TLC Pediatrics & Associates L.L.C.

Patient Registration

Parent/Guardian 1 Information: Relationship to patient (circle one) Mother Father Other: _____

Last name:_____ First name:_____ MI:____Sex: M / F/ NB
Street Address:_____City: _____

State:_____Zip:_____ Email: _____Date of Birth: _____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

SS#: _____ Ethnicity: _____Race: _____

Parents are: Married / Single / Divorced (please circle)

Parent/Guardian 1 Information: Relationship to patient (circle one) Mother Father Other: _____

Last name:_____ First name:_____ MI:____Sex: M / F/ NB
Street Address:_____City: _____

State:_____Zip:_____ Email: _____Date of Birth: _____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

SS#: _____ Ethnicity: _____ Race: _____

Primary Insurance Information:

Insurance Company Name: _____ **Name of Insured**: Parent 1 Parent 2

Street Address: _____ City, State, Zip: _____

SS# of Insured: _____ ID #: _____Group #: _____

Secondary Insurance Information:

Insurance Company Name: _____ **Name of Insured**: Parent 1 Parent 2

Street Address: _____ City, State, Zip: _____

SS# of Insured: _____ ID #: _____Group #: _____

Emergency Contact Information:

Contact Name: _____ Cell Phone: _____ Home:_____

Relationship to Patient: _____ Comment: _____

Patient and Sibling Information:

Name:_____ Date of Birth: _____Sex: M /F /

NB Name:_____ Date of Birth: _____Sex: M /F /

NB Name:_____ Date of Birth: _____Sex: M /F /

NB Name:_____ Date of Birth: _____Sex: M /F /

NB Name:_____ Date of Birth: _____Sex: M /F /

NB Name:_____Date of Birth: _____ Sex: M /F /

NB

Assignment of Benefits/Authorization/Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, fees for in-office services and/or tests, and any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs).

Also, please be advised our office may contact you via an automated system, or text message, regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing.

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for the purposes of patient identification.

Maryland Registry (if applicable)

Please be advised that our office submits confidential data of children and adult vaccinations to the Maryland Immunization Information System per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record of patient's immunization history.

Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

_____

Guarantor/Parent/ Guardian completing this form (Please Print)

_____

Date

_____

Guarantor/Parent/ Guardian Signature Date

TLC Pediatrics & Associates L.L.C.

Payment Policy

It is important that you understand your insurance plan and our financial policies as well. Since it is our primary goal to provide the best healthcare for your children, we provide and offer a variety of services in-office. These services include a variety of labs, tests, and procedures. Some of these services have additional charges associated with them and you are responsible to pay for these services at the time of your visit. A waiver will be provided at the time of service that explains your options.

Insurance: We participate with many insurance plans. If you are not insured by a plan in which we participate, payment in full will be expected at each visit. If you are insured by a plan with which we participate**, it is your responsibility to have a current insurance card** with you for each visit or payment in full may be required until we can verify your coverage. Please contact your insurance company with any questions you have regarding your coverage so as to avoid any surprises.

Proof of insurance: All patients must complete our patient registration form before seeing a doctor. We will need a copy of your driver's license and current valid insurance card to provide proof of insurance.

Co-payments: All co-payments shall be paid at the time of service. This arrangement is part of your/our contract with your insurance company. It is our policy to collect a co-payment at every visit (we accept cash, Visa/MasterCard, Discover, Google and Apple Pay). Some insurance companies may exempt certain types of visits from needing a co- payment. It is impossible for us to know which company exempts which type of visit; often we must wait up to three months for the insurance company's explanation of benefits statement to find this out. If we should find out there is an exemption, we will adjust your previously paid co-payment as either a credit balance or refund.

Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request **and any balance is your responsibility**. If your insurance changes, please notify us before you next visit, or visit the patient portal to submit changes. If you fail to notify us of a change within 60 days, most insurance companies will consider this to be past timely filing and will not process your claims for visit and the balance will become your responsibility. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Non-covered services: Please be aware that some, and perhaps all, of the services you receive may not be covered for whatever reason by your insurance company. Our practice follows nationally acceptable standard for coding and submitting claims to insurance companies. These standards, Current Procedural Terminology, are recognized and accepted by all federal and commercial insurers. Occasionally, insurance companies misinterpret these guide- lines and improperly deny payment for service. Some of their incorrect explanations are that a service is "bundled" or "non-covered" and "non-billable". If an insurer improperly denies or refuses to accept a correctly coded and submitted claim, we will need to bill the improperly "denied" portion to you. This portion becomes your responsibility. If you believe that such a situation has occurred, we will be happy to discuss this with you.

