NEWPORT BEACH PEDIATRIC PULMONOLOGY

NEW PATIENT INTAKE FORM

Child's Name: _____ Phone #: _____

Birth Date: _____ Address: _____

Referred by: _____ Fax #: _____

Reason for referral: _____

_____

CURRENT SYMPTOMS:

- ☐ Cough
- ☐ Wheeze (high pitched whistle sound)
- ☐ Chest congestion
- ☐ Tightness of chest
- ☐ Exercise cough/wheeze/shortness of breath
- ☐ Nasal congestion/sneezing
- ☐ Itchy, red, watery eyes
- ☐ Itchy skin rash
- ☐ Stridor (noise on inspiration)
- ☐ Snoring and/or gasping for air at night
- ☐ Apnea (not breathing)
- ☐ Difficulty chewing or swallowing
- ☐ Frequent spitting up
- ☐ Heartburn
- ☐ Headaches
- ☐ Frequent loose foul smelling stools
- ☐ Frequent infections
- ☐ Breathing hard or fast
- ☐ Color changes: pale or purple
- ☐ Chest pain
- ☐ Muscle weakness

☐ Other: _____

WHAT TRIGGERS YOUR CHILD'S SYMPTOMS:

- ☐ Cold viruses
- ☐ Weather changes
- ☐ Smoke Exposure
- ☐ Animal Exposure
- ☐ Pollens
- ☐ Dusting/vacuuming
- ☐ Exercise/increased activity
- ☐ Emotional stress
- ☐ Feeding

☐ Foods: _____

☐ Seasons: _____

☐ Other: _____

ENVIRONMENTAL EXPOSURES/BARRIERS:

- ☐ School/daycare
- ☐ Siblings in school/daycare
- ☐ Pets
- ☐ Smoke exposure
- ☐ Carpeting
- ☐ Mold/Water damage
- ☐ Older home
- ☐ Stuffed animals
- ☐ Cockroaches

☐ Other: _____

HOME EQUIPMENT IN USE:

- ☐ Aerochamber/Spacer
- ☐ Nebulizer
- ☐ Peak Flow Meter
- ☐ Apnea monitor
- ☐ Oxygen
- ☐ Tracheostomy
- ☐ Suction machine
- ☐ Ventilator/BiPAP/CPAP
- ☐ Airway clearance (Cough assist/Vest)

☐ Vendor: _____ Phone #: _____ Fax #: _____

NUTRITION:

☐ Regular diet for age
☐ Supplemental or special formula/diet ☐ By mouth ☐ By feeding tube

EXISTING TREATMENTS:

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Shift Nursing
- ☐ Respite Care

☐ Other: _____

DEVELOPMENTAL STATUS:

☐ Appropriate for age ☐ Developmental delay: _____

BIRTH HISTORY:

Birth Weight: _____ If Premature, gestational weeks: _____

If NICU admission, how long? _____ If Ventilator, how long? _____

PAST MEDICAL SURGICAL HISTORY:

Has your child ever had:

- ☐ Asthma
- ☐ Bronchitis
- ☐ RSV infection
- ☐ Collapsed Lung
- ☐ Apnea (not breathing)
- ☐ Frequent ear/sinus infections
- ☐ Choking episode
- ☐ Immune Deficiency
- ☐ (+)Tuberculosis skin test or exposure
- ☐ Pneumonia: How many times/when?
- ☐ Croup: How many times/when?

☐ Other: _____

Please list any other health problems your child has had:

Please list any surgeries your child has had:

Has your child ever:

☐ Been admitted to the hospital for a respiratory illness? How many times/when? _____

☐ Been to the Emergency room for a respiratory illness? How many times/when? _____

☐ Been admitted to the intensive care unit for a respiratory problem?

☐ Been on a Ventilator?

☐ Missed school because of breathing problems?

