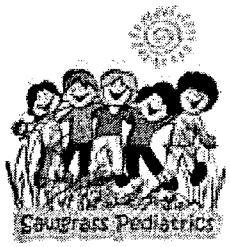

Sawgrass Pediatrics

Coral Springs Office (954) 752-9220 Fax (954) 752-1549
9750 NW 33rd Street, Suite 101 Coral Springs, FL 33065

Boca Raton Office (561) 487-9912 Fax (561) 487-5070
9801 Glades Road, Boca Raton, FL 33434

Susan Waters, M.D. - Lori Miller, M.D. - Anthony Martell, M.D. - Alina Di Liddo, M.D. - Jordan Mussary, M.D. - Alan Cadiz, D.O. - Susan Shulman, D.O.

Child's Name	Date of Birth mm/dd/yyyy	Primary Language	Race

Mother's/Guardian Information

Mother/Guardian is Financially Responsible Yes ☐ No ☐

Mother's/Guardian's Name				D.O.B.	mm/dd/yyyy
Home address				Apt/Bldg #	
City, State, Zip Code					
(Circle One)	Married	Single	Divorced	Legally Separated	Widowed
Home phone				Cell Number	
Home E-mail Address					
Social Security Number					
Drivers License					
Employer Name				Work Number	

Father's/Guardian Information

Father/Guardian is Financially Responsible Yes ☐ No ☐

Father's/Guardian's Name				D.O.B.	mm/dd/yyyy
Home Address				Apt/Bldg #	
City, State, Zip Code					
(Circle One)	Married	Single	Divorced	Legally Separated	Widowed
Home phone				Cell Number	
Home E-mail Address					
Social Security Number					
Drivers License					
Employer Name				Work Number	

Children/Dependent Information

	Children Reside With (circle one)		**Mother**	**Father**	**Both Mother & Father**	**Guardian**
1	Child's Name		M F	D.O.B.	mm/dd/yyyy	
2	Child's Name		M F	D.O.B.	mm/dd/yyyy	
3	Child's Name		M F	D.O.B.	mm/dd/yyyy	
4	Child's Name		M F	D.O.B.	mm/dd/yyyy	
5	Child's Name		M F	D.O.B.	mm/dd/yyyy	

Parent/Guardian Signature

Payment is expected at the time of each visit unless prior arrangements have been made. You, not the insurance company is responsible for all charges and costs of collections including reasonable attorney fees. I authorize Susan W. Waters, M.D., Lori Miller, M.D., Anthony Martell, M.D., Alina Di Liddo, M.D., Jordan Mussary, M.D, Alan Cadiz, D.O. and Susan Shulman, D.O., to perform any necessary emergency care for my child and/or children, named above, if I am unable to be located at the time of the need for such emergency medical care. Any balance more than 60 days past due will be subject to 1½% interest per month. I agree to the terms of the Office Financial Policy.

X	Date	

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Child's Name	D.O.B mm /dd /yyyy

Insurance Information

Please provide the receptionist with a copy of Insurance Card

Policy Holder's Name		D.O.B.	mm /dd /yyyy
Medical Insurance Carrier			
Insurance Address (P.O. Box)			
City, State, Zip Code			
Customer Service Phone #		Name of PCP:	
Policy Number		☐ individual Policy	☐ Group Policy
Group Number		Co payment	$

Parent/Guardian Signature

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sawgrass Pediatrics or insurance company to release any information required to process my claims.

X	Date	

Pharmacy Information

Name of Pharmacy		Phone Number	
Address/Location			
City, State, Zip Code			

Please provide the Name and Relationship of the person/persons authorized to accompany your child to the office for sick and well visits.

Name of Person	Phone Number	Relationship to Child	Authorizing Consent to Treat	
			☐ YES	☐ NO
			☐ YES	☐ NO
			☐ YES	☐ NO
			☐ YES	☐ NO
			☐ YES	☐ NO

Parent/Guardian Signature

I give my permission to the above stated person/persons to sign for medical treatment of my child should the need arise during my absence.

X	Date	

Sawgrass Pediatrics

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LIFETIME SIGNATURE AGREEMENT

Patient Name **DOB** **Date**

TO:_____

Insurance Carrier

I authorize the release of any medical information necessary to process this claim. I also request payment of benefits to either myself or to the party who accepts assignment for the insured party.

