Yuma Kids Clinic

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2851 S Ave B
Suite 2951
Yuma, AZ 85364

Phone: (928) 783-1222
(928) 783-1333
Fax: (928) 783-1444

ATTENTION PARENTS OF NEWBORNS

Congratulations on the arrival of your new family member. Below if important information you will need regarding your newborn and insurance coverage.

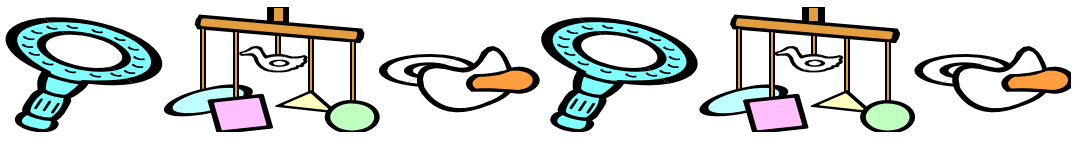
Most insurance companies will cover your newborn for the first 31 days from the date of birth, which includes both the mother and fathers policy. However, most federally funded, self-funded, and AHCCCS plans require you to enroll the newborn before they will pay any claims. Please check with your employer/insurance carrier or Deers for Tricare receipts regarding how to add your newborn to the policy.

We will bill your insurance carrier for the newborn charges as a courtesy to our patients. **If the charges are denied, you will be responsible for the bill. If charges are denied and you have enrolled the newborn you will be responsible for contacting the insurance company to reprocess any denied claims.** We cannot bill AHCCCS under the mothers plan. The newborn must have an AHCCCS ID number and must be enrolled in a plan that we accept. Please ensure that you select Saad Al Alou M.D. as your newborn's primary care physician.

Yuma Kids Clinic billing department is available to assist you with any questions you may have regarding billing and your insurance. Please contact us at 928-783-1222.

I have read and understand that any denied or non-covered charges will be my responsibility. It is also my responsibility to contact the insurance company to dispute any denied or non-covered services. I agree to pay any denied or non-covered charges in full within 10 days of the bill date unless prior arrangements have been made.

Newborn's Full Legal Name (please print)	Newborns DOB
Parent/Legal Guardians Name (please Print)	
Parent/Legal Guardians Signature	Today's Date



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Today's Date: _____

Patient's **Legal** Name				DOB
FIRST, MIDDLE, LAST				**mm/dd/yyyy**
Gender: Male ☐ Female ☐ Other ☐	SS#		Primary Language	
Address	Apt #	City	State	Zip Code
Phone #	Phone # for appointment reminder calls			
Mother or Legal Guardian Name			Mother/LG DOB	
Single ☐ Married ☐ Divorced ☐ Widowed ☐			Phone #	
Address	Apt/Sp #	City	State	Zip Code
E-Mail Address				
Employer Name	Employer Phone #			
Father's Name			Father's DOB	
Single ☐ Married ☐ Divorced ☐ Widowed ☐			Phone #	
Address	Apt/Sp #	City	State	Zip Code
E-Mail Address				
Employer Name	Employer Phone #			

SIBLINGS WHO ARE SEEN IN THIS PRACTICE--Please note a form will need to be completed for each child

Full Name	DOB	Male ☐ Female ☐
Full Name	DOB	Male ☐ Female ☐
Full Name	DOB	Male ☐ Female ☐
Full Name	DOB	Male ☐ Female ☐
Full Name	DOB	Male ☐ Female ☐

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In order to bill your insurance(s) company you must supply your insurance card(s) or a print out from your insurance company that contains all pertinent billing information.

PRIMARY INSURANCE **AHCCCS and Tricare are ALWAYS secondary to any other insurance coverage you may have**		
Name of Insurance Co	ID/Policy #	Group/Plan #
Name of Primary Policy Holder	Policy Holders SS#	Policy Holder DOB
Policy Holder Employer	By checking this box I acknowledge that I fully understand my insurance benefits and my financial responsibility for copays, coinsurance & deductibles ☐	
SECONDARY INSURANCE		
Name of Insurance Co	ID/Policy #	Group/Plan #
Name of Primary Policy Holder	Policy Holders SS#	Policy Holder DOB
Policy Holders Employer	By checking this box I acknowledge that I fully understand my insurance benefits and my financial responsibility for copays, coinsurance & deductibles ☐	

INSURANCE AUTHORIZATION

I authorize Yuma Kids Clinic, PLLC to release any medical or other information to the insurance carrier, which may be necessary to process the claims. I authorize my insurance carrier to pay the provider of service. In the event that payment is made to the policyholder, I agree to submit payment to Yuma Kids Clinic, PLLC immediately. Your social security number below is used for billing and verification purposes only.

