



PATIENT INFORMATION				
Child's Name (Last, First Middle)			Today's Date	
Date of Birth	Age	Gender Male / Female	Patient's SSN	
Home Address (Street/Apt)		City	State	Zip
PARENT / GUARDIAN INFORMATION				
Mother or Guardian/Responsible Party			Relationship to Patient	
Home Address (Street/Apt)		City	State	Zip
Home Phone	Cell Phone	E-Mail	Preferred Phone No	
Employer		Work Phone		
Employer Address		City	State	Zip
Father or Guardian /Responsible Party			Relationship to Patient	
Home Address (if different from above) (Street/Apt)		City	State	Zip
Home Phone	Cell Phone	E-Mail	Preferred Phone No	
Employer		Work Phone		
Employer Address		City	State	Zip
PRIMARY INSURANCE				
Name of Insurance Company			Phone	
Address		City	State	Zip
Name of Policy Holder			Relationship to Patient	
DOB of Policy Holder	SSN of Policy Holder	Group Number	Policy ID Number	
SECONDARY INSURANCE (if applicable)				
Name of Insurance Company			Phone	
Address		City	State	Zip
Name of Policy Holder			Relationship to Patient	
DOB of Policy Holder	SSN of Policy Holder	Group Number	Policy ID Number	



Authorization Form

PATIENT INFORMATION

Child's Name (last, first, middle)	Today's Date
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PLEASE INITIAL THE FOLLOWING STATEMENTS

	I authorize the release of any medical information necessary to process the applicable claim.
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	I authorize payment of medical and surgical benefits to Helotes Pediatrics, PA
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Signature of Responsible Party	Date
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Relationship to Patient

Please let us know if you would like medical records transferred to our office. We will be happy to help you.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Parent/Guardian	Date
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Relationship to Patient

IS ANY OTHER PERSON ALLOWED TO BRING THE ABOVE PATIENT IN FOR A MEDICAL VISIT?

Name	Relationship to Patient	Cell Phone
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Name	Relationship to Patient	Cell Phone
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IN CASE OF EMERGENCY, CONTACT:

Name	Relationship to Patient
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Home Phone	Cell Phone	Work Phone
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Name	Relationship to Patient
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Home Phone	Cell Phone	Work Phone
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FOOD ALLERGIES: Please list any severe food allergies			
Name of Food	Type of Reaction	Name of Food	Type of Reaction

FAMILY HISTORY: Please check any illnesses in close family members and indicate relationship to patient		
ADD ADHD Anaphylaxis Asthma Autism Bipolar Disorder	Cancer Celiac Disease Diabetes Mellitus, Type I (Juvenile) Diabetes Mellitus, Type II (Adult onset) Heart Disease High Blood Pressure	Kidney Disease Migraine Headaches Scoliosis Seizure (Febrile or Non-Febrile) OTHER:

SOCIAL HISTORY:		
Who does the patient live with? (Please check below) Both Parents Mother Father Grandparents Foster Parents Siblings	Education: Public School Private School Home School Special Education Day Care	Type of Pets at Home _____ _____ _____ _____

Preferred Pharmacy (ex. Walgreens on Braun/1604) : _____

Parent signature: _____



Patient Name: _____ DOB: ____/____/____

New Patient Information & Financial Policy

Welcome to Helotes Pediatrics! We appreciate the opportunity to work with you and your child. The following information is provided so that we may serve you better:

Appointments:

- **Appointments** can be scheduled through our office at 210-372-0505 Monday through Friday. ONLY parents or legal guardians may schedule appointments. ONLY parents or legal guardians MUST accompany patients at first initial visit. Picture ID will be required for EVERY visit along with proof of insurance.
- **Cancellations / No shows:** If you need to reschedule your appointment, please call us at least 24 hours in advance of the scheduled time. If you must cancel an appointment our office requests a minimum 2-hour notice so that we may care for another child in need. Missed appointments without proper notice will incur a fee. Effective 06/01/2023, there will be a flat fee of \$50 for all NO SHOWS.
- **Late Arrivals:** Clients arriving more than TEN minutes late will be worked in only if another patient seeing the same physician can be moved up. Otherwise, rescheduling may be necessary.
- **Walk-ins:** We are currently not taking walk-ins however we do maintain a waiting list for same-day appointments, which are often available due to a prior cancellation. Please call our office about availability.
- **Minor Patients:** We cannot see a minor patient without a parent or other responsible adult. Please do not send your minors in for a visit alone. Minor patients who arrive alone will not be seen until a parent arrives, within the 10 min window. When your child turns 18, they are considered legal adults and as such we cannot release any information without their written consent.

Initials _____

Insurance & Billing/Collections:

- **Insurance:** Helotes Pediatrics, PA participates with many insurance plans. Inclusion in the insurance plan does not indicate that we participate in ALL groups provided by these insurers. Please verify with your insurance plan or employer / agent that we participate with your specific group plan. Please remember that your insurance is a contract between you and your insurance company. You are personally responsible for any bill, or portion thereof, not paid by your insurance company. Payment is due at the time services are rendered, including co-pays. If your health plan determines any service to be "not covered," you will be responsible for the complete charge. Prior to your child's first visit, we verify eligibility and benefits with your insurance carrier. Prior to succeeding visits, please notify us of any changes in your insurance.
Parents are responsible for non-covered services.
- **Payments:** All applicable fees, deductibles, coinsurance, or copays must be paid at the time of your appointment. We accept cash, checks, VISA, MASTERCARD, AMEX, and DISCOVER. There is a \$25 charge for returned checks. Parents who present checks that are dishonored are required to pay future amounts due with cash, money orders or credit cards.
- During your wellness visit if another problem or diagnosis is discovered, discussed, and treated there may be an additional charge.
- As an advocate for our young patients, Helotes Pediatrics, PA will not intervene in any custody dispute or financial responsibility dispute between parents or other responsible parties. Helotes Pediatrics PA will send a statement to the address provided and cannot look to more than one party for financial responsibility.

Initials _____

HMO Referrals:

- If your HMO insurer requires written authorization (referrals or pre-certifications) from your Primary Care Physician or Insurance, a copy of the authorization must be on file in our office before we schedule your appointment. It is ultimately your responsibility to ensure that your visit is pre-approved and that your insurance company will pay; otherwise, you are responsible for payment in full.

Newborns:

- Most insurances no longer “auto add” newborns to parents’ policies and will not pay for visits during the first 30 days unless the child has been added to the policy during that time. For unverified newborn visits during the first 30 days, full payment will be due at the time of visit. We will promptly refund and credit balances after insurance has been verified and payment has been received.

Medication Refill Request:

- All refill requests are processed through our parent portal unless your physician prescribes them at the time of your visit. You may also request refills through your pharmacy. After business hours, we will only approve medication refill requests on an emergency basis. NOTE: ADHD medication refills should be initiated 2-3 days in advance.

Telephone Consultations:

- Our physicians do not conduct telephone consultations. Please utilize the Patient Portal for inquiries. We will do our absolute best to respond on the same day, however scheduling may dictate that messages are returned the following day.

Lab Test Results:

- Lab results will be provided through the Patient Portal. Please make sure your account is active and monitored.

Emergency Service:

- If your child has a life-threatening emergency, call 911 or proceed to the nearest emergency facility. For minor emergencies and acute illness (i.e., fever, vomiting) after hours, Call-A-Nurse is available at 210-226-8773.

Answering Service:

- We operate a 24-hour answering service for emergencies. Call our main number at 210-372-0505.

“I, the parent or legal guardian, agree to the above policies and agree to the terms regarding payment and payment responsibilities.” I also agree to give my consent for Helotes Pediatrics P.A. and their staff to leave voicemail messages at the primary number listed on file.

Signature _____ Print _____ Today’s Date ____ / ____ / ____

Patient Name _____ Witness Signature _____

How did you hear about us? Please circle one.

