Chesapeake Pediatrics

I _____ (parent/guardian) give permission for

_____ to accompany

_____ (child(ren) to physician visits when I am unable to attend. To pick up records a release form must be signed.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date

This will expire one year from the date signed.

Chesapeake Pediatric & Adolescent Associates P.A.
106 Milford Street, Suite 201 Salisbury, MD 21804
29 Broad Street, Suite 201 Berlin, MD 21811
Tel: 410-543-1616 · Fax: 410-543-8497 · www.chesapeakepeds.com

Chesapeake Pediatrics & Adolescent Associates, P.A.

Parents are required to pay for their child's health care at the time services are provided. Upon request, we will be happy to provide you with an estimate of the cost for specific services before your appointment. We accept cash, checks, MasterCard, Visa, and Discover cards.

It is your responsibility to bring your most current insurance card with you to ***every*** office visit. You will be asked to present the card upon arrival along with any applicable co-payment. If you have changed insurance since the previous visit, please obtain the expiration date of the old policy and the effective date for the new coverage prior to your appointment. If this information is not provided, you will be expected to pay at the time of service.

Billing and Nonpayment: Co-payment and deductible are payable in full at the time of service. If you do not have an active/ valid insurance card, payment is expected at the time of service. Please check with your plan to verify that we are a participating provider. Any services received and later denied by your insurance carrier are your responsibility. This arrangement is part of your contract with your insurance company. If your balance is 90 days pays due we may refer your account to our collection agency, unless payment plan arrangements are made with our office.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If you do not supply this information within a timely manner, you may be responsible for the balance of a claim. If your insurance changes, please notify us before your next appointment so we can make the necessary changes to help you receive your maximum benefits.

Covered/Non-Covered Services: Chesapeake Pediatrics is not responsible for knowing your insurance policy coverage. You must contact your insurance company to determine what your policy will cover. The billing staff of Chesapeake Pediatrics will file all claims for covered services with your insurance company, if the physician is a contracted provider.

You are responsible for any balances that may be due to the physician as a result of:

- co-insurance or co-payments
- annual deductible amounts
- non-covered services
- out-of-network charges
- terminated coverage
- exhausted benefits
- no insurance coverage
- failure to respond to insurance company correspondence or inquiries
- failure to list our physician as your Primary Care Physician

Release of Information and Payment Authorization:

All Insurance Companies and Third Party Payers: I hereby authorize Chesapeake Pediatrics and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediaries for all services rendered by the physician(s) and authorize my insurance carrier or its intermediaries to issue payment directly to Chesapeake Pediatrics and/or physician(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

Guarantee of Payment: I understand that filing claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges, I further acknowledge that I am responsible for the payment of all charges for services rendered by Chesapeake Pediatrics to my child(ren) or the patient indicated. By signing this document, I personally guarantee the payment of these charges for medical services rendered. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I understand that I will receive a statement for any balance due after the claim has been processed by the insurance company. I understand and agree that the balance on my statement will be paid in full to the physician within 30 days.

_____ _____

Patient Name Patient DOB

X_____ _____

Signature of Patient or Parent/Guardian if Patient is under 18 years of age **Date**

Chesapeake Pediatrics Patient Information

Patient Information

LAST NAME _____ FIRST NAME _____ M.I_____

STREET ADDRESS _____

CITY _____STATE _____ ZIP CODE _____ S.S.N. _____- _____ - _____

D.O.B _____/_____/_____ SEX _____ PHONE _____ CELL _____

EMAIL _____ RACE _____

ETHNICITY: HISPANIC OR LATINO NOT HISPANIC OR LATINO OTHER _____ LANGUAGE _____

Parent(s) or Guardian(s) Guarantor Information

LAST NAME _____ FIRST NAME _____ M.I_____

STREET ADDRESS _____ CITY/STATE/ZIP _____

S.S.N. _____- _____ - _____ D.O.B _____/_____/_____ SEX _____ RELATIONSHIP TO PT_____

PHONE _____ CELL _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____ PHONE _____

LAST NAME _____ FIRST NAME _____ M.I_____

STREET ADDRESS _____ CITY/STATE/ZIP _____

S.S.N. _____- _____ - _____ D.O.B _____/_____/_____ SEX _____ RELATIONSHIP TO PT_____

PHONE _____ CELL _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____ PHONE _____