Childs Name (Please Print)	Childs DOB
Parent/Legal Guardian Name (Please Print)	
Parent/Legal Guardian who is signing this form SS#	DOB
Parent/Legal Guardian Signature	Today's Date

YUMA KIDS CLINIC

PATIENT INTAKE FORM
INFANCY, CHILDHOOD, ADOLESCENCE, HISTORY

PATIENTS FULL LEGAL NAME (please print)	DATE OF BIRTH

PREVIOUSLY SEEN/TREATED BY (Name of Doctor/Practice)

City	State	Zip Code	Phone Number

PHARMACY INFORMATION

NAME OF PHARMACY	PHARMACY PHONE #

ADDRESS/CROSSROADS

CHILD'S BIRTH HISTORY

During your pregnancy with this child:

Did you receive prenatal care ☐Y ☐N		How early did you start seeing a doctor	Month
How long was your pregnancy	Weeks	Did you have a difficult labor/delivery	☐Y ☐N
Delivery Type ☐Vaginal ☐C-Section		Was the baby delivered breech	☐Y ☐N
Was oxygen required ☐Y ☐N		Did baby stay in the NICU	☐Y ☐N
Was the baby jaundiced at birth ☐Y ☐N		Was phototherapy treatment required	☐Y ☐N
How long did baby stay in the Nursery		Does the baby have any birth defects	☐Y ☐N
Did your baby receive blood ☐Y ☐N		Did baby receive any medications at birth	☐Y ☐N
If male, was baby circumcised at birth ☐Y ☐N		If no, do you want the baby circumcised	☐Y ☐N

Please list any other pertinent information regarding the baby:

MATERNAL HISTORY/COMPLICATIONS

Did you have surgery during pregnancy ☐Y ☐N		Please list:	
Did you have high blood pressure ☐Y ☐N		Did you have diabetes during pregnancy	☐Y ☐N
Did you smoke during pregnancy ☐Y ☐N		Did you drink alcohol during pregnancy	☐Y ☐N
Were you taking any medications during your pregnancy			☐Y ☐N

If yes to medication, please list the name(s):

Did you use other drugs during your pregnancy	☐Y ☐N

If yes to drugs please list the name(s):

Did you have any of these infections during your pregnancy	☐Y ☐N

If yes to infections please list:

Please list any other pertinent information regarding your pregnancy:

YUMA KIDS CLINIC

CHILDS HISTORY 0 – 1 YEAR OF AGE					
From newborn to year one, did you breast feed the baby	☐ Y	☐ N			
If yes, for how long did you breast feed the baby	Number of Months				
From newborn to year one, did you formula feed the baby	☐ Y	☐ N			
From newborn to year one, any feeding problems	☐ Y	☐ N			
If yes, please explain the problem(s)					
What age did you start whole milk	Age		What age did you start solid foods	Age	
Any allergies to whole milk	☐ Y	☐ N	Any allergies to food	☐ Y	☐ N
If yes to allergies please list/explain:					

IMPORTANT MEDICAL INFORMATION		
Any serious Illness/Accident/Surgery/Hospitalization(s) Please list below:		Age of Child
1		
2		
3		
4		
Chronic Diseases (Allergies, Asthma, Diabetes, Recurrent Ear Infections Please list below:		Age of Child
1		
2		
3		
4		

Any allergies to food, medications both prescribed and over the counter. If yes please list below	☐ Y	☐ N

Name of Medication & Reaction		Name of Food & Reaction	
1		1	
2		2	
3		3	
4		4	

IMMUNIZATION INFORMATION				
Are your child's immunizations current	☐ Y	☐ N	☐ Unsure	☐ Choose not to vaccinate
Please make sure you bring your child's immunization record to every well child or shot only visit.				

