Welcome to Aquidneck Pediatrics, LLC. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.
Please circle the pediatrician you have chosen as your child's Primary care provider:

Dr. Christina Dierolf Dr. Anthony Amaio Dr. Brooke Roebuck NP Karen Wood Jennifer Budacki DO

As a Patient Centered Medical Home, we very much look forward to working with you to optimize your health and coordinate all your medical needs.
In preparation for your first visit with your new care provider, please review and complete the following forms:

- Patient Registration
- HIPAA
- Personal Medical History
- Vaccine Policy and Agreement
- Medical Record Release

******These forms must be completed/signed and submitted along with your child's immunization record and a copy of the front AND back of your insurance card prior to scheduling your child's first visit******

HOURS OF OPERATION & PHONE HOURS

Scheduled visits:

Monday- Friday	8:00am–5:00pm	Phones: 8:00am–5:00pm
Saturday	9:00am–12:00pm	Phones: 9:00am–12:00pm

QUICK SICK HOUR

Your child must be an established patient (has had at least 1 prior appoinment with us) in order to utlize our Quick Sick Hour which runs from 8:00 am to 9:00 am Monday through Friday. Patients wanting to utilize Quick Sick must arrive to our parking lot and text us at 401-847-2290 with the child's name, date of birth, and symptoms. The nurse will then add your child to the queue in the order that they arrived and respond by text with instructions on when you can come into the building and checkin to be seen.

AFTER-HOURS & EMERGENCIES

If an emergency should arise, please call 911.
Please know that our providers are on call 24 hours a day 7 days a week outside of office hours for medical advice that cannot wait to be addressed during our regular office hours. The on-call provider can be reached by calling our main number 401-847-2290 and pressing '0'.

CHECK-IN

Please bring your insurance card and a photo ID with you for each appointment. All co-pays and any past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

NO-SHOW, CANCELLATION, AND LATE POLICY

We ask that you allow plenty of time to get to the office for your appointment. You will be asked to reschedule your appointment if you are more than 15 minutes late.
If you are more than 15 minutes late for a sick visit, you will forfeit the scheduled appointment time.

We understand that appointments sometimes need to be changed, so we ask that you call at least 24 hours in advance if you cannot keep your scheduled appointment.
Our office policy for a missed appointment is:

- As a new patient, a no-show appointment for your initial visit will result in dismissal from the practice.
- Once established, two (2) no-show appointments within the past 12 months will result in a warning letter. Three (3) no-show appointments within the past 12 months will result in dismissal from the practice.

PRACTICE VACCINE POLICY

In order to protect our current patients who for medical reasons are unable to be vaccinated, we will no longer be accepting any patients that do not vaccinate. We believe that parents should take sole responsibility for their decision NOT to vaccinate their children per the physicians' recommendation. We the physicians at Aquidneck Pediatrics, LLC. will not take on that disease liability risk.
If you decline to fully vaccinate your child according to the schedule recommended by the AAP based on the Advisory Committee on Immunization Practices (ACIP) at the CDC, we will ask you to find a different provider that shares your views.

We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

WELL VISIT NOTICE

During your child's well visit for preventative care, you may be asked to complete certain screening questionnaires. We will also administer hearing screening and laboratory screening for lead poisoning and sexually transmitted diseases. We use these items to help us assess both development and health exposures during your child's growth. We feel strongly that these are necessary and important to your child's overall well-being, and we follow the guidelines for preventative health screening as set forth by the AAP and Bright Futures Screening Guidelines. https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

We will submit to your insurance for these services. If your insurance does not cover these services, you will be responsible for the balance. Please feel free to discuss this with our billing department if there are any concerns or questions or your insurance carrier to inquire about coverage. Additionally, your provider can help you understand what these screenings are for and when they are most important for your child.

PRESCRIPTIONS

Refill requests should be made timely and be directed to the Pharmacy. We require 48 hours to fill a prescription.
If your child is on a medication that is refilled on a monthly basis, please plan accordingly when requesting prescriptions.