If yes, how many days in the past year? _____

List other Physician's involved in the care of your child:

ALLERGIES:

Please list all medication, food, and environmental allergies and reaction:

PREFERRED PHARMACY: _____

CURRENT MEDICATiONS:

IMMUNIZATIONS:

☐ Up to date ☐ Not up to date ☐ Flu vaccine ☐ Pneumococcal

SOCIAL HISTORY:

Who does the child live with (please include siblings)? _____

School Name and phone number: _____

FAMILY HISTORY:

Does any member of your immediate/extended family have any of the following conditions?

- ☐ Asthma
- ☐ Allergies/hayfever
- ☐ Eczema
- ☐ Chronic sinus infections
- ☐ Cystic Fibrosis
- ☐ Chronic Lung Disease
- ☐ Immune deficiency
- ☐ Acid reflux
- ☐ SIDS
- ☐ Sleep Apnea

☐ Other: _____

REVIEW OF HEALTH PROBLEMS:

- ☐ Eyes
- ☐ Ear/nose/throat
- ☐ Heart and blood vessels
- ☐ Stomach
- ☐ Genital-urinary
- ☐ Blood disorders/Tumors
- ☐ Hormone
- ☐ Immune
- ☐ Muscles/Bones/Back
- ☐ Skin
- ☐ Brain/Nervous system

☐ Other: _____

PRiOR WORK UP/TESTING: (check all that apply and list where and when)

- ☐ Chest Xray
- ☐ Chest CT
- ☐ SinusXray
- ☐ Allergy test
- ☐ Sleep Study
- ☐ EKG/Echocardiogram
- ☐ Laryngoscopy/Bronchoscopy
- ☐ Pulmonary Function test

☐ Other: _____

IS THERE ANYTHING ELSE WE NEED TO KNOW
ABOUT YOUR CHILD IN ORDER TO BEST MEET THEIR NEEDS?

Thank you for taking the time to fill out this form. This will help us to better care for your child.

NEWPORT BEACH PEDIATRIC PULMONOLOGY

Patient Account Information

Patient Name:_____ DOB:_____ ☐ Male ☐ Female

Address:_____ City:_____ State:_____ Zip:_____

Referred by:_____ Patient Home Phone#:_____

Have you or any family member been seen here before? ☐ Yes ☐ No

Preferred Contact Method: ☐ Phone ☐ Text ☐ Email

Race/Ethnicity: ☐ Caucasian ☐ African American ☐ Native American ☐ Asian ☐ Hispanic/Latino

☐ Native Hawaiian/Pacific Islander ☐ Other

Preferred Pharmacy:_____

Primary Care Physician:_____

Referring Physician:_____

Responsible Party

Name:_____ DOB:_____ ☐ Male ☐ Female

Relationship to Patient: ☐ Father ☐ Mother ☐ Guardian

Address:_____ City:_____ State:_____ Zip:_____

SS#:_____ Occupation:_____ Employer:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner

Phone# Home:_____ Work:_____ Cell:_____

Name:_____ DOB:_____ ☐ Male ☐ Female

Relationship to Patient: ☐ Father ☐ Mother ☐ Guardian

Address:_____ City:_____ State:_____ Zip:_____

SS#:_____ Occupation:_____ Employer:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner

Phone# Home:_____ Work:_____ Cell:_____

Primary Insurance Information

Insurance Company Name: _____ ☐ HMO ☐ PPO

Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____

Insurance ID#: _____ Group#: _____

Secondary Insurance Information

Insurance Company Name: _____ ☐ HMO ☐ PPO

Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____

Insurance ID#: _____ Group#: _____

Emergency Contact Information

Emergency Contact (other than parent): _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone# Home: _____ Work: _____ Cell: _____