SOCIAL/DEVELOPMENTAL HISTORY				
Childs parents are:	☐ Single	☐ Married	☐ Living Together	
	☐ Separated	☐ Divorced	☐ Widow	
Are stepparents involved in the care of this child	☐ Y	☐ N	☐ Stepmother	☐ Stepfather
Any concerns about relationships with family or friends, If yes please list below	☐ Y	☐ N		
Child is the	☐ Oldest	☐ Youngest	☐ Middle	☐ Only
Does anyone in your household smoke	☐ Y	☐ N	☐ Inside	☐ Outside only

YUMA KIDS CLINIC

SAFETY

Please check any and all that apply in and around the home, car, and while playing

Smoke Detector in home ☐		Carbon Monoxide Detector ☐		Firearms – May Decline to answer ☐	
Car Restraints	Rear Facing ☐	Front Facing ☐	Booster Seat ☐	Seat Belt ☐	None Used ☐
Pool or Spa ☐	TV in child's room ☐	Computer in child's room ☐		Wears Bike/Skate Helmet ☐	

Please list any pets or animals at home:

FAMILY MEDICAL HISTORY

Has any blood relative of your child ever had, been treated for or recently diagnosed with any of the following: If the child was adopted or is in foster care and you do not have birth parents history, please leave blank

ADD/ADHD	☐ Y	☐ N	Alcoholism	☐ Y	☐ N	Allergies	☐ Y	☐ N
Anemia	☐ Y	☐ N	Anorexia	☐ Y	☐ N	Asthma	☐ Y	☐ N
Bladder Disease	☐ Y	☐ N	Bowel Disorders	☐ Y	☐ N	Cancer	☐ Y	☐ N
COPD	☐ Y	☐ N	Crohns Disease	☐ Y	☐ N	Depression	☐ Y	☐ N
Developmental Delay	☐ Y	☐ N	Diabetes	☐ Y	☐ N	Domestic Violence	☐ Y	☐ N
Drug Abuse	☐ Y	☐ N	Hearing Deficiency	☐ Y	☐ N	Heart Problems	☐ Y	☐ N
High Blood Pressure	☐ Y	☐ N	High Cholesterol	☐ Y	☐ N	Kidney Disease	☐ Y	☐ N
Mental Illness	☐ Y	☐ N	Migraines	☐ Y	☐ N	Obesity	☐ Y	☐ N
Seizures	☐ Y	☐ N	Stroke	☐ Y	☐ N	Tuberculosis (TB)	☐ Y	☐ N

Please explain and "YES" answers above:

Other Chronic Illnesses you think we should know about:

YUMA KIDS CLINIC

ADDITIONAL CONCERNS/PROBLEMS												
Does your child have any on-going problem(s) that concern you – please check all that apply												
Eats to little	☐	Eats to much	☐	Cries a lot	☐	Sees poorly	☐	Does not seem to hear you	☐			
Sleeps to little	☐	Sleeps to much	☐	Does poorly in school	☐	Behavioral problems at school	☐					
Wets bed	☐	Frequently constipated	☐	Always has runny nose, cough, itchy eyes	☐							
Has frequent temper tantrums	☐	Speaks unclearly	☐	Other behavioral problems	☐							
Seems small for age	☐	Has separation anxiety	☐	Seems to need constant attention	☐							
Please list any other concerns or problems:												

We appreciate you taking the times to complete this questionnaire.

Parent or Legal Guardian Please Type/Print Your Full Name	Today's Date
Parent or Legal Guardian Signature:	

YUMA KIDS CLINIC PARENTING POLICY

TODAY'S DATE: _____

It is preferred that both custodial parents be present at all visits for the minor child. However, if this is not possible, at least one custodial parent must be present at each visit. A custodial parent must be present for the first visit.

If only one custodial parent is able to attend a visit, it is the responsibility of the custodial parent attending the visit to communicate any visit information to the absent custodial parent.

It is not the responsibility of the physician and/or staff to communicate visit information to each custodial parent separately.

If a custodial parent is not able to be present, we must have a notarized power of attorney or notarized letter on file giving permission for another adult to be present and consent for the care of the minor child.

