

Whole Child Pediatrics

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

By Law, Whole child pediatrics is required to protect the privacy of your personal medical information. We are also required to give you this notice to tell you how we may use and give out (“disclose”) your personal medical information held by us.

*Whole Child Pediatrics **must*** use and give out your personal medical information to provide information:

- To you or someone who has the legal right to act for you (your personal representative),
- Where required by law

*Whole Child Pediatrics **has the right*** to use and give out your personal medical information to be paid for your health care and to operate the office.

- We use your personal medical information to submit your claims, to collect payments, to share your benefit payment with your other insurer(s).
- We may use your personal medical information to make sure you get quality health care, to provide customer services to you, or to resolve any complaints you have.

*Whole Child Pediatrics **may*** use or give out your personal medical information for the following purposes under limited circumstances:

- For public health activities (such as reporting disease outbreaks),
- For government healthcare oversight activities (such as fraud and abuse investigations),
- For judicial and administrative proceedings (such as in response to a court order),
- For law enforcement purposes (such as providing limited information to locate a missing person),
- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability),
- To avoid a serious and imminent threat to health or safety

By law, Whole Child Pediatrics must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back (“revoke”) your written permission at any time, except if Whole Child Pediatrics has already acted based on your permission.

By law, you have the right to:

- See and get a copy of your personal medical information held by Whole Child Pediatrics,
- Have your personal medical information amended if you believe that it is wrong or if information is missing, and Whole Child Pediatrics agrees. If Whole Child Pediatrics disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from Whole Child Pediatrics. The listing will not cover your personal medical information that was given to you or your personal representative, that was given out to bill for your healthcare or for Whole Child Pediatrics operations, or that was given out for law enforcement purposes.
- Ask Whole Child Pediatrics to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. box instead of your home address).
- Get a separate paper copy of this notice

If you believe Whole Child Pediatrics has violated your privacy rights set out in this notice, you may file a complaint at the following address:

Privacy Complaints

Region III – DE, DC, MD, PA, VA, WV

Office for Civil Rights

U.S. Department of Health & Human Services

150 S. Independence Mall West – Suite 372

Philadelphia, PA 19106-3499

(215)-861-4441; (215)861-4440 (TDD)

(215) 861-4431 Fax

By law, Whole Child Pediatrics is required to follow the terms in this privacy notice. Whole Child Pediatrics has the right to change the way your personal medical information is used and given out. If Whole Child Pediatrics makes any changes, you will get a new notice by mail within 60 days of the change.

WHOLE CHILD PEDIATRICS

20925 Professional Plaza, Suite# 340

Ashburn, VA 20147

Tel: [703-723-8900](tel:703-723-8900)

Website: www.wholechildva.com

PARENT AUTHORIZATION

Parent/ Legal Guardian Name: _____

CHILD/CHILDREN NAME AND DATE OF BIRTH

1. _____ D.O.B. _____

2. _____ D.O.B. _____

3. _____ D.O.B. _____

4. _____ D.O.B. _____

5. _____ D.O.B. _____

I hereby authorize Whole Child Pediatrics to furnish information to insurance carriers concerning any illness/injury and or physical examination, and I hereby irrevocably assign to the practice all payments for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

Parent/Legal Guardian

Signature _____ Date _____

I hereby acknowledge that I have read and understand the Notice of Privacy Practices for Whole Child Pediatrics.

Signature: _____