FORMS

School, day care, sports physicals and other forms require at least 2 business days to complete unless presented at the time of a well-child visit.
While every effort will be made to complete forms as quickly as possible, parents should realize that at certain times of the year we may receive hundreds of health forms in one week and remember that each of these has to be carefully reviewed by a physician before it is signed and released.

REFERRALS

In the event that your child requires a referral to see a specialist that the PCP has not initiated, you must notify our office staff who the specialist is and why they are being seen. Our office requires up to five business days to process a referral. If your insurance coverage has changed, we will need that new information in order to process the referral.

SINGLE, SEPARATED OR DIVORCED PARENTS

Single, separated, or divorced parent(s) who is/are authorized to bring the child in for treatment will be responsible for any co-payment/deductible or co-insurance balance. If there is a divorce decree requiring the other parent to pay such charges, the authorized parent will be responsible for collecting said charges from the other parent and presented at time of service. Unless Aquidneck Pediatrics has a court order(s) that states the contrary, our office is legally obligated to disclose medical information to both parents/legal guardians. If at any time legal matters become too intrusive for our staff, we reserve the right to dismiss the patient from our practice.

GROUNDS OF DISMISSAL

- Non-payment of patient responsible balances in a timely manner
- Multiple missed appointments as outlined above
- Vaccine refusal
- Profane, abusive, or demeaning language to staff

Patient Registration

Have you been treated before by a doctor from this practice at our previous locations? ☐ Yes ☐ No

AQUIDNECK PEDIATRICS

PATIENT INFORMATION:

Name: _____ DOB:_____ Birth Gender ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ Nonbinary ☐ Other_____

Race _____ Ethnicity _____

Language_____

Mailing Address: _____City_____ State: _____ Zip:_____

Street Address (if different from above): _____

Phone Numbers: Home_____ Work: _____ Cell: _____

Email Address: _____

Parent / Guardian Name:_____ DOB: _____

Parent / Guardian Name: _____ DOB: _____

PRIMARY INSURANCE

Name:_____

Policy Number _____

Group Number _____

Insured Name: _____ DOB: _____

SECONDARY INSURANCE

Name _____

Policy Number _____

Group Number _____

Insured Name: _____ DOB: _____

EMERGENCY CONTACT:

Name: _____ Relationship to Patient:_____

Address: _____ City_____ State: _____ Zip:_____

Phone Numbers: Home_____ Work: _____ Cell: _____

RESPONSIBLE PARTY *(if different from the patient) person responsible for bills, not necessarily the insurance subscriber:*

Name: _____ DOB:_____ Relationship to Patient: _____

Mailing Address: _____ City_____ State: _____ Zip:_____

Phone Numbers: Home_____ Work: _____ Cell: _____

Email Address: _____

Signature of patient/legally responsible party _____ **Date:** _____

Printed name of legally responsible party_____

Please complete all sections prior to your visit. The signature of the patient, the custodial parent, or the legally responsible party is required.

Name of patient: _____ DOB_____

Payment, Assignment, and Release

I understand that this office may bill my insurance carrier/government program as a courtesy to me but that I am financially responsible for all fees incurred and I agree to pay them in full. I assign all benefits payable to me by my insurance carrier/government program to Aquidneck Pediatrics. I allow a photocopy of my signature to be used to process my insurance/government program claims for my lifetime. I understand that it is my responsibility to understand which treatment options are and are not covered by my health care policy and what I am required to do to secure those benefits.

Signature_____ Date_____

Pharmacy Information:.

Name_____ Location_____ Phone _____

Mail Order Name: _____ Fax # _____

Permission to leave Messages

By Signing Below, I authorize Aquidneck Pediatrics to leave or send non clinical messages in reference to any items that assist in carrying out my healthcare.