The parent or authorized adult bringing in the minor child is responsible for any monies owed for copays, deductibles, and coinsurance or denied claims **at the time of the visit**. We will be happy to let you know an **estimated** amount due for the visit at the time you schedule the appointment. Be advised that the amount given is only an estimate. There may be additional fees charged that we are unaware of or insurance does not cover, etc. We are equipped to take these payments over the phone prior to the visit as an option.

The physicians or office staff of Yuma Kids Clinic will not be put in the middle of domestic issues or disagreements. If we feel this is becoming an issue and compromising the care of the minor child and/or if at any time a family OR non-family member becomes abusive with the staff, we have the right to discharge the family from the care of the practice.

Only in situations where there is a **confirmed, documented Court Order** will one of the parent's be denied access to the minor child's health records or visits at the office. Yuma Kids Clinic **must** have a copy of this Court Order on file in the minor child's electronic chart.

Stepparents, fiancés, girlfriends, boyfriends, or non-legal partners are not considered parents authorized to consent for care without a valid notarized letter signed by both custodial parents.

I have read and agree to abide by the above policy.

Child's Full Legal Name – PLEASE PRINT	**Child's Date of Birth**
Child's Full Legal Name – PLEASE PRINT	**Child's Date of Birth**
Child's Full Legal Name – PLEASE PRINT	**Child's Date of Birth**
Child's Full Legal Name – PLEASE PRINT	**Child's Date of Birth**

Custodial Parent Name – PLEASE PRINT	**Custodial Parent Name – PLEASE PRINT**
Custodial Parent Name – Signature	**Custodial Parent Name – Signature**

YUMA KIDS CLINIC

FINANCIAL POLICY

Thank you for choosing Yume Kids Clinic, PLLC for your child's health care. We are committed to providing quality medical care for your children. In order to reduce potential misunderstandings, our office has adopted the following Financial Policy. We require that you read it and agree to abide by it for all services rendered.

Effective immediately, we require a valid photo identification card of the custodial parents(s), foster parent, or any adult in which you have submitted a notarized statement indicating they may consent to any and all treatment for that child.

A **valid photo ID** card includes any state issued ID card, a valid state driver's license, military ID card, or a valid passport.

We require that you consent to Yuma Kids Clinic taking a photo head shot of your child, which will be updated each year, to be stored in the child's electronic medical record.

Forms of Payment

Yuma Kids Clinic only accepts cash, debit cards that can be run as a credit card, Visa, MasterCard, American Express and Discover Cards. **WE DO NOT ACCEPT CHECKS**.

Insurance

Your insurance policy is a contract between you and your insurance plan. We will file claims to those plans with which we have a contractual agreement as long as we have valid insurance information **AND** insurance card(s). Any claims denied for eligibility issue or timely filing issues due to incorrect insurance information you provide will be your responsibility. Please contact your insurance company if you do not agree with their decision. We do not bill third party insurance carrier i.e., auto insurance, school insurance etc.

We expect you to familiarize yourself with the benefits and limitations of your insurance policy including, but not limited to: deductible, coinsurance, and copay amounts as well as approved labs, radiology facilities, specialists and hospitals contracted with your plan. It is your responsibility to notify our office when either your insurance plan or benefits change within **TEN** days. You will be required to complete a change of insurance/benefit form and submit a copy of the front and back of your new insurance card.

All health plans are not the same and they do not always cover the same services or facilities. In the event that your health plan determines that a service is "not covered" you will be responsible for the entire charge. Any cost incurred by this office because of incorrect information you provided to us may be passed on to you. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage.

No Insurance or Limited Benefits

If you have no insurance coverage or limited benefits, please contact our billing department at 928-723-1222 to discuss payment options that we offer.

Deductibles/Coinsurance/Copays

Our insurance contracts require us to collect deductible, coinsurance, and copays at the time of service. The amount collected for deductibles and coinsurance will be based on the allowed amount by your insurance company. These amounts will be collected prior to service being rendered. Your insurance company may require copays for "immunization only" visits and additional copay if your child receives treatment for an illness during a well visit.

