HAPPY DAYS PEDIATRICS

8700 Crownhill Blvd, Suite 210 San Antonio, TX 78209
Phone: 210-816-1330

Notice of Privacy Practices/Financial Policy

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:

- Get a copy of your paper or electronic medical record
    - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
    - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Correct your paper or electronic medical record
    - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
    - We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communication
    - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
    - We will say "yes" to all reasonable requests.
- Ask us to limit the information we share
    - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
    - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared your information
    - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
    - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months
- Get a copy of this privacy notice
    - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you
    - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
    - We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you believe your privacy rights have been violated
    - You can complain if you feel we have violated your rights by contacting us using the information on page 1.

- o You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- o We will not retaliate against you for filing a complaint.

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. Most psychotherapy notes will not be shared.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you: We can use your health information and share it with other professionals who are treating you.
- Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.
- Help with public health and safety issues: We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.
- Do research: We can use or share your information for health research.
- Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writ ing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request from our office.

Other Instructions for Notice

- Effective Date of this Notice May 15, 2019
- Happy Days Pediatrics will never market or sell any personal information
- The Privacy Rule and Texas Health & Safety Code, Chapter 181 require us to obtain written approval for any release of PHI that is not covered in the previous information contained in this notice of privacy practices.

FINANCIAL POLICY

1. It is the patients'/parents'/guardians' responsibility to know their insurance policy. Families should be aware of their benefit coverage including covered and non-covered benefits, authorization requirements, and cost-share information such as deductibles, co-insurance and copays. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.

2. Co-payments are due at the time of service regardless of who brings in the child. Grandparents, older siblings, Nannies, babysitters etc. must be prepared to pay the co-pay.

3. A $25 fee will be assessed for all returned checks.

4. If we are unable to obtain eligibility within 60 days of the visit, the balance will be expected to be paid by the account holder(s).

5. If our office is **NOT** notified of insurance changes within 30 days of filing a claim, the account hold er(s) will be held responsible for charges.

6. Claims denied by the insurance company will be billed to the responsible party. If there are questions, you may dispute them with your insurance company.

RECEIPT OF NOTICE OF PRIVACY PRACTICES - WRITTEN ACKNOWLEDGEMENT FORM

Names of Children to be Seen at this Practice:

_____

_____

I, _____, have received a copy of Happy Days Pediatrics' Notice
(**print name**)
Of Privacy Practices and Financial Policy. As the parent or legal guardian, I hereby authorize the physicians at Happy Days Pediatrics and/or their medical representative(s) to perform the required medical treatment considered advisable for the patient. I realize that no guarantees can be made as to the eventual outcome of the medical treatment advised or performed.

Please note that written authorization will be required for the parent/legal guardian allowing anyone other than immediate family to bring the child to this office to be examined by the doctor.

I authorize the release of medical information on the patient(s) to the insurance companies for the purpose of filing insurance claims.

Date:_____ Signature:_____

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