Preferred Communication: ☐ Text ☐ Voicemail Preferred Phone: Home ☐ Cell ☐ Work ☐

Signature:_____ Date:_____

RX History Consent

By signing below, I agree to allow Aquidneck Pediatrics to review any prescription history available to my electronic health record.
Signature_____ Date_____

For Minors:

Persons or agencies with a legal right to access this minor's medical record (such as parents, grandparents, DCYF) It is assumed both parents may access the record legally unless documentation to the contrary is provided, such as proof of termination of parental rights.

_____ _____
_____ _____

Disclosure of Protected Health Information of a Minor *(only applicable for minor patient's age 11 through 18th birthday)*

I understand that medical records containing the following information about the care listed below:

- HIV testing and treatment
- Testing and treatment for reportable sexually transmitted diseases;
- Family Planning and abortion services; and
- Alcohol and drug treatment services.

by law, cannot be disclosed by Aquidneck Pediatrics to the parent/guardian of a minor patient unless permission is granted by the minor. On some occasions, Aquidneck Pediatrics may call the minor about the release of his/her information. Minor cell phone number:

_____

PATIENT NAME : _____

DATE OF BIRTH : _____

PRIVACY PRACTICES (HIPAA)

By signing below, I acknowledge that I was provided with the Notice of Privacy Practices of Aquidneck Pediatrics, *LLC Kathy Pugatch, Privacy Manager (401) 847 2290.*

Please list any persons to whom your protected health information can be disclosed *(e.g., spouse, parent, etc.).*

This list should include your emergency contact person.

Name: _____Relationship _____ Phone number _____

Name: _____Relationship _____ Phone number _____

Name: _____Relationship _____ Phone number _____

Name: _____Relationship _____ Phone number _____

Name: _____Relationship _____ Phone number _____

Name: _____Relationship _____ Phone number _____

Name: _____Relationship _____ Phone number _____

Name: _____Relationship _____ Phone number _____

NAME OF PERSON COMPLETING THIS FORM: _____

DATE: _____


QUIDNECK
PEDIATRICS

Pediatric Medical History Form

(Please Print)

Name: _____

Date of Birth: _____ Age: _____

Parent /Guardian's Name: _____ DOB: _____

Parent /Guardian's Name: _____ DOB: _____

Social History

Are there siblings? If so, please list their names, ages, and where they live _____

_____

What is the child's living situation if not with both biological parents? ☐ Lives with adoptive parents

☐Joint custody ☐Single custody ☐Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

Medical History

Does your child have, or has your child ever had,

- ☐ Chickenpox -- When?
- ☐ Frequent ear infections
- ☐ Problems with ears or hearing
- ☐ Nasal allergies
- ☐ Problems with eyes or vision
- ☐ Asthma, bronchitis, bronchiolitis, or pneumonia
- ☐ Any heart problem or heart murmur
- ☐ Anemia or bleeding problem
- ☐ Blood transfusion
- ☐ HIV
- ☐ Organ transplant
- ☐ Malignancy/bone marrow transplant
- ☐ Chemotherapy
- ☐ Frequent abdominal pain
- ☐ Constipation requiring doctor visits
- ☐ Recurrent urinary tract infections
- ☐ Congenital cataracts/retinoblastoma
- ☐ Metabolic/Genetic disorders
- ☐ Cancer
- ☐ Kidney disease or urologic malformations
- ☐ Bed-wetting (after 5 years old)
- ☐ Soiling underwear (encopresis)
- ☐ Sleep problems; snoring
- ☐ Chronic or recurrent skin problems (acne, eczema)
- ☐ Frequent headaches
- ☐ Convulsions or other neurologic problems
- ☐ Obesity
- ☐ Diabetes
- ☐ Thyroid or other endocrine problems
- ☐ High blood pressure
- ☐ History injuries/fractures/concussions
- ☐ Use of alcohol or drugs
- ☐ Tobacco use
- ☐ ADHD/anxiety/mood problems/depression
- ☐ Developmental delay
- ☐ Dental decay
- ☐ History of family violence
- ☐ Sexually transmitted infections
- ☐ Pregnancy
- ☐ (For girls) Problems with her periods
- ☐ Has had first period -- Age of first period?