Responsible Party Signature **Date**

I authorize payment of medical benefits to the undersigned physician or supplier for services described for my children covered under my policy.

I also understand that I and/or my spouse are responsible for any unpaid balance due the above referenced physician.

Responsible Party Signature **Date**

Sawgrass Pediatric Partners, LLC
9750 NW 33rd Street, Suite 101 – Coral Springs, FL 33065
Telephone: 954.752.9220 ~ Fax: 954.752.1549

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

_____
(Practice Name)

Patient Name: _____ ID Number: _____

Date of Birth: _____

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	**Persons/organizations receiving the information:**
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.

Notice of Privacy Acknowledgement

Sawgrass Pediatric Partners, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

Notice of Privacy Practices
Sawgrass Pediatric Partners, LLC

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

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the pediatric care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have 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 our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. 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 by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form

Virginia Wiley
9801 Glades Road
Boca Raton, FL 33434
Office: (954) 752-9220
Fax: (954) 752-1549

Sawgrass Pediatrics

9750 NW 33rd Street
Suite 101
Coral Springs, FL 33065
Telephone # (954) 752-9220
Fax # (954) 752-1549

Susan Waters, M.D., F.A.A.P.
Lori Miller, M.D., F.A.A.P.
Anthony Martell, M.D., F.A.A.P.
Alina Di Liddo, M.D., F.A.A.P.
Jordan Mussary, M.D., F.A.A.P.
Alan Cadiz, D.O., F.A.A.P.
Susan Shulman, D.O, F.A.A.P.

9801 Glades Road
Boca Raton, FL 33428
Telephone # (561) 487-9912
Fax # (561) 487-5070

HEALTH HISTORY FORM

Patient Name _____ **DOB** _____ **Date** _____

BIRTH HISTORY

Where was your child born? (Hospital Name or City)

What was his or her birth weight?

Was he/she full term? Yes ☐ No ☐
If not, how many weeks early or late was he/she?

Were there any complications during pregnancy? Yes ☐ No ☐
If yes, what were they?

Was the delivery of your child Vaginal ☐ C-section ☐

Were there any complications during delivery? Yes ☐ No ☐
If yes, what were they?

Were there any complications for the baby? Yes ☐ No ☐
If yes, what were they?

Was the baby in NICU (Newborn Intensive Care Unit)? Yes ☐ No ☐
If yes, how long? And why was he/she in NICU?

Did the baby require phototherapy (light therapy) for jaundice? Yes ☐ No ☐

MEDICATIONS

Taking any medications If yes, what? (including vitamins, over the counter medications and prescriptions) Yes ☐ No ☐

Allergic to any medications? If yes, what medication(s) and what reaction(s)? Yes ☐ No ☐

ALLERGIES

Allergic to any foods? If yes, what foods? Yes ☐ No ☐

Allergic to anything in the environment? If yes, to what? Yes ☐ No ☐

Are these allergies? Suspected ☐ Definite (Tested) ☐

Please describe any other birth complications:

PAST ILLNESSES, HOSPITALIZATIONS

Was your child ever admitted to the hospital overnight? If so, when? For what? Yes ☐ No ☐

Have you ever had to take your child to the emergency room? If yes, what for? Yes ☐ No ☐

Please describe:

SURGICAL HISTORY – Has your child ever had surgery? If yes please check the individual boxes

Head or Skull	☐	Cochlear Device	☐		☐	Pyloric Stenosis Repair	☐	**Testicular Surgery**	☐
Eyes	☐	**Tonsils**	☐	Chest Tube	☐	Kidney Surgery	☐	Torsion Reduction	☐
Ears	☐	**Adenoids**	☐	**Gastrointestinal**	☐	**Urological Surgery**	☐	Undescended Testicle	☐
Tear Duct Probe	☐	**Oral Surgery**	☐	Upper Endoscopy	☐	Circumcision	☐	**Orthopedic Surgery**	☐
Strabismus Correction	☐	**Sinus**	☐	Colonscopy	☐	Chordee Release	☐	Scoliosis	☐
Ear Tubes	☐	**Neck**	☐	**Abdominal Surgery**	☐	Hypospadias Repair	☐	Setting Bone Fracture	☐
Ear Tube Removal	☐	**Heart Surgery**	☐	Appendectomy	☐	Hydrocele Repair	☐	**Neurologic**	☐
Ear Drum Repair	☐	Lung Surgery	☐	Inguinal Hernia Repair	☐	Meatoplasty	☐	**Dermatologic/Skin**	☐
Cholesteotoma	☐	Brochoscopy	☐	Umbilical Hernia Repair	☐	**Bladder Surgery**	☐		