Social Media



Friend/Family

Newspaper

Insurance

Drove by

Other _____



Patient Financial Responsibility Statement

The patient, parent or guardian accompanying the patient is responsible for providing our office with a valid and current insurance card. We must be notified of any changes prior to rendering services. Patients unable to provide valid insurance information may be required to pay in full at time of service or reschedule their appointment.

The patient, parent or guardian accompanying the patient must pay any co-payment and applicable deductible amounts, as directed by insurance, at the time of service unless prior arrangements have been made with our office.

The bill will be sent to the health plan on record for direct payment to our office.

If insurance has not paid our claim within 60 days, we may expect payment from the patient.

If by mistake, the health plan remits payment to the patient, payment should be forwarded to our office along with all the paperwork sent to you at the time.

The patient, parent or guardian will remain responsible for any services that are not covered or noted as patient responsibility by the health plan.

Some of the reasons health plans may refuse or deny payment of a claim are:

- The provider of service is not listed as the primary care physician "PCP" for the patient, and/or no referral was obtained, or the provider is out of network.
- Services provided were for a pre-existing illness that is not covered by the patient's health plan.
- The patient's deductible or co-insurance amount has not been met.
- The type of medical services received is not covered by your plan or subject to a maximum benefit allowance (generally per calendar year).
- The health plan was not in effect at the time the service was rendered.
- Failure to provide required documentation requested by insurance company.
- The patient has other insurance noted as the primary carrier which must be filed first.
- The insurance company requires the patient to contact them regarding whether or not the patient is covered by another health plan (generally required to update at least annually).
- Services indicate the patient was seen for an injury or accident. The patient must provide information regarding the accident or injury to the health plan as requested before the claim is paid.
- The patient or dependent receiving the services is not shown as a covered dependent under the health plan.

Please note that payment collected at the time of service may not reflect the full patient responsibility after insurance. Our office is not responsible for any limitations in coverage that may be included in your plan. Should your health plan deny claims for any of the above reasons, you will then become responsible for the bill. It is the responsibility of the patient to pay the denied amounts in full. We advise our families to understand their insurance benefits and review explanation of benefits and patient billing statements carefully. If you feel there has been an error, always contact the appropriate party with questions within a timely manner. Patient amounts owed are considered past due 30 days after the date of the initial billing statement. Anytime the patient is aware there will be a delay in payment, whether by the patient or insurance, it is important to notify our billing office of the situation. Helotes Pediatrics P.A. understands that circumstances can sometimes arise. However, to allow additional time to pay, work through insurance problems or to establish other payment arrangements, we must be informed.



Failure to Pay

Continued failure to respond to billing statements or make payments may result in the suspension of certain non-urgent services and ultimately in dismissal from our practice. Please be advised outstanding debts will be forwarded to a collection service where unpaid balances will be reported to the appropriate credit agencies. Should you feel you have made an overpayment to our office or are awaiting a refund based on insurance reimbursement, please contact the appropriate account representative in our Billing Office with questions. If you are entitled to a refund, our office will issue a refund check to the responsible party listed on the account, upon request. Due to the frequency of visits in pediatrics, if we do not receive a specific request for a refund, overpayments are applied as a credit to the patient's account and applied towards future visits in our office. Should you have any questions about this summary or any billing issues, we encourage you to discuss it with our Billing Office. We appreciate your dedication to our physicians and are happy to have your family as part of our practice. We look forward to providing many years of service to your family.

Newborn or Dependent Changes and Insurance

We understand when a change in dependent status occurs it is likely to be a very busy time in our families' lives. However, it can be very costly to overlook the requirements of your health plan with relation to dependent changes. It is extremely important to understand this process and the time restrictions involved.