Any other significant problem? _____

Birth History □ Don't know birth history

Birth weight _____Was the baby born at term? _____OR _____ weeks
Were there any prenatal or neonatal complications? □Yes □No Explain _____
_____
Was a NICU stay required? □Yes □No Explain _____
During pregnancy, did mother: Use tobacco □Yes □No Drink alcohol □Yes □No
Use drugs or medications □Yes □No Used prenatal vitamins? _____
Was the delivery □Vaginal □Cesarean If cesarean, why? _____
Was initial feeding □Formula □Breast milk How long breastfed? _____
Did your baby go home with mother from the hospital? □Yes □No Explain _____
_____

General DK = don't know

Do you consider your child to be in good health? □Yes □No □DK Explain _____
Does your child have any serious illnesses or medical conditions? □Yes □No □DK Explain _____
Has your child had any surgery? □Yes □No □DK Explain _____
Has your child ever been hospitalized? □Yes □No □DK Explain _____
Is your child allergic to medicine or drugs? □Yes □No □DK Explain _____
Do you feel your family has enough to eat? □Yes □No □DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?
Childhood hearing loss □Yes □No □DK Who _____ Comments _____
Nasal allergies □Yes □No □DK Who _____ Comments _____
Asthma □Yes □No □DK Who _____ Comments _____
Tuberculosis □Yes □No □DK Who _____ Comments _____
Heart disease (before 55 years old) □Yes □No □DK Who _____ Comments _____
High cholesterol/takes cholesterol medication □Yes □No □DK Who _____ Comments _____
Anemia □ Yes □No □DK Who _____ Comments_____
Bleeding disorder □Yes □No □DK Who _____ Comments _____
Dental decay □Yes □No □DK Who _____ Comments _____
Cancer (before 55 years old) □Yes □No □DK Who _____ Comments _____
Liver disease □Yes □No □DK Who _____ Comments _____
Kidney disease □Yes □No □DK Who _____ Comments _____
Diabetes (before 55 years old) □Yes □No □DK Who _____ Comments _____
Bed-wetting (after 10 years old) □Yes □No □DK Who _____ Comments _____
Obesity □Yes □No □DK Who _____ Comments _____
Epilepsy or convulsions □Yes □No □DK Who _____ Comments _____
Alcohol abuse □Yes □No □DK Who _____ Comments _____
Drug abuse □Yes □No □DK Who _____ Comments_____
Mental illness/depression □Yes □No □DK Who _____ Comments _____
Developmental disability □Yes □No □DK Who _____ Comments _____
Immune problems, HIV, or AIDS □Yes □No □DK Who _____ Comments _____
Tobacco use □Yes □No □DK Who _____ Comments _____
Additional family history _____

Pediatric Vaccination Policy

Revised 02/03/2021

As medical professionals, we confirm that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults.

We confirm that based on all available literature, evidence and current studies, vaccines do not cause autism or other developmental disabilities.

We confirm that that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers.

All of our own children have received each and every recommended vaccine according to the recommended schedule. We would be happy to discuss concerns or questions, and would be happy to share information based on scientific study and data-gathering on millions of children by thousands of our brightest scientists and physicians.

In order to protect our current patients who for medical reasons are unable to be vaccinated, we will no longer be accepting any patients that do not vaccinate. We believe that parents should take sole responsibility for their decision NOT to vaccinate their children per the physicians' recommendation. We the physicians at Aquidneck Pediatrics, LLC. will not take on that disease liability risk.

If you decline to fully vaccinate your child according to the schedule recommended by the AAP based on the Advisory Committee on Immunization Practices (ACIP) at the CDC, we will ask you to find a different provider that shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

VACCINATION AGREEMENT

I understand that I must vaccinate my child according to the schedule required by Aquidneck pediatrics, LLC as we follow CDC and AAP guidelines unless a medical condition requires otherwise. I understand that my child will receive vaccines according to the required schedule which is in accordance with the recommendations of the American Academy of Pediatrics and the Centers for Disease Control and Prevention unless a medical condition requires early or delayed vaccination. I understand that this is a private practice and the providers can choose to deny care to my child if I do not follow the required schedule.