PATIENT'S MOTHER MAIDEN NAME _____

IN CASE OF EMERGENCY, PLEASE PROVIDE THE NAME OF A RELATIVE OR FRIEND **A DIFFERENT ADDRESS**

NAME _____ PHONE _____

ADDRESS _____ RELATIONSHIP TO PT _____

PREFERRED PHARMACY _____ **LOCATION** _____

STATEMENT OF RESPONSIBILITY

The policy of this office is the parent or legal guardian who requests treatment for this child is responsible for all fees and services. Insurance co-payments are expected the day of service unless arrangements are made in advance. Any remaining balances after insurance payments are that of the financially responsible party. When payment is not made as agreed, account balances inclusive of all charges and reasonable collection costs agreed to herein including but not limited to reasonable attorney's fees may be sent to outside collection firms for legal collection action. The patient and/or guarantor or responsible party shall be responsible for and agree to pay all reasonable collection costs including but not limited to, reasonable collection agency fees, attorney's fees, and court costs. I Also understand and agree that if my personal check is returned for any reason, I will pay a $35.00 returned fee and my personal checks will no longer be accepted as payment for services rendered.

_____ _____ _____/_____/_____

Parent or legal Guardian Print Name Parent or legal Guardian Signature Today's Date

Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight_____Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization:_____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) _____	No ☐	Yes ☐	_____
_____			
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____
_____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
_____		
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ____	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐
_____		

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review:

Maryland Healthy Kids Program

Cuestionario de Historial Médico Familiar

Nombre del Paciente:	Fecha de Nacimiento:	Sexo: M F (circule)
Persona que llenó el Formulario: / Fecha de Hoy:	Relación con el Paciente::	

HISTORIAL DURANTE EMBARAZO Y AL NACER

Nombre del Hospital: _____
Enfermedades durante el embarazo No ☐ Si ☐
Medicamentos durante embarazo No ☐ Si ☐
Abuso de Alcohol o drogas No ☐ Si ☐
Problemas al Nacer No ☐ Si ☐
Describa: _____
Tipo de Parto ☐ Vaginal ☐ Cesárea
Peso al Nacer_____Peso al darle de alta_____
El bebé recibió vacuna para Hepatitis B No ☐ Si ☐
Fecha de la vacuna de Hepatitis B:_____
Examen Auditivo para recien nacidos No ☐ Si ☐

HISTORIAL PSICOSOCIAL

¿Quién vive en el hogar?_____
_____
¿Cuántas personas viven en el hogar?_____
☐ Alquilan ☐ casa propia ☐ refugio
¿Quién cuida el niño/a?_____
Fecha de Nacimiento Madre_____
Padre_____
Trabajan los Padres Madre No ☐ Si ☐
Padre No ☐ Si ☐
Hogar Sustituto _____Fecha:_____
¿Qué otro idiomas se hablan en la casa?_____
_____

HISTORIAL FAMILIAR

Hay alguien en la familia (padres, abuelos, tíos/as, hermanos/as) que haya tenido:

Alergias (a qué) _____			¿Quién?
	No ☐	Si ☐	_____
Asma	No ☐	Si ☐	_____
TB/Enfermedad del Pulmón	No ☐	Si ☐	_____
VIH/SIDA	No ☐	Si ☐	_____
Intentos Suicidas/Problemas	No ☐	Si ☐	_____
Mentales	No ☐	Si ☐	_____
Enfermedad del Corazón	No ☐	Si ☐	_____
Presión alta/Derrame	No ☐	Si ☐	_____
Colesterol Alto	No ☐	Si ☐	_____
Desórdenes de la	No ☐	Si ☐	_____
Sangre/"Sickle Cell"	No ☐	Si ☐	_____
Diabetes	No ☐	Si ☐	_____
Convulsiones	No ☐	Si ☐	_____
Alergias/Asma	No ☐	Si ☐	_____
Desórdenes Mentales	No ☐	Si ☐	_____
Cáncer	No ☐	Si ☐	_____
Defectos de Nacimiento	No ☐	Si ☐	_____
Pérdida de Audición	No ☐	Si ☐	_____
Problemas de habla	No ☐	Si ☐	_____
Enfermedades Renales	No ☐	Si ☐	_____
Abuso de Alcohol/ Droga	No ☐	Si ☐	_____
Hepatitis/Enfermedad del	No ☐	Si ☐	_____
Hígado	No ☐	Si ☐	_____
Enfermedad de la Tiroide	No ☐	Si ☐	_____
Problemas de Aprendizaje/	No ☐	Si ☐	_____
Deficit de Atención ("ADD")	No ☐	Si ☐	_____
Violencia Doméstica			
Otras:_____			

