share that information.
6. **Health Information Exchange Opt-Out.** You have the right to opt-out of disclosure of your medical records to or via an electronic health information exchange ("HIE") (For example, Surescripts, Commonwell, ConnectVirginia and/or the Chesapeake Regional Information System for our Patients, Inc. ("CRISP")). However information that is sent to or via an HIE prior to processing your opt-out may continue to be maintained by and be accessible through the HIE. You must opt out of disclosures to or via an HIE through each of your individual treating providers who may participate in any given HIE. See I. USING TECHNOLOGY TO IMPROVE HEALTHCARE below for more

information regarding HIE.

7. **Right to Receive a Notice of a Breach of Unsecured Medical/Billing Information.** You have the right to receive prompt notice in writing of a breach of your PHI that may have compromised the privacy or security of your information.
8. **Right to a Paper Copy of This Notice.** You have the right to receive a paper copy of this notice at any time even if you have agreed to receive the notice electronically. You may also obtain a copy of this notice at our website: www.chesterfieldpediatrics.com.
9. **Right to File a Complaint.** If you believe your rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services ("HHS"), Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

H. ADDITIONAL INFORMATION

10. **Portal and Other Patient Electronic Correspondence.** Chesterfield Pediatrics may use and disclose your PHI through various secure patient portals that allow you to view, download and transmit certain medical and billing information and communicate with certain health care providers in a secure manner when using the portal. For more information on the Chesterfield Pediatrics patient portal, please visit our website at www.chesterfieldpediatrics.com.
11. **Your Contact Information: Home and Email Addresses/Phone Numbers.** If you provide us with a home or email address, home/work/cell telephone number, or other contact information during any registration or administrative process we will assume that the information you provided us is accurate and that you consent to our use of this information to communicate with you about your treatment, payment for service and health care operations. You are responsible to notify us of any change of this information. Chesterfield Pediatrics reserves the right to utilize third parties to update this information for our records as needed.
12. **Email or Downloading PHI.** If you email us medical or billing information from a private email address (such as a Yahoo, Gmail, etc. account), your information will not be encrypted unless you use a secure messaging portal to send it to us. If you request that Chesterfield Pediatrics email your PHI to a private email address, we send it in an encrypted manner unless you request otherwise. If you request us to post your information in drop-boxes, on flash drives, CDs, etc., your information may not be secure. Chesterfield Pediatrics is not responsible for the privacy or security of your PHI if you request that we send it to you in an unsecured manner or download or post it on a drop-box, flash drive, CD or other unsecure medium. In addition, Chesterfield Pediatrics is not responsible if your PHI is redisclosed, damaged, altered or otherwise misused by an authorized recipient. In addition, if you share an email account with another person (for example, your spouse/partner/roommate) or choose to store, print, email, or post your PHI, it may not be private or secure.
13. **Sensitive Health Information.** Federal and state laws provide special protection for certain types of health information, including psychotherapy notes, information about substance use disorders and treatment, mental health and AIDS/HIV or other communicable diseases, and may limit whether and how we may disclose information about you to others.
14. **Substance Use Disorder Records and Information.** The confidentiality of patient records maintained by federally assisted substance use disorder rehabilitation programs is protected by Federal law and regulations. Generally, such programs may not disclose any information that would identify an individual as having or being treated for a substance use disorder unless:
    a. the individual consents in writing;
    b. the disclosure is allowed by a court order;
    c. the disclosure is made to medical personnel in a medical emergency or to qualified personnel

for research, audit, or program evaluation; or

d. as otherwise permitted by law.

Violation of these laws and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not prevent any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

15. **Consent to Disclose Sensitive Health and Substance Use Disorder Information.** During the registration process, you consent to the release of federally assisted substance use disorder information, information regarding treatment of communicable diseases and mental health information. If you do not wish for this information to be disclosed, you must notify us in writing.
16. **Incidental Disclosures.** Despite our efforts to protect your privacy, your PHI may be overheard or seen by people not involved in your care. For example, other individuals at your provider's office could overhear a conversation about you or see you getting treatment. Such incidental disclosures are not a violation of HIPAA.
17. **Business Associates.** Your PHI may be disclosed to individuals or entities who provide services to or on behalf of Chesterfield Pediatrics. Pursuant to HIPAA, Chesterfield Pediatrics requires these companies sign business associate or confidentiality agreements before we disclose your PHI to them. However, Chesterfield Pediatrics generally does not control the business, privacy, or security operations of our business associates.
18. **Authorization for Other Uses and Disclosures.** Chesterfield Pediatrics will obtain your written authorization for uses and disclosures that are not identified by this notice or otherwise required or permitted by applicable law. Any authorization you provide regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. However, your revocation will not affect actions we have already taken; in other words, we are unable to take back any disclosures of PHI we have already made.

