HEIGHTS PEDIATRICS, P.C.
NOTICE OF PRIVACY PRACTICES (WITH HITECH UPDATES)

Effective Date: September 20, 2013

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

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Katerina Silverblatt, MD
Mailing Address: 145 Henry street suite 1G; Brooklyn, NY, 11201
Telephone: 718 858 4924
Fax: 718 522 4954

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

Protected Health Information is information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

For Treatment. We may use Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose Protected Health Information to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.

For Payment. We may use and disclose Protected Health Information so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for that treatment. We also may tell your health plan about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give Protected Health Information to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies.

For Health Care Operations. We may use and disclose Protected Health Information for our health care operations. For example, we may use Protected Health Information for our general business management activities, for checking on the performance of our staff in caring for you, for our cost-management activities, for audits, or to get legal services. We may give Protected Health Information to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you. If you do not call within 24 hours of your scheduled appointment we will charge a small sum of $50.00 as a no show fee.

Minors. We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Personal Representative. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your Protected Health Information.

Research. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual.

As Required by Law. We will disclose Protected Health Information about you 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 Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclosure the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your Protected Health Information.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

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

Workers' Compensation. We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for

contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities. We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves if you sue us.

Law Enforcement. We may release Protected Health Information if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be
the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security. We may release Protected Health Information to authorized federal officials for national security activities authorized by law. For example, we may disclose Protected Health Information to those officials so they may protect the President.

Coroners, Medical Examiners, and Funeral Directors. We may release Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.
Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. We may disclose Protected Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. But before we do that, we will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures. Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information. Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some

parts of this general Notice of Privacy Practices may not apply to these kinds of Protected Health Information. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your Protected Health Information. You have the following rights, subject to certain limitations, regarding your Protected Health Information:

Right to Inspect and Copy. You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Security Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of your Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days after we discover the breach. "Unsecured Protected Health Information" is Protected Health Information that has not been made unusable, unreadable, and undecipherable to unauthorized users. The notice will give you the following information:

- a short description of what happened, the date of the breach and the date it was discovered;
- the steps you should take to protect yourself from potential harm from the breach;
- the steps we are taking to investigate the breach, mitigate losses, and protect against further breaches; and contact information where you can ask questions and get additional information. If the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach in a major print or broadcast media.

Right to Request Amendments. If you feel that Protected 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 us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (2) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (unless the disclosures were made through an electronic medical record, in which case you have the right to request an accounting of those disclosures that were made during the 3 years before your request), (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or by e-mail). The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the

reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you
only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.
Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights. To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice. The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.
Immunization Registry

You grant us the permission to submit immunizations to the immunization registry.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Heights Pediatrics Office Financial Policy

Thank you for choosing Heights Pediatrics as your child's pediatrician.

1. **Payment Responsibility: Copays, deductibles, and coinsurance are due at the time of service,** before your appointment begins. The accompanying adult (parent, guardian, etc.) is responsible for payment. We accept cash, checks, and major credit cards (Visa, Mastercard, Discover, Amex). You may also keep a card on file for automatic billing. **Bounced/Returned checks:** $35 fee + original balance.

2. **Card on file agreement** - You have the option of leaving your credit card on file to be charged as balances accrue. You understand that you may change your payment method. If you do not change the payment method prior to the charge, you are authorizing the practice to charge the card on file up to $500 per transaction.

3. **Insurance Verification:** Present your **current insurance card** at every visit and ensure the correct copy is uploaded on digital check-in. If the insurance is incorrect, you will be responsible for payment of the full cost of the visit and will be required to submit the charges to the correct plan
.
4. **Certain insurances require you to select a Primary Care Physician or a PCP**. Please call your insurance and ensure your PCP is assigned to a Heights Pediatrics physician **before** your visit. If they have not been notified you may be financially responsible for this visit and/or your appointment will need to be rescheduled.

5. **Secondary Insurance:** We do not bill secondary plans. If you have a secondary insurance, you must pay the balance and we can provide you with a receipt to submit for reimbursement. You are responsible for any balances on your account.

6. **Non-Participating Insurance:** For out-of-network or uninsured patients, payment in full is due at the time of service. We will provide the necessary documentation for you to submit to your insurance for reimbursement. Any prior balances must be paid before your appointment.

7. **Referrals & Prior Authorizations:** It is your responsibility to understand your benefits and to know if you require referrals for specialist visits. Referrals and prior authorizations for services require a**t least 5 business days to complete.** No retroactive referrals can be provided.

8. **Balances:** Patient balances are billed immediately once your insurance plan's explanation of benefits (EOB) has been received by our office. **Your payment is due within 10 business days of your receipt of your bill.** Any balance left unpaid over 90 days will be forwarded to a collection agency.

9. **Appointment Policies: Standard Appointments:** Cancelations/reschedules within 24 hours prior to the appointment incur a $75 cancellation fee. **ADHD Initial Appointments:** A credit card is required to book your initial ADHD appointment. We require 48 hours' notice for cancellations or rescheduling. A $150 fee will be automatically charged to your card on file for late cancellations, reschedules, or no-shows.

10. **Well and Sick Visits at the Same Time:** Please be aware that your insurance treats well (preventive) visits and sick (problem) visits differently. If a separate sick issue is addressed during a well visit, your provider may bill for both services. You may be responsible for any copays, coinsurance, or deductibles required by your plan for the sick portion of the visit. Alternatively, the provider may choose to reschedule the well visit to focus on the acute concern, in which case standard sick visit fees will apply.

