BIDABADI PEDIATRICS

Patient Privacy Policy

Information regarding how your child(ren)'s medical records may be used, disclosed and how you may obtain access to records.We are obliged under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices when requested. Federal law allows us to use your child(ren)'s protected health information for your treatment without further notice to you and without further written authorization by you. For example, when forwarding medical records to a specialty physician.

Federal law allows us to use or disclose your medical information to obtain:

- Payment for our services (submitting your diagnosis to your insurance carrier)
- Health care operations (audits by our accountants)
- Requests by public health agencies (Department of Health)
- Requests by law (enforcement, judicial or administrative proceedings)

You have the right to:

- Request restrictions on certain uses or disclosures described above. However, we are not required to agree to such restrictions.
- Obtain copies of your medical information.
- Request an accounting of any disclosures we make of your medical information with the exception of disclosures we make to you or in order to carry out treatment, payment or health care operations.

Out-of-Network Insurance Agreement: Bidabadi Pediatrics, LLC participates with most major insurance companies. However, it is your responsibility as the subscriber to verify that we are in-network with your specific policy. If we are out-of-network you may still elect to have services rendered by our office. Please be advised you may be responsible for a certain percentage and/or all fees based on your insurance company's out-of-network policy. You have the right to refuse services based on this information.

Child 1: Name and DOB (please print): _____

Child 2: Name and DOB (please print): _____

Child 3: Name and DOB (please print): _____

We may contact you by mail or telephone to remind you of appointments or to provide information about treatment. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence. If you have a preference of contact number(s) used, please indicate below:

Home (_____) - _____ - _____ **Cell** (_____) - _____ -_____

** The individuals listed below have my permission to speak to the physician(s) or staff regarding my child(ren)'s treatment, appointments or billing issues.

_____

Name(s)/relationship to child

non parent/guardian

My signature below indicates I have read, and agree to this Patient Privacy Policy.

_____

Signature **Printed name** **Date**