Nonpayment: If your account is over 60 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Please be aware that if a balance remains unpaid, we will need to refer your account to our collection agency and you may be discharged from our practice. Should this occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you for emergency care. We hope this never happens!

Missed appointments: We reserve the right to charge for missed appointments. These charges will be your responsibility and billed directly to you. We understand that sometime in our hectic world appointments can not be kept however a quick call to our office will avoid a "missed appointment" charge.

Bill payment: You may call in or mail your payment, or contact our billing department at 301.352.6515.

Understanding Your Insurance: Your insurance coverage is based on a contract between you (or your employer) and the insurance company and **it is your responsibility to know the specifics of your plan**. Although we may participate with your insurance company, we cannot know the terms and conditions of your specific policy. Please be sure to understand your benefits and bring any questions or concerns to our attention.

Following are coverages that may vary among policies:

- You may have restrictions in your policy. These restrictions could include annual limits or excluded procedures such as vision or hearing screening. It is imperative that you understand these limits, as you will be financially responsible for any non-covered service.
- Copays, co-insurance and deductibles are part of every insurance plan. These fees are due at the time of service and collection of these amounts is required under the terms or our agreement with the insurance companies.

The timing and frequency of appointments can affect your coverage. Therefore, please keep the following in mind when scheduling your child's appointments:

- Physical exams for school or sports, if they are in addition to a regular exam, are not covered by your insurance.

If you have any questions regarding your specific coverage, you should contact your insurance company. Please do not hesitate to contact our billing department if you need any assistance.

I assign directly to TLC Pediatrics & Associates all medical payments and benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, including annual deductibles, co-payments, or charges denied by my insurance company, for service rendered by TLC Pediatrics & Associates that I choose to have performed outside of insurance coverage, or charges denied by my insurance company as not covered or not medically necessary. I am responsible for any fees incurred should my account require collection action (i.e... Late fees, collection agency fees, court or attorney costs). I authorize the use of my signature on all insurance submissions, whether written or submitted electronically. The practice may use my health care information and may disclose such information to any insurance company and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. This authorization shall remain valid unless/until I rescind it in writing.

Signature: _____

Printed name: _____

Date: _____

TLC Pediatrics & Associates L.L.C.

Acknowledgment of
Privacy and Payment Policy

By signing this form, I acknowledge that I have reviewed and consent to the Notice of Privacy Practices and Payment Policy of TLC Pediatrics & Associates.

I hereby give my consent for TLC Pediatrics & Associates to use and disclose protected health information about me/ my children to carry out treatment, payment, or healthcare operations as outlined in the Notice of Privacy Practices.

A copy of the Notice of Privacy Practices and/or The Payment Policy may be obtained by forwarding a written request to us at 4357 Northview Drive, Bowie, MD 20716, on our website, or at the front desk.

In addition, TLC Pediatrics & Associates may:

1. Call or text me at the location indicated on my executed ***patient registration form*** and leave a message on voice mail or in person, such as appointment reminders, insurance items and any topic related to clinical care including laboratory results, among others. Yes_____ No_____
2. E-Mail to the location indicated on my executed ***patient registration form*** any items such as appointment reminder cards and patient statements. Yes _____ No _____

Parent/guardian printed name: _____ Date: _____

Parent /guardian signature: _____

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301.352.6515 •pediatricsbowie.com

Patients Name: _____ Date of Birth: _____ Today's Date: _____

Name of person completing this form: _____ Relationship to patient: _____

Name of child's previous pediatrician: _____

Delivery & Birth History adopted? Y / N Date of Adoption: _

Unknown Was your child ☐

Place of birth: Name of Hospital/Home _____City and State: _____

Type of delivery: ____Vaginal If vaginal breech/feet first? Y / N ____Caesarean If Caesarean was it planned: Y / N

If known, how old was the birth mother at time of delivery? _____ Was the child premature? Y / N days:_____weeks:_____

Child's birth weight: _____ birth length: _____ head circumference: _____

Were there any significant medical problems during your pregnancy? Y / N

Were there any significant complications during labor or the baby's newborn period? Y / N

If yes, to any of the above, please explain: _____

_____

Growth and Development

Have you or your prior pediatrician ever had any concerns about your child's growth or development? Y / N
(speech/language, social skills, motor skills, etc.)