HISTORIAL DE SALUD

Alguna vez su niño/a ha tenido:

Alergias (a qué)_____		
Asma	No ☐	Si ☐
Varicela (año) _____	No ☐	Si ☐
Infecciones frecuentes de oído	No ☐	Si ☐
Problemas de Audición/Infecciones	No ☐	Si ☐
de la Vista	No ☐	Si ☐
Problemas de la Piel/Eczema	No ☐	Si ☐
Asma/Alergias	No ☐	Si ☐
TB/Enfermedad del Pulmón	No ☐	Si ☐
Convulsiones/Epilepsia	No ☐	Si ☐
Hipertensión/Presión Alta	No ☐	Si ☐
Enfermedad del Corazón/Defectos	No ☐	Si ☐
Hepatitis/Enfermedad del Hígado	No ☐	Si ☐
Diabetes	No ☐	Si ☐
Enfermedades del Riñón/Vejiga	No ☐	Si ☐
Problemas Físicos o de Aprendizaje	No ☐	Si ☐
Desórdenes de la Sangre/Hemofilia	No ☐	Si ☐
Enfermedades Transmitidas		
Sexualmente	No ☐	Si ☐
Problemas Emocionales o de		
Comportamiento	No ☐	Si ☐
Depresión/Pensamientos Suicidas	No ☐	Si ☐
Hospitalizaciones/Cirugías	No ☐	Si ☐
Abuso /Físico/Emocional/ o Sexual	No ☐	Si ☐
Problemas en las Coyunturas/Huesos	No ☐	Si ☐
Obesidad/Trastornos Alimenticios	No ☐	Si ☐

Otras: _____
Lista de Medicamento/s que toma:_____

Revisado por:	Fecha que fue Revisado:

Updated: 4/06

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

NAME OF PATIENT: _____ DATE OF BIRTH: _____

I authorize CHESAPEAKE PEDIATRICS AND ADOLESCENT ASSOCIATES, P.A. to use or disclose my health information, as described below:

1. Description of health information that may be used and/or disclosed: any records pertaining to health and treatment of your child: including immunizations, school med forms, day care, school forms and camp forms, pharmacies or diagnostic facilities.

2. Name(s) of organization(s) or person(s) who may receive and use the information: Any Physician that Chesapeake Pediatrics and Adolescent Associates, P.A. refer me to for further treatment.

3. The purpose for which the information will be used or disclosed: To enable my physician to receive the maximum amount of information concerning my health in order to treat my condition to the full extent of their ability.

4. To be able to leave text message, or voice message on personal voicemail boxes, or at places of employment pertaining to appointments for this office and/or for specialist appointments.

5. To retrieve prescription history if available, and reconcile medications.

6. Authorize consent to participate in a telemedicine appointment with provider. During the telemedicine appointment:

   a. Details of your medical history will be discussed through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d. Video, audio and/or photo recording may be taken of you during the procedure(s) or service(s)

7. I understand what I may revoke this authorization in writing at any time by sending a written request to the practice at the above address, except to the extent that action has been taken in reliance on this authorization as a condition for obtaining treatment or payment. I understand that I am not required to sign this authorization as a condition for obtaining treatment or payment. I understand that information disclosed pursuant to this authorization potentially could be subject to redisclosure by the recipient, and if redisclosed the information would no longer be protected by federal privacy rule.

By Signing below, I acknowledge that I have read, and I understand this authorization form.

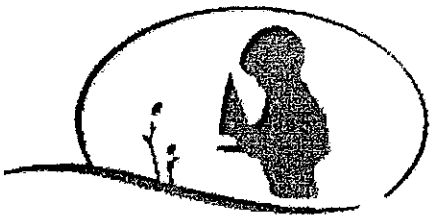
_____ _____

Signature of Patient or Guardian Date

If signed by Patient's Guardian, please print name and describe that relationship to the patient.

_____ _____

Printed Name Relationship



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PATIENT ACKNOWLEDGMENT FORM

PATIENT'S NAME: _____ DATE OF BIRTH: _____

I understand that patient's health information is private and confidential. I understand that this practice and its physicians work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health.

I understand that this practice may use and disclose my personal health information to help provide health care, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses or disclosures of this information without my permission. The situations are very unusual.

The practice has a detail document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting my patient privacy and is at my disposal at any time. I understand that I have the right to read the notice before signing this acknowledgement.

The practice may update this acknowledgement and "Notice of Privacy Practices". If I ask, the practice will provide me with the most current "Notice".