YUMA KIDS CLINIC

Payment for Account Balance

Payment for outstanding balances is due immediately upon receipt of the bill. If you need to setup a payment plan, please contact our office prior to any upcoming appointments. All payment plans must be secured with a valid credit card. Any outstanding balances will be due at the time of the appointment if the balance has not been **received** prior to the appointment. Please see our parenting regarding responsibility of payment.

Appointments

Our goal is to provide the best possible care and physician availability to each of our patients. If you are unable to keep a scheduled appointment, please call at least 24 hours in advance to cancel. If it is after hours, you may leave a message with our answering service (24 hour policy still applies). The following fees will be charged for no-show, missed, late appointments or those canceled with less than a 24 hour notice. The fee applies to each appointment and each child scheduled. Please note: any combination of the list below is counted and accrued as such.

NO-SHOW		**MISSED – more than 30 minutes late**		**CANCELLED–less than 24 hours**	
1st	Waived	1st	Waived	1st	Waived
2nd	$25.00	2nd	$25.00	2nd	$25.00
3rd	$25.00*****	3rd	$25.00*****	3rd	$25.00*****
4th	Family may be dismissed from the practice	4th	Family may be dismissed from the practice	4th	Family may be dismissed from the practice

*** Following the 3rd offence, you will be required to confirm your appointment at least 24 hours before the scheduled time. The appointment may be confirmed via our automated call system or by contacting our office. The earliest appointment we will schedule will be at 10:15 am Tuesday through Friday. Any appointment not confirmed will be automatically cancelled by our office and will be given to another patient.**

I have read and agree to abide by the above policy.

Child's Full Legal Name – PLEASE PRINT	**Child's Date of Birth**
Child's Full Legal Name – PLEASE PRINT	**Child's Date of Birth**
Child's Full Legal Name – PLEASE PRINT	**Child's Date of Birth**
Child's Full Legal Name – PLEASE PRINT	**Child's Date of Birth**

Custodial Parent Name – PLEASE PRINT	**Custodial Parent Name – PLEASE PRINT**
Custodial Parent Name – Signature	**Custodial Parent Name – Signature**

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received and/or read a copy of Yuma Kids Clinic Notice of Privacy Practice for:

Patients Full Legal Name:	Patients DOB:
Parent or Legal Guardian: (please print)	Relationship To Patient:
Signature of Parent or Legal Guardian:	Today's Date:

YUMA KIDS CLINIC HIPAA PRIVACY POLICY
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.

During your treatment at Yuma Kids Clinic, doctors, nurses, and other caregivers may gather information about your medical history and your current health. This notice explains how that information may be used and shared with others. It also explains your privacy rights regarding this kind of information. The terms of this notice apply to health information created or received by Yuma Kids Clinic. We are required by law to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; follow the terms of the notice that is currently in effect; and notify you in the event there is a breach of any unsecured protected health information about you.

Most patients of Yuma Kids Clinic are minors (i.e., individuals under the age of 18). Under state and federal law, the minor patient's parent, guardian or other legally authorized representative has the same rights as the minor patient with regard to health information about the minor patient. The health information we refer to in this notice ("your information") is that of the minor patient. For purposes of giving an authorization or making decisions about disclosures of the minor patient's health information and the rights associated with such information, "you" will refer to the parent/guardian/legal representative.

How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it on a computer and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

Payment: We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations: We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their

population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign In Sheet: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification and Communication With Family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Marketing: Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

Sale of Health Information: We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

Required by Law: As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public Health: We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability;

reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Health Oversight Activities: We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

Judicial and Administrative Proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law Enforcement: We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Coroners: We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

Organ or Tissue Donation: We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Public Safety: We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
Proof of Immunization: We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

Specialized Government Functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Workers' Compensation: We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Breach Notification: In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Psychotherapy Notes: We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

Research: We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

When This Medical Practice May Not Use or Disclose Your Health Information
Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information, which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy: You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

Right to Amend or Supplement: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you

can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
Right to a Paper or Electronic Copy of this Notice: You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

Changes to this Notice of Privacy Practices
We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website yumakidsclinic.com.

Complaints
To file a complaint with Yuma Kids Clinic, or to ask a question about this Notice, contact Privacy Official, PO Box 1010, Yuma, AZ 85366, 928-783-1222. All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

OCRMail@hhs.gov