Please provide your child's age when they first:

Sat up without help: _____ Crawled: _____ Walked without help: _____ Spoke his/her first words: _____ Slept through the night: _____

Girls only: Age at first period: _____

Please indicate any developmental concerns or issues you would like to speak to the provider about: _____

_____

_____

Child's Medical History

Please indicate with a "Y" if your child has had any of the following conditions:

Been hospitalized overnight		Pneumonia		Eating Disorder/Anorexia or Bulimia	
Asthma/wheezing		Seizure/Epilepsy		Seasonal Allergies	
Used a nebulizer		Liver Disease/hepatitis		Learning Delay	
Surgery		Kidney Disease		Learning Disability	
Broken bones		Bladder infection		ADD	
Frequent or severe sprains		Sexual Transmitted Disease		Lead Poisoning	
Mental or behavior challenges		Skin problems		Obesity/overweight	
Seen in the Emergency Room		Hearing problems		Emotional/Behavioral Challenges	

If yes, to any of above, please describe on next page.

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Child's Medical History (continued)

Please describe: _____

_____

_____

Medications and Allergies

Please list current medications, vitamins, and supplements, even those used intermittently: _____

_____

_____

Please list allergies or reactions to medications, vaccines or foods:

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Social History

Please list all those living in the child's household:

Name	Age	Relationship

Does your child attend school: Y / N Homeschool: Y / N Daycare: Y / N Have a FT Nanny: Y / N

Does your child attend aftercare: Y / N Does your child attend summer camp: Y / N

Do you have pets in the home: Y / N

If yes, type and number of pets:_____

Parents working outside of the home: Y / N _____

What language(s) are spoken at home: _____

Approximately how many hours a day does your child spend in front of a screen: _____

Does your child exercise/play sports: Y / N If yes, when, where and how long: _____

_____

_____

Has your child or anyone in your household traveled internationally in the past 5 years? Y/N If yes, who/m and to where:

_____

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Please see Family Health History on next page

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Family History

Please indicate with a "X" family member who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Asthma/Wheezing												
Cystic Fibrosis												
TB/Lung Disease												
Autism												
Autoimmune Disorder												
Birth Defect/Congenital Anomaly												
Bleeding Problem												
Blood Disorder												
Sickle Cell												
Anemia												
Thalassemia												
Depression												
Diabetes												
Eczema (Atopic Dermatitis)												
Food Allergy												
Genetic Disorder												
Hearing Disorder												
Heart Disease												
Sudden Cardiac Death												
Heart Attack												
High Blood Pressure												
High Cholesterol												
Immune Disorder												
Inflammatory Bowel Disease												
Kidney Disease												
Mental Retardation												
Learning Disability												
Migraine Headaches												
Psychiatric/Mental Illness												
Scoliosis												
Seizure Disorder												
Stroke												
Substance Abuse												

Thyroid Disorder												
Tobacco Use												
Tuberculosis												
Death before age 56												

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Release of Information:

TLC Pediatrics understands that a child's teacher, childcare provider, counselor or any school official may have questions regarding your child's health and well-being at school. If you wish to decline the release of healthcare information to school officials please sign.

_____ _____

Signature Printed Name

Please note:

***If there is a custody case involving your child please be advised unless a court order is submitted to TLC Pediatrics both parents will have rights to child's healthcare records.**

Patient Portal:

If you are interested in our "Patient Portal" please provide the following information. (**please print clearly**). Unfortunately, at this time only one email is accepted at this time. However, you are able to share login credentials.

Email address: _____

Pharmacy Information:

(We will keep this pharmacy on file for all prescriptions. To avoid delay in the transmission of prescriptions correct information is required. If you wish to change your pharmacy, remember to update pharmacy information with our office)

Name: _____ Phone: _____

Address: _____Fax: _____

TLC Pediatrics does not discriminate against age, race or gender. The following fields are voluntary. This information will not be viewed or shared with any third party.

Ethnicity: ___African American ___Caucasian ___Hispanic ___Asian ___American Indian

___Hawaiian or Pacific Islander __Two or more races: _____

___Other: _____ ___*I decline to answer

Language: ___English ___Spanish Other: _____

In the event that you are not able to bring your child to an appointment and you give permission for others to be involved in their healthcare please remember to complete an accompany child to appointment form at www.pediatricsbowie.com

Consent for Testing

(ONLY applies in the event that it may happen)

In order to comply with the Occupational Safety & Health Administration (OSHA) Bloodborne Pathogens standard (29 CFR 1910.1030), we are requesting your consent to submit to testing of your blood for bloodborne pathogens (hepatitis B, hepatitis C, and HIV) IF an exposure occurs (e.g. needle stick injury, blood splatter) to one of the employees of TLC Pediatrics LLC. Testing will be done at no cost to you. All information regarding an exposure is confidential.