Within this "Notice" is contained a complete description of my privacy/confidentiality right. These rights include, but aren't limited to my medical records; Restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specific methods or to alternative location.

The practice has established procedures which help them meet their obligations to me as a patient. These procedures may include other signatures requirements, written acknowledgments; and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist the Practice by following these procedures if I choose to exercise any of my rights described in the "Notice".

My signature below indicates that I have been given the chance to review a current copy of this practice's "Notice of Privacy Practices".

_____ _____

Parent Signature Date

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APPOINTMENT POLICY

This office see's patients by appointment only. Appointments may be made by calling 410-543-1616 ext. 1 or sending a text message 443-523-0532. Under extenuating circumstances, we will take walk-ins if is necessary.

Our hours of operation are as follows:

Monday thru Friday 8:00 a.m. to 7:30 p.m.

Saturdays (emergency only by appointment) 8:00 a.m. to 10:30 a.m.

We always have a doctor on call after hours and you may contact them by calling our office at 410-543-1616 and you will be forwarded to our answering service.

If you feel you child has a life- threatening illness, we advise you to call 911 or go to the nearest emergency room.

If we are in the office and it not a life-threatening emergency, we would prefer to have your child seen here by one of the providers in the office.

Our no-show policy is as follow:

If you find that you cannot keep an appointment that you have made for your child, we ask that you call us at least 2 hours before the appointment. This will allow us to schedule other patients in those appointment spaces.

If you are new patient and you no show 2 appointments in a row, we ask that you find a new pediatrician.

Otherwise: If you no show 3 appointments in a 12- month period this will be grounds for dismissal from our practice. You will be sent a letter on your 3rd no show appointment. On the 4th no show you will be asked to find another pediatrician.

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Vaccine Policy Statement

- We believe in the effectiveness of vaccines to prevent serious illness and to save and that the protection of children from vaccines-preventable diseases is critical.
- We believe that parents should follow the immunization schedule provides by the centers for disease control, American Academy of Pediatrics, and the American Academy of Family Physicians.
- We believe **NOT advisable** to skip or delay vaccines as this will leave the children vulnerable to disease for a longer period of time and delaying and modifying the schedule gives vaccines has not been studied.
- We believe that the safety of vaccines used for our children is of utmost importance as outlined by the American Academy of Pediatrics, American Medical Association, and the Institute of Medicine and that the known risks from disease are far greater than any unknow/theoretical risk from vaccines.
- We know that vaccine preventable disease can have dangerous consequences including seizures, brain damage, and death. Currently 20% of the patients with measles are hospitalized.
- In order for vaccines to protect everyone, an estimated 85-95% of the population must be immunized.
- Most parents have never seen the devastating diseases that vaccines prevent. It is our goal to make sure they never do.
- Regretfully parents who refuse vaccine completely or want to follow a schedule other than the one recommended by the American Academy of Pediatrics may be asked to find another primary care provider who agrees with their views and opinions of vaccines.
- Websites for reference: www.aap.org www.cispimmunize.org

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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.

WE UNDERSTAND THAT YOUR HEALTH INFORMATION IS PERSONAL TO YOU, AND WE ARE COMMITTED TO PROTECTING THE INFORMATION ABOUT YOU. THIS NOTICE OF PRIVACY PRACTICES OR ("NOTICE") DESCRIBES HOW WE WILL USE AND DISCLOSE PROTECTED INFORMATION AND DATA THAT WE RECEIVE OR CREATE RELATED TO YOUR HEALTH CARE.

OUR DUTIES: We are required by law to maintain the privacy of your health information, and to give you this notice describing our legal duties and privacy practices. We are also required to follow the terms of the notice currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: We will not use or disclose your health information without your authorization, except the following situations.

TREATMENT: We will not use and disclose your medical information while providing, coordinating or managing your health care. For example, information obtained by a nurse, physician or other member of your healthcare team will be recorded in our record and used to determine the course of treatment that should work best for you. Your physician will put in the records his or her expectations of the members of your healthcare team. Members of your healthcare team will that record that actions they took and their observations. In that way, the physician will know how you are responding to treatment. We may also provide the other healthcare providers with your information to assist him or her in treating you.

PAYMENT: We will use and disclose your medical information to obtain or provide compensation or reimbursement for providing our health. For example, we may send a bill to your or your health plan. The information on or accompanying the bill may include information that identifies your, as well as your diagnosis, procedures, and supplies used. As another example, we disclose information about you to your health plan so that the health plan may determine your eligibility for payment for certain benefits.