PAST MEDICAL HISTORY – If There is No Past Medical History Check Here ☐ (otherwise check the individual boxes)

Skin Problems	☐	**Cardiac Problems**	☐	**Gynecologic Issues**	☐	**Neurological Disorders**	☐	Has your child had a poistive PPD Test	☐
Acne	☐	Murmurs	☐	**Rheumatology Disorders**	☐	Headaches	☐		
Eczema	☐	Heart Defects	☐	Rheumatoid Arthritis	☐	Febrile Seizures	☐	**Oncology Disease (Cancer)**	
Eye/Vision Problems	☐	High Cholesterol	☐	Lupus	☐	Epilepsy	☐		
Glasses for Reading	☐	**Stomach Intestinal Disorders**	☐	**Endocrine Disorders**	☐	**Developmental Delay**	☐		
Glasses for Distance	☐	GERD (Heartburn)	☐	Diabetes Type I (Child)	☐	Speech/Language Delay	☐		
Ear/Nose/Throat	☐	Constipation	☐	Diabetes Type II (Adult)	☐	Fine Motor Delay	☐	Please Describe	
Recurrent Ear Infections	☐	Irritable Bowel	☐	Thyroid Disease	☐	Social Delay	☐		
Recurrent Sinus Infections	☐	Ulcerative Colitis	☐	**Orthopedic Disorders**	☐	Cognitive Delay	☐		
Hearing Loss	☐	Crohn's Disease	☐	Fractures in the Past	☐	**Psychiatric Disorders**	☐		
Allergies	☐	Pyloric Stenosis	☐	Scoliosis	☐	ADD/ADHD	☐	**Immune Disorders**	☐
Respiratory Problems	☐	**Renal/Kidney Disease**	☐	**Blood Disorders**	☐	Depression	☐	Please Describe	
Asthma	☐	Polycystic Kidney	☐	Anemia	☐	**Genetic Disorders**	☐		
Pneumonia	☐	Proteinuria	☐	Bleeding Disorders	☐		☐		
Cystic Fibrosis	☐	Urine Reflux	☐	Low Platelets	☐		☐		

Any Other Past Medical History Not Mentioned

(See Reverse Side For More Questions)

Sawgrass Pediatrics

HEALTH HISTORY FORM

FAMILY HISTORY If yes please check Please include the PATIENT'S, parents, grandparents, aunts, uncles, brothers, sisters, first cousins

If There is No Family History of Disease Check Here ☐ (otherwise check the individual boxes)

Heart Disease	☐	Asthma	☐	Crohn's Disease	☐	Psychiatric Disorder	☐	**No History Available**	☐
High Blood Pressure	☐	Emphysema	☐	Bleeding or Clotting Disorder	☐	ADD/ADHD	☐	Adopted	☐
High Cholesterol	☐	Cystic Fibrosis	☐	Immune Defect	☐	Birth Defects	☐		☐
Diabetes Type I (Child)	☐	Tuberculosis	☐	HIV Infection	☐	Any Other Past Medical History Not Mentioned			
Diabetes Type II (Adult)	☐	Hepatitis	☐	Arthritis	☐				
Cancer	☐	Allergies	☐	Seizure Disorder	☐				
Thyroid Disease	☐	Cirrhosis of the liver	☐	Stroke	☐				
Kidney Disease	☐	Ulcerative Colitis	☐	Neurologic Disorder	☐				