11. **Service Coverage:** Not all services we provide are covered by every plan; non-covered services, those services that the insurance determines to not be covered will be your responsibility, i.e.: *Holiday/Evening/Weekend Codes, forms/letters,*

phone calls, telemedicine, portal messages, prior authorizations, in-house testing such as *strep, Covid-19, RSV, flu, urinalysis*, etc.

12. **Medication Refills:** We encourage submitting medication refill requests at least 5 business days in advance. For non-PSP members, same-day requests would incur a fee of $50. **Please note refill requests will not be processed on weekends or after business hours.**

13. **Medical Records:** Printed: $20 (first 40 pages) + $0.75/page thereafter. Electronic (fax/USB): $20 flat fee. Mailed Records: If mailed, (printed or USB) records are subject to an additional delivery fee, determined by Fedex, which will be charged via card on file.

14. **Patient Service Plan (PSP):** All patients are subjected to opting in or out of the **Patient Service Plan (PSP)** as detailed here :

Services	**Accept PSP 2024 ($200 per child)**	**Decline PSP 2024 (Individual fees)**
Forms Completion (i.e. camp/sports forms or school-specific forms, other than the free DOE & 504 forms requested during well visits)	**Included -** *up to 5 business days turnaround time*	**$50 each -** *up to 10 business days turnaround time*
Expedited Form Fee (same day service add-on)	**$10 each**	**$50 each**
Refill Requests for Chronic Conditions - will only be processed during business hours (Mon-Fri) (i.e. asthma & mental health meds that are requested outside of follow-up appointments.)	**The request will be processed within 1 business day.**	**The request will be processed within 5 business days.** **Same day service requests are $50 each**
Miscellaneous Non-Medical Services (i.e. meetings with schools/therapists or phone meetings with parents when they are not present during the visit)	**Included**	**$50 each**
Heights Pediatrics Educational Zoom Classes	**Included**	**$20 each**
Infant and Toddler CPR Class	**$70 per person**	**$130 per person**
Heights Pediatrics Educational In-Person Classes (New Mom's Group, Playful Connection, etc.)	**$150 per person**	**$250 per person**

Prices subject to change.

Please reach out to our office if you have a question about your bill. Most problems can be resolved quickly and your call will prevent misunderstandings. If you have trouble paying a bill, please discuss the situation with us and arrangements can be made. Financial considerations should never prevent children from receiving the care they need at the time that it is needed.

Authorization for Access to Patient Information Through a Health Information Exchange Organization

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Heights Pediatrics to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

Details about the information accessed through Healthix and the consent process:

1. How Your Information May be Used. Your electronic health information will be used **only** for the following healthcare services:

- **Treatment Services.** Provide you with medical treatment and related services.
- **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
- **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
- **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. What Types of Information about You Are Included. If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases
- Medication and Dosages
- Diagnostic Information
- Allergies
- Substance-use history
- Clinical notes
- Discharge summary
- Employment Information
- Living Situation
- Social Supports
- Claims Encounter Data • Lab Test

3. Where Health Information About You Comes From. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical

laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Heights Pediatrics at (718) 858-4924; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.

By agreeing, I give consent for Heights Pediatrics to access ALL of my electronic health information through Healthix to provide health care unless stated otherwise on the agreement page. My questions about this form have been answered and I have been provided a copy of this form.My questions about this form have been answered and I have been provided a copy of this form.

heights pediatrics

HIPAA / Financial Policy / Healthix / Consent To Treat Parent/Guardian Agreement

Patient's Full Name: _____ Date of Birth: _____/_____/_____

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American
☐Hawaiian Native/Pacific Islander ☐White ☐Decline to Specify

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Decline to Specify

Language: _____ ☐Decline to Specify

Preferred Pharmacy: _____ Phone: (_____)_____-_____ Zip Code: _____

CONSENT TO TREAT:

☐ **CONSENT FOR ONLY PARENTS TO BRING IN PATIENT**

☐ **CONSENT TO PERMIT INDIVIDUALS OTHER THAN PARENTS TO ACCOMPANY CHILDREN FOR TREATMENT**

(Authorize nanny/grandparent/step-parent/sitter to accompany child(ren) to Heights Pediatrics, P.C. for the provision of medical services and to view/discuss child's protected health information.) Please list all names of individuals allowed to bring in your child(ren): _____

These individuals are able to authorize procedures such as (check categories):

☐ Immunizations ☐ Lab Orders ☐ X-Rays ☐ In-house Tests (strep test, RSV test, flu test, urine test, etc.)

☐ **CONSENT TO TREAT UNACCOMPANIED MINOR AT HEIGHTS PEDIATRICS, P.C. [13 YEARS AND OLDER]**

(Request and authorize Heights Pediatrics, P.C. and its personnel to deliver medical care to my MINOR CHILD. This includes routine immunizations, in house lab work and treatments.)

Child's Name: _____ Date of Birth: _____/_____/_____

Child's Name: _____ Date of Birth: _____/_____/_____

By signing below, I agree to the following: I consent to treatment for myself/my child; I have read, understand, and agree to the Financial Policy and accept full responsibility for any payments due; and I authorize the use and disclosure of my protected health information as outlined in the HIPAA notice, including for treatment, payment, healthcare operations, and specific programs such as the immunization registry and Healthix.

☐ Accept Healthix ☐ Decline Healthix

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Print Parent/Guardian Name **Child's Name**