Upon the birth of a newborn dependent, adoption, or other change to a dependent status, you must contact the employer and/or health plan to add new dependents within the time limits defined by the health plan. Most insurances companies require notification of the change within 30 days from the date of birth, adoption, or event date. If you already had dependent coverage prior to the birth of a newborn, adoption, etc., please be advised the insurance company will not automatically add the new dependent to the health plan. Failure to add the new dependent may result in a lapse of insurance coverage for the new dependent, meaning all services provided during the lapse time are the responsibility of the patient. Contact the employer or health plan with further questions regarding this process.

"I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and payment responsibilities."

Signature _____ Print _____ Today's
Date ____/____/____

Patient Name _____ Witness Signature _____



Medical Records Release Authorization

Patient Name: _____ Date of Birth: _____ Date of Request: _____

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

- 1) I authorize the release of my confidential health information, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.
- 2) The following individual or organization is authorized to make the disclosure

Doctor or Office: _____

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

Phone Number: _____ Fax Number: _____ Dates to be released: _____

- 3) The type of Information to be disclose:

<input type="checkbox"/> Complete Health Record	<input type="checkbox"/> Lab results	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> History and Physical Report	<input type="checkbox"/> Old Records	<input type="checkbox"/> Immunization Record
<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Physical/Wellness Exams	<input type="checkbox"/> Hospital Records

Reason for Request: _____

- 4) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- 5) This information may be disclosed to and used by the following individual or organization for the purpose of Continuity of Care:

- Please mail to: **Helotes Pediatrics, PA**
11085 Bandera Rd. Ste. 102
San Antonio, TX 78250
Phone: (210) 372-0505
- Please fax to: Fax: **(210) 372-0404**

- 6) I understand that I have a right to revoke this authorization at any time; I understand that if I revoke this authorization I must do so in writing and present my revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise, revoked, this authorization will expire after **180 days**.
- 7) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information I can contact the office manager.
- 8) A copy of this authorization is as valid as the original. Member/Patient has a right to a copy of this authorization.

Signature: _____ Date: _____ Phone Number: _____

HELOTES PEDIATRICS, P.A.

Name of Practice

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please see the receptionist to request a copy.

This Notice Describes:

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH THE COMPLIANCE OFFICE AT THE NUMBER ABOVE OR IF YOU HAVE ANY QUESTIONS.

Who We Are.

This patient notice ("Notice") describes our privacy practices and is prepared in accordance with the regulations governing the privacy of substance use disorder ("SUD") treatment records found at 42 C.F.R. Part 2 ("Part 2").

We reserve the right to change the terms of this Notice and to make the new notice provisions effective for records that it maintains.

If we revise this Notice, we will provide you with a copy by posting it on our website and at our locations. We will also provide a copy of the then-current Notice upon request.

While treating you, our employees and health care professionals follow this Notice. In addition, any person involved in your care, entities, sites, and locations may share medical information about you with each other for treatment, payment, or health care operations as described in this Notice.

We are required by law to maintain the privacy of your health information and to provide you with this Notice.

Our Duties to Safeguard your Protected Health Information.

Protected Health Information ("PHI") is any information related to your health care that is shared or maintained in any manner. It includes your insurance information as well. This Notice applies to all PHI we generate. This Notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights and certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

- ▶ maintain the privacy of your PHI and SUD Records (defined below);
- ▶ to provide you with this Notice;
- ▶ follow the terms of the Notice that is currently in effect; and
- ▶ to notify you following a breach of any unsecured PHI

How We May Use and Disclose Medical Information About You - Treatment, Payment, and Health Care Operations.

Single Consent: Except in an emergency or other special situations, you may provide a single consent for all future uses or disclosures of SUD Records for the purposes of treatment, payment, and/or health care operations pursuant to Part 2, so that we may use and disclose your PHI and/or SUD Records for the following purposes:

Healthcare Operations: We use and disclose health information about you in order to perform administration, financial, legal, and quality improvement activities necessary to run a healthcare business. This may include quality assessment, staff training/credentialing, risk management, auditing and business planning.