SOCIAL BACKGROUND

CHILD LIVES WITH		**Both Parents (Married)**	☐	**Guardian/Other**	☐	**Child Lives In**		**PETS AT HOME**	
Mother	☐	**Father**	☐	Grandparent(s) in the Home	☐	House	☐	Dogs (s)	☐
Separated	☐	Separated	☐	Grandparent(s) as Guardian	☐	Apartment/Condo	☐	Cat (s)	☐
Divorced	☐	Divorced	☐					Bird (s)	☐
Joint Custody	☐	Joint Custody	☐	Other Relatives in the Home	☐			Fish (s)	☐
Sole Custody	☐	Sole Custody	☐	Other Relatives as Guardian	☐			Lizard/Turtle	☐
W/Stepfather	☐	W/Stepfather	☐	**Please Indicate Name of Guardian if other than Mom or Dad:**				Other	
W/Stepbrother	☐	W/Stepbrother	☐						
W/Stepsister	☐	W/Stepsister	☐						
Mother's Occupation		**Father's Occupation**							

ETHNIC BACKGROUND		**NATIVE LANGUAGE**	
Caucasian	☐	English	☐
Hispanic	☐	**Spanish**	☐
African American	☐	Creole	☐
Asian	☐	Other (please specify)	
American Indian	☐		
Haitian	☐		
Other	☐		

SMOKING/DRUGS/ALCOHOL		
Does anyone smoke inside or outside the house?	Yes ☐	No ☐
FOR PATIENTS 13 OR OLDER		
History of Drug Use	Yes ☐	No ☐
History of Alcohol Use	Yes ☐	No ☐
History of Tobacco Use	Yes ☐	No ☐

Pharmacy Information: All Prescriptions will be sent electronically – you will no longer receive paper prescriptions

Name and Phone Number of your Pharmacy	**Address or Cross Streets of your Pharmacy**

Please describe any other problems with your child where we may be able to help:

Parent/Guardian Signature _____ **Date** _____

English Notice of Nondiscrimination

This medical practice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This medical practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This medical practice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the office administrator.

If you believe that this medical practice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the office administrator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the office administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish Notice of Nondiscrimination / Aviso español de no discriminación

Esta práctica médica cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Esta práctica médica no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

Esta práctica médica:

• Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:

- Intérpretes de lenguaje de señas capacitados.
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).

• Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:

- Intérpretes capacitados.
- Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con el administrador de la oficina.

Si considera que esta práctica médica no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: el administrador de la oficina. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el administrador de la oficina está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web
http://www.hhs.gov/ocr/office/file/index.html.

Haitian Creole Notice of Nondiscrimination / Avi kreyòl ayisyen nan Diskriminasyon

Sa a pratik medikal konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks. Sa a Pratik medikal pa ekskli moun oswa trete yo nan fason ki diferan akoz ras, koulè, peyi orijin, laj, enfimite oswa sèks yo.

Sa a pratik medikal:

• Bay èd ak sèvis gratis pou moun ki andikape pou yo kominike avèk nou nan fason ki efikas, tankou:

  ○ Enèprèt langaj siy ki kalifye

  ○ Enfòmasyon ekri nan lòt fòma (gwo lèt, odyo, fòma elektwonik ki aksesib, lòt fòma)

• Bay sèvis lang gratis a moun lang prensipal yo pa Anglè, tankou:

  ○ Enèprèt kalifye

  ○ Enfòmasyon ki ekri nan lòt lang

Si w bezwen sèvis sa yo, kontakte administratè nan biwo

Si w kwè sa a pratik medikal pa t bay sèvis sa yo oswa te fè diskriminasyon nan yon lòt fason sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks, ou ka depoze yon plent nan: administratè nan biwo. Ou ka depoze yon plent an pèsòn oswa pa lapòs, pa faks oswa pa imel. Si w bezwen èd pou w depoze yon plent administratè nan biwo disponib pou ede w.

Ou ka depoze yon plent pou dwa sivil tou nan U.S. Department of Health and Human Services, (Ministè Sèvis Sante ak Imen Ameriken), Office for Civil Rights (Biwo Dwa Sivil) atravè Office for Civil Rights Portal, pa mwayen elektwonik ki disponib nan https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, oswa pa lapòs oswa:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Fòmilè pou plent yo disponib nan http://www.hhs.gov/ocr/office/file/index.html.

Notice of Privacy Practices
Sawgrass Pediatric Partners, LLC

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

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the pediatric care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have 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 our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. 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 by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form

Virginia Wiley
9801 Glades Road
Boca Raton, FL 33434
Office: (954) 752-9220
Fax: (954) 752-1549

2013