If my child is new to the practice, I agree to continue vaccinating according to the CDC schedule or according to the recommended catch-up schedule appropriate for my child's age. The providers at Aquidneck Pediatrics, LLC. may be willing to adjust the required schedule provided that each vaccine is given within the age range recommended by the CDC and all children are fully vaccinated within the time frame outlined by my provider. The providers at Aquidneck Pediatrics, LLC. reserve the right to approve or deny alterations to the required vaccine schedule. I understand that I am responsible for any additional fees associated with an alternate vaccination schedule.

I understand that if I choose to not vaccinate my child at all or choose to completely eliminate any vaccine from the schedule, my provider can refuse to provide services to my child. I understand that a detailed vaccination policy is available for my review. I also understand that there are vaccine information statements on file in the office for patient education, and I have the right to request and obtain said documents if I so desire.

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: ____ /____ /____

Patient's Name: _____ Date: ____ /____ /___

Pediatric No-Show Policy

- This policy refers to appointments scheduled in advance with the office such as well visits, medication checks, follow ups, and same day sick appointments.

- If a patient is unable to keep their appointment, they are required to cancel their appointment with an appropriate prior notice of at least 24 hours. Is this is not done, a $50 fee may be charged to the patient, payment for which would be due immediately and prior to the next scheduled appointment.

- If you are late for your scheduled appointment by 15 minutes or more, it is considered a no-show and the appointment must be rescheduled.

- If the missed appointment was for a new patient, the appointment will not be rescheduled with any of our providers and the patient along with any siblings will be discharged from our practice.

- After 2 missed appointments within the past 24 months (2 years), a warning letter and a copy of our no-show policy will be sent by mail to the parent or guardian. The letter will inform them that if a 3rd appointment is missed it may be necessary to discharge the patient and any other pediatric patients (siblings) within their family from the practice.

- Upon a 3rd missed appointment, the parent or guardian will be sent a letter of discharge by certified mail as well as a medical record release form.

- We will be available to treat the child and any siblings for 30 days on an emergency basis only, after which he or she must access care from another provider.

- After 30 days has passed, the patient's and siblings' charts will be marked as inactive and they will not be able to receive care from any pediatrician at Aquidneck Pediatrics, LLC.


QUIDNECK
PEDIATRICS

AQUIDNECK PEDIATRICS

1272 West Main Road, Middletown, RI 02842 Phone 401-847-2290 Fax 401-849-8446

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Name of Patient: _____ DOB: _____

Patient's Street Address: _____

_____ Telephone: _____

Reason for request: □ getting second opinion only □ living elsewhere during part of year

□ leaving group due to move □ leaving group due to dissatisfaction □switching PCP □ other: _____

As the patient or the patient's legal representative, I authorize:

Name of physician: _____

Address of physician: _____

To disclose to:

Name of recipient: _____

Address of recipient: _____

If these records are to be picked up at our offices, I authorize them to be released to:

Name of recipient: _____

Address of recipient: _____
Relationship to patient: _____

MEDICAL RECORDS (*Please check one.*)

□ Information and records or copies of records relating to the history, examination, tests, treatment, and services rendered to me both as an outpatient and/or inpatient in connection with any condition or disease for the purpose of ___ .

