CARING HEARTS PEDIATRICS, LLC.

518 E. Carolina Ave. Ste. B
Hartsville, SC 29550
Phone: 843-383-4426
Fax: 843-383-8509

Authorization for Release of Health Information

Name of facility records are being released from:

NAME _____

ADDRESS _____

_____

PHONE NUMBER _____

I hereby authorize the above named facility to release/disclose medical information to CARING HEARTS PEDIATRICS, LLC. 518 E. Carolina Ave. Ste. B Hartsville, SC 29550 regarding:

NAME OF PATIENT _____

DOB _____

SSN _____

Purpose of Disclosure:

[ ] Transferring to practice

[ ] Other: _____

Specific Information to be Released:

[✓] All medical information

[✓] Copy of growth chart

[✓] Immunization record

[✓] Radiology reports

[✓] Laboratory reports

[✓] Other: _____

I understand that the information in my health record may contain information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, and that I do not need to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.

I understand that this authorization will expire in **6 months** unless otherwise specified.

_____ _____

Signature of patient or legal representative Date

_____ _____

Signature of witness Date

CARING HEARTS PEDIATRICS, LLC.
REGISTRATION FORM

(Please Print)

Today's date:	Acct. #

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Birth Date: / /	Sex: ❑ F ❑ M
Street address:		SSN:	Home Phone: ( )	
P.O. box:	City:	State:	ZIP Code:	
Mother's Name:	Father's Name:	Legal Guardian:	Cell/Alternate Phone: ( )	

Race: ❑ White/Caucasian ❑ Black/African American ❑ Asian ❑ Native American/Native Indian/Alaska Native ❑ Pacific Islander ❑ More Than One Race ❑ Other:_____

Ethnicity: ❑ Hispanic ❑ Not Hispanic Primary Language: ❑English ❑ Spanish ❑ Other:_____

Pharmacy Name and Location:

INSURANCE INFORMATION

Responsible Party Name:	Birth date: / /	Address (if different):	Home Phone: ( )
Relationship to patient:		Responsible Party's SSN:	

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Does the patient have Insurance coverage: ❑ Yes ❑ No

Name of Primary Insurance:

Insured's name:	Insured's SSN:	Birth date: / /	Group no:	Policy no:	Co-payment: $

Patient's relationship to Insured: ❑ Self ❑ Child ❑ Other: Insurance Phone:

Name of secondary insurance (if applicable):	Insured's name:	Group no:	Policy no:

Patient's relationship in Insured: ❑ Self ❑ Child ❑ Other: Insurance Phone:

PLEASE LIST NAMES OF PERSON(S) ALLOWED TO BRING PATIENT FOR TREATMENT:

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone#:
Name:	Relationship:	Phone#:

I authorize Caring Hearts Pediatrics, LLC. to provide medical screening, assessment, diagnosis, and treatment as is found necessary. I also authorize the release of any medical information necessary to process claims and promote continuity of care with other healthcare agencies. I authorize any insurance benefits to be paid directly to Caring Hearts, and understand that I am financially responsible for any balance.

*Patient/Guardian Signature:*_____ *Date:*_____

CARING HEARTS PEDIATRICS
PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** ____/____/____

PATIENT & FAMILY HISTORY

CONDITION	Patient	Family
Anemia	☐	☐
Autism	☐	☐
ADHD/ADD	☐	☐
Asthma	☐	☐
Birth Defects	☐	☐
Bleeding Disorders	☐	☐
Cancer	☐	☐
Cerebral Palsy	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Down Syndrome	☐	☐
Drug Abuse	☐	☐

CONDITION	Patient	Family
Genetic Disorders	☐	☐
Headaches	☐	☐
Heart Disease	☐	☐
High Cholesterol	☐	☐
High Blood Pressure	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Seizures	☐	☐
Skin Problems	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐

Other: _____

If Needed, Please Explain Above Responses:

PATIENT'S PAST MEDICAL HISTORY:

- Surgeries_____
- Hospitalizations_____
- Infections_____
- Other_____

BIRTH HISTORY:

- Was patient full term? ☐ Yes ☐ No
- Birth Weight: _____
- Delivery: ☐ Vaginal ☐ C-section
- Birth Complications: _____
- Hospital patient was born at: _____

Allergies:

- ☐ None
- ☐ Medications_____
- ☐ Food_____
- ☐ Environmental_____
- ☐ Latex

Medications:

- List any medications taken by patient: _____
  _____
  _____
  _____
  _____
- ☐ None

Has patient seen or consulted specialists or other health care providers? ☐ Yes ☐ No

If so, please list: _____

ACKNOWLEDGEMENT OF RECEIPT OF CARING HEARTS PEDIATRICS, LLC. NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Caring Hearts Pediatrics, LLC. Notice of Privacy Practices.

Print Name	Signature	Date

Employee Signature	Date Acknowledgement Received

If notice or acknowledgement were not received, please list the reason why below:

_____

_____

_____

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

NOTICE OF PRIVACY POLICY

Effective date June 11, 2012

The following is the privacy policy of CARING HEARTS PEDIATRICS, LLC as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires us by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information, without your consent.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications with case management or care coordination; (c) reviewing the qualifications of training health professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) to avert a serious threat to health or safety; (h) correctional institutions and other law enforcement custodial situations; (i) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes: Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for

use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS").

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

You have the right to receive a written accounting of all disclosures of your personal health information. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer.