Notice of Privacy Practices

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This notice describes how medical information about you may be used and disclosed by Wee Care Pediatrics, your rights and how to access to this information in accordance with the Health Insurance Portability and Accountability Act of 1996, HIPAA Omnibus regulations and HITECH Act.

Uses and Disclosures

Treatment-Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, we may need to disclose your health information when we refer you to a specialist for further treatment or diagnosis, to other medical professionals, nurses, physicians, medical students or other professionals to determine the best course of treatment.

Payment- Your health information may be used to file a medical claim to your health plan on your behalf to seek payment for medical services provided by Wee Care Pediatrics. For example, your health plan may request additional information such as the services provided, supportive documentation such as health history and the medical condition being treated.

Health Care Operations-Your health information may be used as necessary to support the day-to-day activities such as verifying your health insurance or to help assess the quality of healthcare and services we provide. For example, health insurances use a review team to audit the services and quality of care provided by medical practices.

Electronic communications-Your health and personal information may be disclosed or transferred by electronic data interchange or EDI. As of January 1, 2014, The American Recovery and Reinvestment Act of 2009, made it mandatory for all public and private healthcare providers to adopt Electronic Health Records or EHR. For example, your complete medical record, lab reports or consults are now kept electronically to improve accuracy and streamline health care. If you have disclosed your email address to Wee Care Pediatrics, we may send you email notifications for appointment reminders or account statements for balances due. These notifications will never include your protected health information. If you no longer wish to receive email notifications, you may submit a written request at any time to have your email address removed.

Business Associates- Your health or personal information may be disclosed to third parties or *"Business Associates"* to perform day-to-day activities. For example, we may utilize an outside billing company who will have access to your personal and medical information for filing medical claims. All *Business Associates* must follow the same privacy standards in place to protect your personal and or protected health information.

Other uses and disclosures that require your authorization-Disclosure of your health information or its use for any purposes other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use that occurred before you notified us of your decision to revoke the authorization.

Notice of Privacy Practices

Understanding Your Rights

You have certain rights under federal privacy standards which include: The right to request restrictions on the use and disclosure of your Protected Health Information or "PHI". The right to receive confidential communications concerning your medical condition and treatment; The right to inspect your PHI or health records- Requests to inspect your PHI may be done in writing or by submitting a records request form to our Privacy Officer. Your request will be reviewed within 10 days of receipt and will be provided to you at 0.60/page per NRS 629.061; The right to amend or submit corrections to your PHI; The right to receive an accounting of how and to whom your protected health information has been disclosed; The right to receive a printed copy of this notice. Medical record requests will be processed within 30 days from receipt.

Our Responsibilities

Wee Care Pediatrics is required by law to maintain the privacy of your "Protected Health Information" and to provide you with this notice of privacy practices. We are required to abide by the privacy policies outlined in this notice. In the event your information is compromise by a breach of unsecured "PHI," it is our duty to notify you. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may be required by federal and state laws regulations. Upon request, we will provide you with the most recent revised notice at any time. The revisions will apply to all PHI we maintain.
***Medical Record Retention Policy:** Medical records will be retained until the patient is at least 23 years of age. For patients that have attained the age of 23 years on the date of proposed destruction and have been retained for at least 5 years or a longer period provided by federal law, may be destroyed in accordance with Nevada and Federal Law pursuant to NRS.629.051. (www.leg.state.nv.us/nrs/NRS-629.html)

Complaints-If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you may do so in writing by submitting a letter describing the cause of your concern and any details of how you believe your privacy has been violated. You will not be penalized or retaliated against for filing a complaint. All concerns should be sent to our Privacy Officer/Office Manager 4785 S. Durango Dr. Ste 101 Las Vegas, NV 89147 or fax (702) 933-4282. You may also file a complaint with the Secretary of Health and Human Services (HHS).

I acknowledge that I have read the Notice of Privacy Practices Wee Care Pediatrics has provided with an effective date of September 1, 2001. I understand that if I have any questions regarding this notice, I may contact the Privacy Officer at any time and I may request a printed copy of this notice upon signing.

Signature: ____ Date: _________________
Parent or Legal Guardian

Printed Name: ___________________________________ Relationship: _________________

Patient Name: ____ DOB: _________________