NEWPORT BEACH PEDIATRIC PULMONOLOGY

OFFICE AND FINANCIAL POLICIES

- OFFICE HOURS: Monday through Friday 9am to 5pm.
- APPOINTMENTS: Please arrive on time for your scheduled appointments. Patients who arrive more than 15 minutes late may have their appointment cancelled and rescheduled.
- PAYMENTS, CO-PAYMENTS, AND OUTSTANDING BALANCES: All payments, co-payments and outstanding balances are due at the time of service. Newport Beach Pediatric Pulmonology will kindly file your claims to your insurance company as a courtesy to you.
- COVERAGE: Not all services are covered by all insurance policies. Any services that are not covered by your insurance are your responsibility. It is your responsibility to know the terms and conditions of your policy. As a courtesy, Newport Beach Pediatric Pulmonology will attempt to verify eligibility and benefits, however, we are unable to obtain the exact details of payment until the claim is processed.
- INSURANCE UPDATES: You are responsible for providing us with any updates to your insurance at each visit. If any charges are denied due to not providing current insurance information, the guarantor will be responsible for any unpaid balances.
- INSURANCE DISPUTES: It is your responsibility to contact your insurance company with any disputes regarding your coverage.
- NO-SHOWS OR LATE CANCELLATIONS ON DAY OF VISIT: When appointments are missed or cancelled with little notice, it leaves an opening that could have been used by another patient. We will charge $50 (or the amount of your co-pay) for NO-SHOWS or late cancellations on the day of clinic visit. <u>This fee is not covered by your insurance.</u>
- RETURNED CHECKS: There will be a service charge of $35 for all returned checks.
- FINANCIAL HARDSHIP: We realize that temporary financial problems may affect timely payment on your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.
- PAYMENTS: Payments can be made via credit card held on file and processed once insurance explanation of benefits (EOB) has been released. Please be assured that your payment card information is stored by an encrypted merchant service and Newport Beach Pediatric Pulmonology only has access to the last 4 digits of your card. Payment can also be made directly on our web page at www.newportbeachpediatric pulmonology.com via credit card. Checks can be made to Newport Beach Pediatric Pulmonology, Inc.

By my signature below, I state that I have read and understand the policies of Newport Beach Pediatric Pulmonology, Inc.

SIGNATURE: _____ DATE: _____

Printed name: _____

AMY HARRISON, MD, FAAP

1501 Superior Avenue, Suite 202 | Newport Beach, CA 92663-3640

OFFICE (949) 220-0510 | FAX (888) 563-0922 | EMAIL info@nbpedpulm.com

NEWPORT BEACH PEDIATRIC PULMONOLOGY

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I, the undersigned parent or legal guardian of _____
DOB ____/____/____, a minor, do hereby authorize and consent to any x-ray examination, spirometry, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician of Newport Beach Pediatric Pulmonology, Inc., licensed under the provisions of the Medicine Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power to render care which the aforementioned physicians in the exercise of their best judgement may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but any of the above treatment will not be withheld if the undersigned cannot be reached.

This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of California and shall remain valid for all medical encounters at Newport Beach Pediatric Pulmonology, Inc. until revoked in writing.

_____ ____/____/____ _____
Signature of Legal Guardian Date Relationship to Patient

_____
Printed Name

I (We) also give permission to the following adult family members and/or caregivers to authorize medical care and treatment on my behalf in the event I cannot personally accompany my child. I can revoke this permission at any time by notifying Newport Beach Pediatric Pulmonology, Inc. in writing:

_____

_____

_____

_____

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CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my name or my child's full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and /or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition or my child's and that (I/he/she) would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

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7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto-remember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. I agree to the use of photography during my telemedicine visit and that any images obtained will become part of my permanent medical record.