I specifically _____ to the disclosure and release of sensitive medical
(consent or refuse)
information concerning my treatment of mental illness, Human Immunodeficiency Virus, drug addiction, abuse, or dependency, or venereal disease, if any.
□ Only those specific records as I describe:_____
I may withdraw my consent by giving written consent to the above party, at any time prior to the disclosure or release of the information. In the absence of the withdrawal of permission, this consent will expire one year after it is signed. A photographic copy of this authorization shall be as valid as the original.
I may refuse to sign this authorization. If so the refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
If my information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and, as a result, it may no longer be protected by the Privacy Rule
Rhode Island law requires medical records to be copied within thirty days from receipt of the request and allows for a reasonable processing fee. **Aquidneck Pediatrics will charge a fee for these requests (See back for fee structure). I agree to pay this fee.**

_____ _____
Authorized Signature **Date**

_____ _____
Print Name **Relationship if not patient or custodial parent**

Patient Record Reproduction Fee Approval Form

RI Code of Regulations R5-37-W1D/DO: Rules & Regulations Pertaining to Licensure and Discipline of Physicians - Medical Records.

11/2 Medical records and medical bills may be requested by the patient or an authorized representative. All medical record requests to physicians shall be made in writing or upon receipt of a properly executed Authorization for Release of Health Care Information. Reimbursement to the physician for copying of medical records shall not exceed 25 cents per page for the first 100 pages. After 100 pages, the fee shall not exceed 10 cents per page. A maximum fee of $15.00 may be charged for retrieval regardless of the amount of time necessary to retrieve the record. A special handling fee of an additional $10.00 may be charged if the records must be delivered to the patient or authorized representative within forty-eight (48) hours of the request. The healthcare provider shall ensure that the copies are transmuted (mailed) within 30 days after receiving a valid written request

FEE Schedule (check off all selections that apply):

It is the goal of Aquidneck Pediatrics. LLC to provide our patients various options based on level of need. Based on that principle, please review the following fee schedule:

_____ Provide a 2 year abstract (includes 5 years of diagnostics). Copy fee is $20.00.

_____ Entire record, You will be invoiced at the allowable R.I. Statute Copy Fee: $15.00 clerical fee, plus $.25 for the first 100 pages, $.10 for any pages over 100.

_____Any records requiring mailing will have a cost of shipping and handling of $3.50 added to the order.

_____ There is a special handling fee of $10.00 for records required in less than 48 hours. In some instances, this turn-around time may not be feasible,

Please indicate selection(s) above and remit payment with the completed form to: Aquidneck Pediatrics, LLC, 1272 W Main Road, Middletown RI 02842, ATTN: Medical Records. Please be advised that we accept checks, VISA, and MasterCard.

Patient Signature: _____ Date: _____

Print Name: _____

Patient Address: _____

___ Bill my credit card. Card type/number: _____Exp Date: _____

___ Check Enclosed (Payable to Aquidneck Pediatrics, LLC.)

Form updated 06/17

NOTICE OF PRIVACY PRACTICES

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

A Federal regulation, known as "HIPAA Privacy Rule," requires that we provide detailed notice in writing of our privacy practices. We know that this notice is long. The HIPAA Privacy Rule requires us to address many specific things in this notice.

OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient, or may be used to identify a patient. This information is called "Protected Health Information" or "PHI." This notice describes your rights as our patient and our obligations regarding the use and disclosure of PHI. We are required by law to:

- Maintain the privacy and security of PHI about you.
- Give you this Notice of our legal duties and privacy practices with respect to PHI.
- Comply with the terms of our Notice of Privacy Practices that is currently in effect.

We are required to abide by the terms of this notice, which we may change from time to time. Any new notice will be effective for all PHI that we maintain at that time. If and when this notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised notice upon your request made to our Privacy Official.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

For uses and disclosures relating to treatment, payment, or health care operations, we do not need authorization to use or disclose your medical and behavioral health information:

Treatment: We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. We may consult with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, we may use and disclose PHI when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider so that the health care provider has the information necessary to treat you.

Payment: We may use and disclose PHI so that we can bill and collect payment for the treatment and services provided to you. Before providing treatment or services, we may share details with your health plan concerning the services you are scheduled to receive. For example, we may ask for payment approval from your health plan before we provide care of services. We may use or disclose PHI to find out if your health plan with cover the cost of care and services we provide. We may use and disclose PHI to confirm you are receiving the appropriate amount of care to obtain payment for services. We may use and disclose PHI for billing, claims management, and collection activities. We may disclose PHI to insurance companies providing you with additional coverage. We may disclose limited PHI to consumer reporting agencies relating to collection of payment owed to us. We may also disclose PHI to another health care provider or to a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that health care provider, company, or health plan. For example, we may allow a health insurance company to review PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.