I. USING TECHNOLOGY TO IMPROVE HEALTHCARE

Health Information Exchange (HIE) enables your healthcare providers to quickly and securely share your health information electronically among a network of healthcare providers, including physicians, hospitals, laboratories and pharmacies. Your health information is transmitted securely and only authorized healthcare providers with a valid reason may access your information.

How does HIE Help You?
Improved access to information will enable us to provide better care for our patients.

- **Improved Care** - Access to information about your health history and medical care gives your healthcare provider a more complete picture of your overall health. This can help your provider make better decisions about your care. The information may also prevent you from having repeat tests, saving you time, money and worry.
- **Emergency Treatment** - In an emergency, your providers may immediately check to see if you have allergies, health problems, test results, medications or previous concerns that may help them provide you with emergency care.
- **Helps to Protect Privacy and Information Security** - By sharing information electronically through a secure system, the risk that your paper or faxed records will be misused or misplaced is reduced.

How does HIE help protect your medical information and keep it secure?

Chesterfield Pediatrics is committed to protecting the privacy and security of your health information, including the sharing and accessing of your information through HIE.

- Every HIE and its participants must protect your private medical information under HIPAA law, as well as applicable state laws and regulations.
- Information shared via HIE is encrypted, meaning it can be accessed only by authorized users. This prevents hackers from accessing your information.
- Every individual who can access your information must have their own username and password and must receive training before they can access your information.
- The HIE records every time someone accesses your information. Upon request, the HIE can track who accessed your information and provide a report to the Chesterfield Pediatrics Privacy Officer.

What HIEs does Chesterfield Pediatrics participate in?
Chesterfield Pediatrics participates in a number of HIEs, including, but not limited to, Surescripts, Commonwell, ConnectVirginia and CRISP. (Note: This list is subject to change.)

You have choices about participating in HIE.
Chesterfield Pediatrics recognizes you have certain rights related to how we share your information. You have the following choices:

Choice 1: Say Yes. No further action needed.
If you agree to have your medical information shared through HIE and you have a current Authorization and Consent to Treat form on file, you do not need to do anything. By signing the form, you have granted us permission to share your health information to HIE.

Choice 2: Say No Thanks. Follow the Instructions on the HIE Opt-Out Form.
We recognize your right to choose not to participate in HIE, also referred to as opting-out. If you decide to opt-out of HIE, healthcare providers will not be able to access your health information through HIE. You should understand that providers may still request and receive your medical information from other providers using other methods permitted by law, such as fax, mail or other electronic communication.

If you want to opt-out of participating in HIE, please follow the appropriate procedure as outlined on the Chesterfield Pediatrics HIE Opt-Out Request Form and/or contact the HIE directly. You may download and print the form on your computer or ask for a copy at any Chesterfield Pediatrics care center location. Please read the Opt-Out Request Form carefully and follow the instructions on the form to opt out of HIE.

Please note, your opt-out does not affect health information that was disclosed through HIE prior to the time that you opted out.

Choice 3: You can change your mind at any time.
You can consent today to the sharing of your information via HIE and change your mind later by following the instructions on the opt-out form described under Choice 2.

You can opt out of HIE today and change your mind later by submitting a Chesterfield Pediatrics HIE Reinstatement of Participation Form or, in certain cases, by contacting the HIE directly. The reinstatement form is available to download and print on your computer or you may ask for a copy of the form at any Chesterfield Pediatrics care center location. Please follow the instructions on the form to opt back in to HIE.

If you have any questions about HIE or for more information, please call the Chesterfield Pediatrics Privacy Officer at (804) 744-4495.

J. CHANGES TO THIS NOTICE.

Chesterfield Pediatrics reserves the right to change this Notice at any time. Chesterfield Pediatrics reserves the right to make the revised or changed Notice effective for medical information we already have about you, as well as for any information we receive in the future. Chesterfield Pediatrics will post the current Notice at registration sites throughout Chesterfield Pediatrics and on our website at www.chesterfieldpediatrics.com.

K. CONTACT INFORMATION.

If you have any questions about this Notice or wish to file a privacy complaint, please contact:

Eve Pugh, Privacy Officer
5955 Harbour Park Drive
Midlothian, VA 23112
(804) 744-4495

Chesterfield Pediatrics Notice of Privacy Practices
Effective: January 2019

CHESTERFIELD
PEDIATRICS

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____
Date _____