Payment: Activities to obtain reimbursement for services, including billing, claims management, and coverage determination. This may include submitting claims to insurance, eligibility checks, reviewing services for medical necessity, and coordinating benefits with third parties.

Treatment: Providing, coordinating, or managing healthcare and related services by one or more providers, including consultation and referrals. This may include sending records to a specialist, reviewing ambulance notes or prescription verification.

As Permitted or Required by Law: We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Special Protections for Substance Use Disorder Records: We are required by law to maintain the privacy and security of your SUD records and to notify you if a breach of your unsecured records occurs. If we intend to use or disclose your SUD records for fundraising purposes, we will provide you with a clear and conspicuous opportunity to opt out.

You may provide a single written consent that allows us to use and disclose your SUD records for all future treatment, payment, and health care operations. You have the right to revoke this consent at any time in writing, except to the extent that we have already acted in reliance on it. Information disclosed with your consent may be subject to redisclosure by the recipient; however, federal protections under 42 CFR Part 2 may still apply.

SUD records cannot be used in civil, criminal, administrative, or legislative proceedings against you without your written consent or a court order that meets strict federal requirements. You also have the right to request a restriction on how these records are shared (including the right to restrict disclosures if you pay for a service in full out-of-pocket) and to request an accounting of certain disclosures of your SUD records made over the past three years.

Pursuant to your Authorization: When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy: In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you _____ for each page. Your request to inspect or review your health information must be submitted in writing.

Right to an Accounting of Disclosures: You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

Right to Amend: If you believe that information within our records is incorrect or missing, you have a right to request that we correct the incorrect or missing information.

Right to Request Restrictions: You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications: You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice: If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the Privacy Officer listed below.

Legal Information: We are required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our current notice at any time. For more information about our privacy practices, contact the person listed below:

Filing a Complaint: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the Privacy Officer listed below. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The Privacy Officer listed below can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information.

Other Uses and Disclosures of Your PHI for which Authorization is Not Required.

Unless we have a consent signed by you, we may only disclose records related to you that are maintained now or in the future in its health record including, but not limited to, SUD treatment records—except, subject to certain exceptions, SUD counseling notes—(“SUD Records”) in accordance with the limited circumstances permitted by Part 2 related to:

Disclosure to Relatives and Close Friends. We may disclose your PHI to a family member, other relative, a close personal friend or any other person if we: 1) obtain your agreement; 2) provide you with the opportunity to object to the disclosure; or, 3) we can reasonably infer that you do not object to the disclosure. Disclosure of SUD Records is subject to a stricter standard.

Incapacity or Emergency Circumstances. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure of PHI to relatives and/or close friends is in your best interest (disclosure of SUD Records is subject to a stricter standard). If we disclose information to a family member, other relative, or a close personal friend, we would disclose only information that is directly relevant to the person’s involvement with your health care.

Fundraising. We may contact you to request a contribution to support important activities. In connection with any fundraising, we may use and disclose your demographic information as well as the dates on which you received health care services, the department where you received your services, your treating physician, and outcome information related to your care. If you do not want to receive any fundraising requests, you may contact us.

Public Health Activities. We may disclose your PHI and/or SUD Records for public health activities under certain circumstances, including the following:

- ▶ Reporting births or deaths
- ▶ To prevent or control disease, injury, or disability
- ▶ To report child abuse or neglect
- ▶ To report reactions to medications or problems with products
- ▶ To notify individuals who may have been exposed to a disease or may be at risk for contracting a disease or condition
- ▶ Reporting PHI and/or SUD Records to your employer as required by laws addressing work-related illnesses and injuries or workplace medical surveillance

Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, in accordance with current state law, we may disclose your PHI and/or SUD Records to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

Health Oversight Activities. We may disclose your PHI and/or SUD Records to a health oversight agency that is responsible to ensure compliance with rules of government health programs such as Medicare and Medicaid. These oversight activities include, for example, audits, investigations, inspections, and licensure.