11. I have a right to access my medical information or my child's and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me or my child will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Parent/Legal guardian signature Date

AMY HARRISON, MD, FAAP

1501 Superior Avenue, Suite 202 | Newport Beach, CA 92663-3640

OFFICE (949) 220-0510 | EMAIL info@nbpedpulm.com

Newport Beach Pediatric Pulmonology, Inc.; 1501 Superior Ave, Suite 202; Newport Beach, CA 92663;
Privacy Officer: Dr. Amy Harrison (949) 220-0510

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 01/01/2020

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 the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Health Information

This medical practice collects medical and related identifiable patient information (such as billing information, claims information, referral and health plan information) and stores it in a chart, in administrative or billing files, and on a computer. The medical record is the property of this medical practice, but the information in the medical record is accessible to the patient. This information is considered "protected health information" (PHI) under the HIPAA Privacy Rule. The law permits us to use or disclose health information for the following purposes without the patient's written authorization:

1. Treatment. We use medical information to provide medical care. We disclose medical information to our employees and others who are involved in providing the care our patients need. For example, we may share 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, or a laboratory that performs a test. We may also disclose medical information to members of patients' families or others who can help them-when they are sick or injured, or following the patient's death.

2. Payment. We use and disclose PHI to obtain payment for the services we provide. For example, we give health plans the information they require for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to our patients.

3. Health Care Operations. We may use and disclose PHI to operate this medical practice e. 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 health plans 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 PHI 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 this PHI. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, health care clearinghouse, or one of their business associates, California law prohibits all recipients of health care information from further disclosing it except as specifically required or permitted by law.

a. We may also share PHI with other health care providers, health care clearinghouses, or health plans that have a relationship
with our patients 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, 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, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

b. We may also share PHI 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 that collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind our patients about appointments. If the patient is not home, we may leave this information on the patient's answering machine or in a message left with the person answering the phone.

5. Sign-in Sheet. We may use and disclose medical information about our patients by having them sign in when they arrive at our office. We may also call out their names when we are ready to see them.

6. Notification and Communication with Family. We may disclose our patients' health information to notify or assist in notifying a family member, personal representative or another person responsible for their care about their location or general condition in the event of their death, unless a patient had instructed us otherwise. 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 our patient's care or helps pay for care. If our patient is able and available to agree or object, we will give the patient the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over the patient's objection if we believe it is necessary to respond to the emergency circumstances. If our patient is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient's family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact our patients to encourage them to purchase or use products or services related to their 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 them. We may similarly describe products or services provided by this practice and tell our patients which health plans we participate in. We may receive financial compensation to talk with our patients face-to-face, to provide them with small promotional gifts, or to cover our cost of reminding them to take and refill medication or otherwise communicate about a drug or biologic that is currently prescribed for the patient, but only if the patient either:
(1) has a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise the patient about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) the patient is a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while the patient has a

chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) the patient's right to opt-out of future remunerated communications by calling the communicator's toil-free number. We will not otherwise use or disclose PHI for marketing purposes or accept any payment for other marketing g communications without the patient's prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity our patients authorize, and we will stop any future marketing activity to the extent the patient revokes that authorization.

8. Sale of Health Information. We will not sell our patients' health information without their prior written authorization. The authorization will disclose that we will receive compensation for PHI if the patient authorizes us to sell it, and we will stop any future sales of information to the extent that the patient revokes that authorization.

9. Required by Law. As required by law, we will use and disclose our patients' 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.

10. Public Health. We may, and are sometimes required by law, to disclose our patients' 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 our patients or their personal representative promptly unless in our best professional judgment, we believe the notification would place a patient at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

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

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose our patients' 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 our patients in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify them of the request and they have not objected, or if their objections have been resolved by a court or administrative order.

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

14. Coroners. We may, and are often required by law, to disclose our patients' health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose our patients' health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose our patients' 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.

17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if the patient has agreed to the disclosure on behalf of themselves or their dependent.

18. Specialized Government Functions. We may disclose our patients' health information for military or national security purposes or to correctional institutions or law enforcement officers that have the patient in their lawful custody.

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

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

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify our patients as required by law.
If they have provided us with a current email address, we may use email 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.

22. Other disclosures specified in our Notice of Privacy Practices. We may disclose our patients' health information as otherwise described in our Notice of Privacy Practices.

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

B. When this Medical Practice May Not Use or Disclose 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 individual patients without their written authorization. If a patient authorizes this medical practice to use or disclose health information for another purpose, the patient may revoke the authorization in writing at any time.