HIPAA and a Patient's Right to Restrict Disclosure of Protected Health Information when Paying Out of Pocket

(All claims will be sent to your insurance carrier unless stated otherwise)

You have the right to request restrictions of disclosures of protected health information (PHI) to health care plans if you consent to pay-out-of-pocket in full for services rendered at TLC Pediatrics LLC. At your request we will not disclose your PHI to your health care plans for purposes for carrying out payment. In addition, TLC Pediatrics LLC may not send PHI to health care operations, unless the purpose is to continue treatment.

For example, if you choose to pay-out-of-pocket in full for an office visit pertaining to your child and you request that we do not bill the claim to your insurance company; TLC Pediatrics LLC must comply and is legally not permitted to send out your child's PHI to any insurance company or health care facility. Although if further treatment is needed for the child's complete evaluation, including referrals, TLC Pediatrics LLC may send your PHI to another health care facility in order to legally and effectively treat him or her but is still legally not permitted to send PHI to any insurance company.

By signing below, you acknowledge the above terms:

_____

Printed name of Parent, Guardian, or Patient 18 years or older

_____ _____

Signature of Parent, Guardian, or Patient 18 years or older Date

TLC Pediatrics & Associates L.L.C.

Medical/Health Forms
Guidelines and Policy

Helpful tips:

- Please ask your school/organization for forms that you may need filled out.
- Try to anticipate your need for form completion prior to your child's well check visit.
- Many forms require the information to be based on an examination completed within 12 months of the date on the form.
- Typically, we receive school forms, camp forms, medication forms, day care center forms, sports forms, travel forms, State Department forms, etc. Try to plan ahead!
- Forms can be uploaded by visiting https://www.tlcpbowie.com/

Blank forms will not be accepted.
Forms will only be accepted for completion if the patient's name and other information has been completed.

Turnaround time for form completion is usually 5 business days.
Especially at certain times of the year we may receive hundreds of health forms in one week! *Each* form has to be carefully reviewed by a physician before it is released. ***Parents are strongly advised not to wait until the last moment.***

Forms will be held here for 60 days for parents to pick up
Because of Health Insurance Portability and Accountability Act (HIPAA) regulations, forms will be released *to parents only.* We will not mail, fax or email forms once completed.

Many forms require the information to be based on an examination completed within 12 months of the date the form is completed or may require specific evaluations that were not performed at the routine physical, i.e. sport vitals, asthma/allergy treatment plans. An additional office visit may be required additional fee may apply. No form will be completed without a physical examination in our office within the past 1 year.

Forms are completed on the basis of examinations conducted by providers in this medical group only. ***Examinations performed by other health facilities will not be co-signed by our providers***.

The fee for having a form filled out is as follows:
- $25.00 per form and for any additional forms. May change without notice.
- $40.00 for "Rush Service" forms that need to be completed within 24 hours. May change without notice.

Insurance companies do not reimburse for form completion and we do not bill insurance for completing any forms.

No member of TLC Pediatrics & Associates staff is authorized to make exception to this policy!

Thank you!

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Notice of Privacy Practices

This Notice describes how health information about you may be used and disclosed and how you can get access to

this information. This Notice provides you with information to protect the privacy of your confidential health care information, hereafter referred to as protected health information (PHI). The Notice also describes the privacy rights you have and how you can exercise those rights. Please review it carefully.

If you have any questions about this Notice, please contact The Office Manager by calling 301.352.6515.

This Notice is effective on January 1, 2017.

OUR COMMITMENT REGARDING YOUR PERSONAL HEALTH INFORMATION

TLC Pediatrics & Associates is committed to maintaining and protecting the confidentiality of our patient's personal information. This Notice of Privacy Practices applies to all patients of TLC Pediatrics & Associates. TLC Pediatrics & Associates is required by federal and state law to protect the privacy of your individually identifiable health information and other personal information. We are required to provide you with this Notice about our policies, safeguards and practices.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

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.

OUR OBLIGATIONS:

We are required by law to:
Maintain the privacy of protected health information
Give you this notice of our legal duties and privacy practices regarding health information about you
Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Office Manager.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We may also provide your Health Information to our accountants, attorneys, consultants, and others in order to make sure we are complying with laws that impact us.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your child's medical care or payment for their care, such as your family or a close friend. This in accordance to your permission on our Patient Consent for Use agreement.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received an- other, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your child's health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract with them.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

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

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Direct

We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES The following uses
and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

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

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Office Manager.

We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs- based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information, we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Office Manager.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Office Manager.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health Information we use or disclose for treatment, payment, or health care operations. You also have the right to re- quest a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. To request a restriction, you must make your request, in writing, to the Office Manager. We are not required to agree to your request.

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

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Office Manager. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.pediatricsbowie.com

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Office Manager. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

You may contact our office at:

TLC Pediatrics & Associates

Attn: Office Manager

4357 Northview Drive

Bowie, MD 20716