Legal Proceedings and Law Enforcement. PHI and/or SUD Records, or testimony relaying the content of such records, will not be used or disclosed in any civil, administrative, criminal, or legislative proceedings against you unless based on specific written consent or a court order. Records will only be used or disclosed based on a court order after notice and an opportunity to be heard is provided to you and/or the holder of the record required by Part 2 and 42 U.S.C. 290dd-2, which are a federal statute and set of regulations that, among other things, protect the privacy of SUD treatment records. A court order authorizing use or disclosure must be accompanied by a subpoena or other similar legal mandate compelling disclosure before the record is used or disclosed.

Deceased Persons. We may release PHI to a coroner or medical examiner authorized by law to receive such information.

Organ and Tissue Donation. We may disclose your PHI and/or SUD Records to organizations that obtain organs or tissues for banking and/or transplantation.

Public Safety. We may use or disclose your PHI and/or SUD Records to prevent or lessen a serious or imminent threat to the safety of a person or the public.

Research. Usually, we will ask for your permission or authorization before using your PHI and/or SUD Records for research purposes. However, we may use and disclose your PHI and/or SUD Records without your authorization if a qualified Institutional Review Board (“IRB”) has waived the authorization requirement. An IRB is a committee that oversees and approves research involving human subjects.

Disaster Relief Efforts. We may disclose your PHI and/or SUD Records to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Military, National Defense, and Security. We may release your PHI and/or SUD Records if required for military, national defense and security, and other special government functions.

Workers’ Compensation. We may release your PHI and/or SUD Records for workers compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Communications from Us. We may use or disclose your PHI and/or SUD Records to identify health-related services and products that may be beneficial to your health, such as notification of a new physician and/or additional products and services and then contact you about those products and services. If you do not wish to receive information of this type, please contact us..

As Required by Law. We may use and disclose your PHI and/or SUD Records when required to do so by any other laws not already referenced above.

Uses and Disclosures Requiring Your Specific Authorization.

Highly Confidential Information. Federal and State laws require special privacy protections for certain highly confidential information about you. This includes PHI that is: 1) maintained in psychotherapy notes or SUD counseling notes; 2) documentation related to mental health or developmental disabilities services; 3) drug and alcohol abuse, prevention, treatment and referral information; and 4) information related to HIV status, testing and treatment as well as any information related to the treatment or diagnosis of sexually transmitted diseases. Generally, we must obtain your authorization to release this type of PHI. However, there are limited circumstances under the law when this type of PHI may be released without your consent. For example, certain sexually transmitted diseases must be reported to the Department of Health.

Other Uses or Disclosures Not Described in This Notice. Other uses and disclosures of PHI and/or SUD Records not covered by this Notice or permitted under the laws that apply to us will be made only with your written permission. Except as permitted under this Notice or as permitted by law, we will seek your written permission prior to using or sharing your information for marketing purposes or selling your information.

Revocation. Even after you give consent, you have the right to revoke that consent at any time in writing delivered to the address contained in this Notice or to the email address listed on this form. After we receive your written notice to revoke, it will terminate your earlier consent within five business days. Prior to such termination, we may have shared some or all of my information or otherwise taken action in reliance on your consent; neither the organization nor any of its representatives are liable for any release of information during such time.

Changes to This Notice.

We reserve the right to change this Notice. Revised Notices will be posted in appropriate locations and online at our website listed below. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. A copy of the current Notice is available upon request.

Complaints.

If you believe your privacy rights have been violated, you may file a complaint in writing at:

U.S. Department of Health and Human Services. <https://www.hhs.gov/ocr/complaints/index.html> . We will not penalize you if you file a complaint.

Breach Notification.

We will notify you in the event of a breach (as defined by HIPAA) of your PHI and/or SUD Records.

PRIVACY OFFICER NAME AND CONTACT INFORMATION

Name: VICTORIA GARVIN

Address: 11085 BANDERA RD., #102, SAN ANTONIO TX 78250

Phone: 210-372-0505

Email: vgarvin@helotespediatrics.com

Website: www.helotespediatrics.com