C. Our Patients' Health Information Rights

1. Right to Request Special Privacy Protections. Our patients have the right to request restrictions on certain uses and disclosures of their health information by a written request specifying what information they want to limit, and what limitations on our use or disclosure of that information they wish to have imposed. If our patients tell us not to disclose information to their commercial health plan concerning health care items or services for which they paid for in full out-of -pocket, we will abide by their 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 our patients of our decision.

2. Right to Request Confidential Communications. Our patients have the right to request that they receive their health information in a specific way or at a specific location. For example, they may ask that we send information to a particular email account or to their work address. We will comply with all

reasonable requests submitted in writing which specify how or where our patients wish to receive these communications.

3. Right to Inspect and Copy. Our patients have the right to inspect and copy their health information, with limited exceptions. To access their medical information, our patients must submit a written request detailing what information they want access to, whether they want to inspect it or get a copy of it, and if they want a copy, their preferred form and format. We will provide copies in the requested form and format if it is readily producible, or we will provide our patients with an alternative format they find acceptable, or if we can't agree and we maintain the record in an electronic format, their choice of a readable electronic or hardcopy format. We will also send a copy to any other person our patients 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, as allowed by federal and California law. We may deny our patients' request under limited circumstances. If we deny a request to access a child's records or the records of an incapacitated adult because we believe allowing access would be reasonably likely to cause substantial harm to the patient, the guardian or legal representative will have a right to appeal our decision. If we deny a patient's request to access their psychotherapy notes, our patients will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement Our patients have a right to request that we amend their health information if they believe it is incorrect or incomplete. Our patients must make a request to amend in writing, and include the reasons they believe the information is inaccurate or incomplete. We are not required to change our patients' health information, and will provide them with information about this medical practice's denial and how they can disagree with the denial. We may deny their 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 they 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 a request, our patients may submit a written statement of their disagreement with that decision, and we may, in turn, prepare a written rebuttal. Our patients also have the right to request that we add to their record a statement of up to 250 words concerning anything in the record they believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. Our patients have a right to receive an accounting of disclosures of their health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to them or pursuant to their 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.

6. Right to Paper Copy of Notice of Privacy Practices. Our patients have a right to notice of our legal duties and privacy practices with respect to their health information, including a right to a paper copy of this Notice of Privacy Practices, even if they have previously requested its receipt by email. If we have a website, we must post our current Notice of Privacy Practices on our website.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. 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.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles our patients' health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If our patients are not satisfied with the manner in which this office handles a complaint, they may submit a formal complaint to:
Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(800) 368-1019; (800) 537-7697 (TDD)
(202) 619-3818 (fax)
OCRMail@hhs.gov

NEWPORT BEACH PEDIATRIC PULMONOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices which describes how my health information is used and shared. I understand that Newport Beach Pediatric Pulmonology, Inc. may share my child's health information for treatment, billing, and healthcare options. I may obtain an additional copy by contacting the Privacy Officer, Dr. Amy Harrison, at the number above or by visiting the web site at www.newportbeachpediatricpulmonology.com.

Patient name _____

_____ ____/____/____ _____
Signature of Legal Guardian Date Relationship to Patient

_____
Printed Name

AUTHORIZATION TO CONSENT FOR HEALTH INFORMATION EXCHANGE

This consent is to acknowledge consent for Newport Beach Pediatric Pulmonology to view health information from other medical institutions (such as local hospitals or urgent cares via Health Information Exchange noted as Commonwell/CareEquality). This consent also approves Newport Beach Pediatric Pulmonology to import your child's prescription drug refill history for the purposes of improved accuracy of our medical records unless noted below.

- ☐ I would like to opt out of Commonwell/CareEquality
- ☐ I would like to opt out of importing my child's prescription drug refill history

Patient name _____

_____ ____/____/____ _____
Signature of Legal Guardian Date Relationship to Patient

_____
Printed Name

AMY HARRISON, MD, FAAP
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