Health Care Operations: We may use and disclose PHI in performing business activities that are called health care operations. Health care operations include doing things that allow us to improve the quality of care we provide and to reduce health care costs. We may use and disclose PHI about you in health care operations such as:

- Reviewing and improving the quality, efficiency and cost of care that we provide to our patients. For example, we may use PHI about you to develop ways to assist our physicians and staff in deciding how we can improve the medical treatment we provide to others.
- Improving health care and lowering costs for groups of people which have similar health problems and helping to manage and coordinate the care for these groups of people. We may use PHI to identify groups of people with similar health problems to give them information, for instance, about treatment alternatives, and educational classes.
- Reviewing and evaluating the skills, qualifications and performance of health care providers taking care of you and our other patients.
- Providing training programs for students, trainees, health care providers, or non-health care professionals (for example, billing personnel) to help them practice or improve their skills.
- Cooperating with various people who review our activities. For example, PHI may be seen by doctors reviewing the services provided to you, and by accountants, lawyers and others who assist us in complying with the law and managing our business.
- Assisting us in making plans for our practice's future operations.
- Resolving complaints within our practice.

- Reviewing our activities and using and disclosing PHI in the event that we sell our practice to someone else or combine with another practice.
- Business planning and development, such as cost-management analyses.
- We will share your PHI with "business associates" who require the information to perform various activities (e.g interpreter services).
- We may use sign in sheets where you will be asked to sign your name and/or physician. We may also call you by name in the waiting room when your doctor is ready to see you.
- In addition, unless you object, we may use your health information to send appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION

Required by Law: We may use and disclose PHI as required by federal, state, or local law. Any disclosure complies with the law and is limited to the requirements of the law.

Public Health Activities: We may use or disclose PHI to public health authorities or other authorized persons to carry out certain activities to public health, including the following activities:

- To prevent or control disease, injury or disability;
- To report disease, injury, birth or death;
- To report child abuse or neglect;
- To report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
- To locate and notify persons of recalls of products they may be using;
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease; or
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a patient has been a victim of domestic violence, abuse, or neglect.

Health Oversight Activities: We may disclose PHI to health oversight agency for oversight activities including, for example, audits, investigations, licensure and disciplinary activities conducted by health oversight agencies.

Lawsuits and Other Legal Proceedings: We may use and disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery requests, or other required legal processes.

Law Enforcement: Under certain conditions we may disclose PHI to law enforcement officials. These law enforcement purposes include:

- Limited requests for identification location purposes.
- Legal processes required by law.
- Suspicion that death has occurred as a result of criminal conduct.
- In the event that a crime occurs on the premises of the practice.
- Pertaining to victims of a crime.
- In response to a medical emergency not occurring at the office, where it is likely that a crime has occurred.

Coroners and Medical Examiners: We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death.

Organ and Tissue Donation: If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye, or tissue donation and transplantation.

Research: We may use and disclose PHI about you for research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule.

To Avert a Serious Threat to Health or Safety: We may use or disclose PHI about you in limited circumstances when necessary to prevent a threat to the health and safety of a person or to the public. This disclosure can only be made to a person who is able to help prevent the threat.

Specialized Government Functions: Under certain circumstances we may disclose PHI:

- For certain military and veteran activities, including determination of eligibility for veterans benefits and where deemed necessary by military command authorities.
- For national security and intelligence activities.
- To help provide protective services for the president and others.
- For the health and safety of inmates and others at correctional institutions.

Disclosures required by HIPAA Privacy Rule: We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule. We are also required in certain cases to disclose PHI to you upon your request to access PHI or for an accounting of certain disclosures of PHI about you.