HEALTH CARE OPEARATIONS: We will use and disclose your health information to deal with certain administrative aspects of your health care, and to manage our business more effectively. For example, members of our medical staff may use information in your health records to asses the quality of care and outcomes in your case and others like it. This information will then be used in an effort to improve the quality and effectiveness of the healthcare and services we provider.

BUSINESS ASSOCIATES: The are some services provided in organization through contracts with business associates. We may disclose your health information to our business associates, so they can perform the job we've asked them to do. However, we require the business associate to the precautions to protect your health information.

NOTIFICATION AND COMMUNICATION WITH FAMILY: We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, your location and general condition.

RESEARCH: consistent with applicable law we may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the search proposal and established protocols to ensure the privacy of your health information.

A HEALTH CARE PROVIDER MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION WITHOUT AN INDIVIDUALS WRITTEN AUTHORIZATION IN THE FOLLOWING CIRCUMSTANCES:

A. **FUNERAL DIRECTOR, CORONER, AND MEDICAL EXAMINER**
B. **ORGAN PROCUREMENT ORGANIZATIONS**
C. **FOOD AND DRUG ADMINSTRATIONS (FDA)**
D. **PUBLIC HEALTH**
E. **VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE**
F. **HEATH OVERSITE**
G. **COURT PROCEEDING**
H. **LAW ENFORCEMENT**
I. **INMATES**
J. **THREATS TO THE PUBLIC HEALTH OR SAFETY**
K. **SPECIALIZED GOVERNMENT FUNCTIONS**
L. **WORKERS COMPESATION**

OTHER USES: We may also use and disclose your personal health information for the following purposes:

To contact you to remind you of an appointment for treatment.
To describe or recommend treatment alternatives to you.
To furnish information about health-related benefits and services that may be of interest to you.

PROHIBITION ON OTHER USE OR DISCLOSURE: We may not make any other uses or disclosure of your personal health information without our written authorization. Once given, you may revoke the authorization by writing to the contact person listed below. Understandably, we are unable to take back any disclosure we have already made with your permission.

INDIVIDUAL RIGHTS: You may have many rights concerning the confidentiality of your health information. You have the right:

To request restrictions on the health information we may see and disclose for treatment, payment and health care operations. We are not required to agree to this request. To request restrictions; please send a written request to address below. To receive confidential communications of health information about your in a certain manner or at a certain location. For instance, you may request that we only contact you at work or by mail. To make such a request, you must write to us at the address below, and tell us how or where you wish to be contacted. To inspect or copy your health information. You must submit your request in writing to the address below. If you request of copy of your health information, we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information. If you are denied access to your health information, you may request a denial be reviewed. Another licensed health professional will then review our request and the denial. The person conducting the review will not be the person who denied your request. We will comply with outcome of the review. To amend health information. If you feel that health information, we have about your is incomplete, your must write to us at the address below. You must also give us a reason to suppose your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to suppose your request. WE may also deny your request if:

The information was not already created by us, unless the person that created.

The information is no longer available to make the amendment.

The information is not part of the health information kept by or for us.

The information is not part of the information you would be permitted to inspect or copy, or

The information is accurate and complete.

To receive an accounting of disclosures of your health information. You must submit in writing to the address below. Not all health information is subject to this request. Your request must state a time period, no longer than 6 years and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically). The first accounting request within 12-month period is free. For additional accountings, we may charge you the cost of providing the accounting. We will notify you of this request before charges are incurred.

To receive a paper copy of this notice upon request, even if you have agreed to receive the notice electronically. You must submit a request for a paper notice in writing to the address below.

Chesapeake Pediatrics

All requests to restrict use of your health information for treatment, payment and health care operations, to inspect and copy health information to amend your health information or to receive an accounting of disclosures of health information must be made in writing to the contacted person listed below.

COMPLAINS: If you believe that your privacy rights have been violated, a complaint may be made to our privacy officer at 410-543-1616, or the address listed below. You may also submit a complaint to the Secretary of the department of health and human services. We will not retaliate against you for filing a complaint.

CONTACT PERSON: Our contact person for all questions, request or further information related to the privacy of your health information is:

Natalie Bloodsworth
106 Milford Street, Suite 201
Salisbury, MD 21084
410-543-1616
Attn: Office Manager

CHANGES TO THIS NOTICE: We serve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in revised notice that will be poses prominently in our practice.

Effective date: May 22, 2020