PATIENT INFORMATION

Pediatric Associates of Alexandria, Inc.
6355 Walker Lane, Suite 401
Alexandria, VA 22310
Phone: 703-924-2100 Fax: 703-922-6067
www.pedsalex.com

Dear Parents,

We look forward to meeting you and your child(dren). We are also pleased to be able to provide you with quality medical care that will promote the healthy growth and development of your child. Included are all of the new patient registration forms for you to complete. We ask that you arrive 30 minutes early for your scheduled appointment. Parking at this facility can be difficult; arriving early will allow you ample time to find parking and will give our staff time to enter all of your child's information in our electronic system.

We ask that parents/legal guardians bring the child to their initial visit; there are forms that need to be completed at this first visit by the legal guardian.

We ask that you bring the following to your child's first office visit:

- **If here for a well check please bring your child's immunization record**
- **Legal guardian's picture ID and child's insurance card**
- **If you are not the biological parent please bring proof of guardianship (court documents)**

See you soon,

PAA Providers & Staff

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- **Office Hours**
  - **Monday- Thursday 6:00 am - 8:00 pm**
  - **Friday 6:00 am - 5:00 pm**
  - **Saturday 8:00 am – 12:00 pm**

- **Walk in Hours 6:00am - 6:30am Monday thru Friday (for established patients only)**
- After 6:30 am, Walk-in patients will be seen in the next available appointment slot; HOWEVER, we strongly recommend that you call the office first to speak with an advice nurse.
- If you arrive for your appointment more than 15 minutes late, it will be necessary to reschedule your appointment due to time constraints. You will be assessed a missed appointment fee of $50.00 per missed appointment.

Extended Hours PAA is required to report all services rendered, to your insurance carrier; even those that occur outside of normal business hours (M-F 8am-4:50pm). The Extended Hours are assessed an additional fee, which is submitted to your insurance carrier; most insurance companies do pay this fee.

Immunization Appointments Are scheduled Tuesday thru Thursday between the hours of 8:00 am-5:00.

Missed Appointments If you miss a scheduled appointment with us and did not call with at least 24 hours advance notice, there will be a $50.00 Missed Appointment fee charged to your child's account.

Sibling Appointments For check up appointments and sick visits, siblings are scheduled in different consecutive time slots. We ask that you do not bring a sick sibling in (who does not have a scheduled appointment) with a child who has a scheduled appointment, as this causes the physicians and nurse practitioner to run behind.

Routine Check Ups Well check appointments are 20 minutes and are limited in our daily schedule, therefore, we recommend that you call a minimum of 2-3 weeks in advance to schedule your child's next well check appointment.

Yearly Sports Physicals Yearly sports physicals should be scheduled well in advance of beginning the sports activity. Schools require physicals to be done after May 1st for the fall sports season. (Please check the appropriate forms for instructions.)

Insurance **Each calendar year we ask that new demographic forms be completed and signed as well as copies of each patient's insurance card. Insurance mandates as well as HIPAA requirements. All patients or their guardian are asked to sign that they were given our HIPAA guidelines.**

Co-payments/ Deductibles/Coinsurance/Past Due Balances If your insurance plan requires you to pay a co-payment, it is due at the time of your visit. There are no exceptions. Any balance on your account will also be collected at this time. Staff will inform parents of past due balances on their account. I understand and agree to pay an assessed $10.00 late fee for each co-payment not paid at the time of visit.

There is a $50 fee charged for returned checks.

Poison Control 1 800 222 1222 Children's Hospital Information line 1 888 884 BEAR (2327)

Insurance Referral Process: Please be advised that if your insurance company requires a referral, we will need three (3) to five (5) business days to complete this process. It is the parents' responsibility to schedule an appointment with the specialist, ensure that the specialist participates with their insurance AND allow us adequate time to generate the appropriate referral for your visit. The parent must notify our referral specialist with the date of the appointment, the name of the specialist and their office location, so that a referral can be generated.
It is recommended that you bring the original referral with you to the specialist's office. It is the parent's responsibility to pick up the original referral form from us (if required by the insurance company) before seeing the specialist. Do not go to the specialist office without a referral if it is required by your insurance carrier. For additional information please call our referral specialist or your insurance carrier. REFERRALS CANNOT BE BACK DATED.