Workers' Compensation: We may disclose PHI as authorized by workers' compensation laws or other similar programs that provide benefits of work-related injuries or illness.

Decedents: In case of patient death, we may take relevant disclosures to the deceased's family and friends under essentially the same circumstances such disclosures were permitted when the patient was alive; that is, when these individuals were involved in providing care or payment for care unless the decedent had expressed a contrary preference.

Childhood Immunizations: We may disclose immunizations to schools required to obtain proof of immunization prior to admitting the student so long as the physicians have and document the patient or patient's legal representative's "informal agreement" to the disclosure.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRE YOUR AUTHORIZATION

All other uses and disclosures of PHI about you will only be made with your written authorization. If you have authorized us to use or disclose PHI about you, you may revoke your authorization at any time, except to the extent we have taken action based in the authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Under federal law, you have the following rights regarding PHI about you:

Right to Request Restrictions: You have the right to request additional restrictions on the PHI that we may use for treatment, payment and health care operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care that otherwise are permitted by the Privacy Rule. We are not required to agree to your request. If we do agree to your request, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you in the case of an emergency. To request restrictions, you must make your request in writing to our Privacy Official. In your request, please include (1) the information that you want to restrict (2) how you want to restrict the information and (3) to whom youwant these restrictions to apply. You also have the right to request that any services performed that were paid for in full by you and not billed to your insurance company not be disclosed- this request must be in writing. For example, for services you request no insurance claim be filed and for which you pay privately, you have the right to restrict disclosures for these services for which you paid out of pocket.

Right to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. For example, you may request that we contact you at home, rather than at work. You must make your request in writing to our Privacy Official. You must specify how you would like to be contacted (for example, by regular mail to your post office box and not your home). We are required to accommodate reasonable requests.

Right to Inspect and Copy: You have the right to request the opportunity to inspect and receive a copy of PHI about you in certain records that we maintain. This includes your medical and billing records but does not include any psychotherapy notes or information gathered or prepared for a civil, criminal, or administrative proceeding. We may deny your request to inspect and copy PHI only in limited circumstances. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. Please contact our Privacy Official if you have questions about access to your medical record. If you request a copy of PHI about you, we may charge a reasonable fee for the copying, postage, labor and supplies used in meeting your request.

Right to Amend: You have the right to request that we amend PHI about you as long as such information is kept by and for our office. To make this type of request you must submit your request in writing to our Privacy Official. You must also give us a reason for your request. We may deny your request in certain cases.

Right to Receive an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures that we have made of PHI about you. This is a list of disclosures made by us other than disclosures made for treatment, payment, and health care operations. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The first list that you request in a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred. In some limited circumstances, you have the right to ask for a list of the

disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or health care operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

Right to a Paper Copy of This Notice: You have a right to receive a paper copy of this notice at any time. You are entitled to a paper copy of this notice and/or an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request even if you have previously agreed to receive this notice electronically. To obtain a paper copy of this notice, please contact our Privacy Official.

Right to supply an alternate address:
You have the right to ask that we send you information at an alternative address or by an alternative means. We will consider your request, but are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so.

Right to Notification:
In the event of an unauthorized disclosure or access to your PHI, we will contact you promptly as required by law.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with us and/or the Secretary of the United States Department of Health and Human Service at the Office for Civil Rights' Regional Office. We will provide the mailing address at your request. We will take no retaliatory action against you if you make any complaints, whether to us or the Department of Health and Human Services. We support your right to the privacy of your health information.
I*f you have questions about this Notice or any complaints about our privacy practices, please contact our Privacy Official either by phone or in writing as follows:*

O**FFICIAL CONTACT INFORMATION**
You may contact our Privacy Official at the following address and phone number:
Kathleen Pugatch
Practice Manager
Aquidneck Pediatrics, LLC
1272 West Main Road Middletown, RI 02842 Tel: 401-847-2290
(This notice was published and first became effective on June 1, 2017.)