Prescription Renewals: When prescription refills are needed, please call your child's pharmacy to see if there are any refills left. If not then ask the pharmacist to call us. WE DO NOT MAIL PRESCRIPTIONS, ESPECIALLY CONTROLLED SUBSTANCES. Therefore, it is not advisable to wait until the last dose has been given to your child.

Emergency Referral Info: If you are out of town and your child requires emergency treatment, you do not need to call our office to get a referral. Please refer to your insurance handbook and review the section on out-of-area network emergency visits. You can also call your insurance carrier for instructions; their telephone number should be listed on the back of your insurance card.
Please make sure to call our office upon your return so that we can log your child's chart and/or to schedule an emergency follow up visit.

Allergies: At your office visit, always let the nurse know (before being seen by the physician or nurse practitioner) if your child has any known medical allergies.

Medical Records are retained only up to the age of 21 years. Remember to request your child's shot records prior to age 21.

Negative Test Results: Our policy regarding routine laboratory test results is that the parent will be notified only if the tests are abnormal. You may call and get the results if you wish; however please allow ample time for the results to come back to our office from the lab.

Our advice nurses are available M-Th 6-8, Friday 6-5, and Saturday 8-12 to answer telephone calls of a medical nature. If necessary, one of the physicians will return your call later that day.

Specific Provider Requests: We suggest you meet all the health care providers in our group. Should you prefer anyone in particular, we will try to accommodate your wishes. When possible, follow-up visits for the same illness can best be handled by the original person treating your child. Please inform the person scheduling your appointment if you prefer a specific provider. If possible, they will try to accommodate your request.

On-Call Physician: One doctor from our group is on call EVERY evening, night, weekend, and holiday for emergency calls only. Because the doctor will be paged at home, WE ask that all routine, non-urgent or non-dangerous concerns be reserved for regular office hours. There is a $20.00 After Hours Fee assessed to your child's account for all after hour calls to the physician.

Patient Balance Due/Collection Agency: Upon payment from your insurance plan, remaining balances are to be paid upon receipt of the statement. Unless a previous financial payment schedule has been established with our office, any balance that is not paid within 60 days may be turned over to our collection agency. At our discretion, delinquent accounts may be terminated from our practice.

Transfer of Medical Records: A **medical record release of information** form must be completed prior to the release of all medical information. You can obtain a release form from our office or on line at www.pedsalex.com. After the request has been received, you will be contacted by our medical records department for any additional information needed and to obtain payment. Please allow up to 14 days to complete the process.

Parental Authorization Form: When you cannot accompany your child for treatment we have a form letter available for you to complete prior to your child's visit that authorizes treatment and/or immunizations. The completed form will be kept in your child's chart.

Poison Control 1 800 222 1222 Children's Hospital Information line 1 888 884 BEAR (2327)

PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

6355 Walker Lane ● Suite 401 ● Alexandria, Virginia 22310 ● 703-924-2100 ● Fax 703-922-6067

❒**New Patient**
❒**Existing/Update**

PATIENT REGISTRATION

New Patient(s): ***PLEASE PRINT –FILL ALL AREAS IN BLACK INK***

CHILD'S FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX
				M F
				M F

Do You have other children already established with our practice? If yes, please list them so our computer system can link them together as a family.

				M F
				M F

Mother ❒Address Update Only ❒Stepmother ❒Married ❒ Unmarried ❒ Divorced

If divorced, does child reside with Mother? **YES** / **NO**

Mother's Full Name		Social Security Number	Home Phone Number ( )
Home Address	City	State	Cell Phone Number ( )
State			Zip
Mother's Employer name & Address			Work Phone Number ( )

Father ❒Address Update Only ❒Stepfather ❒Married ❒Unmarried ❒Divorced

If divorced, does child reside with Father? **YES** / NO

Father's Full Name		Social Security Number	Home Phone Number ( )
Home Address	City		Cell Phone Number ( )
State			Zip
Father's Employer name & Address			Work Phone Number ( )

Emergency Contact (Friend or Relative)

Name	Relationship	Home Phone Number ( )

Insurance Information *Insurance info and copy of insurance cards needed to file for benefits*

❒ **Insurance Update Only**

Policy Holder's Name		Social Security Number of Subscriber	Co-Payment / Co-Insurance Amount	
Primary Insurance Company	Identification / Policy Number	Sex of Policy Holder ❒Male ❒Female	Birthdate of Policy Holder	Effective Date

Try our new patient portal, ask our receptionist for details, sign up by providing us with your email:

New Patients- How did you hear about Pediatric Associates of Alexandria?_____

I certify that the information I have reported is true and correct. As the Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration as stated on the Conditions of Registration Form. *****In cases of divorce or separation, unless otherwise specified in a court order, I understand that both parents will be permitted to schedule appointments, bring the child(dren) in for exams, and have full access to the child's medical records. If you have any concerns in this area, please contact the office supervisor for further questions.

PARENT: MAKE SURE FORM IS COMPLETELY FILLED OUT

_____ _____ _____

Signature of Parent/Guardian/Guarantor **Print Name** **Date**

PAYMENT IS DUE AT TIME OF SERVICE

Read Conditions of Registration on the Back of this Form

CONDITIONS OF REGISTRATION

THE PRACTICE

Pediatric Associates of Alexandria, Inc. and/or its physicians, employees, agents or assignees will hereafter be referred to as "The Practice".

CONSENT FOR TREATMENT

The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, surgery, laboratory and x-ray procedures.

HIV/HEPATITIS B & C VIRUSES TESTING NOTIFICATION

In accordance with Virginia law, any patient to whose body fluids a healthcare worker has been exposed, will be deemed to have consented to HIV/HEPITITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPITITIS B & C TESTING. We do not randomly test for HIV.

AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS

I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child(ren) under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION

I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Health Care Financing Administration, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons I agree to pay any applicable charges for having records copied. Such charges not to exceed .50 per page for the first 50 pages and .25 per page thereafter in addition to a $10.00 Administrative/regular postage/handling fee.

REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from The Practice or insurance company prior to such non-emergency services being rendered. I further understand that I must notify The Practice prior to going, if possible, or within 48 hours, or in accordance with my insurance company's requirements, of any emergency room visit. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for my (our) child(ren)s claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information.

FINANCIAL AGREEMENT

I agree that payment in full is due at the time of treatment. I the undersigned (jointly and severally if more than one) further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by my children, step children or any other extended family members, including but not limited to grandchildren, nieces and nephews. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through or conformation. I understand that I am responsible for and agree to pay the $10.00 late fee for each co-payments not paid at the time of visit. I understand that I am responsible for and agree to pay the assessed $40.00 Emergency Walk-In Fees in addition to the office visit if I arrive without a scheduled appointment, excluding scheduled walk in clinic hours. I understand that I am responsible for and agree to pay a $50.00 Missed Appointment Fee for all scheduled appointments that I was more than 15 minutes late for or that were not cancelled with at least 24 hours advance notice. I understand that I am responsible for and agree to pay a $20.00 "Emergency After Hours fee" for all after hour's calls to the covering provider. These after hour calls are considered an emergency; and will be charged to the member's account on the date services were rendered. The after hour calls are not covered by commercial and or Medicaid policies and are the member's responsibility. I understand that I am responsible for and agree to pay a $10.00 administrative fee for each form I request to be completed. I understand that I am responsible for the entire balance in my child's account; including co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason. I understand and agree that I am expected to pay all balances within 30 days of services being rendered. I understand and agree that if for any reason my personal check is returned for any reason, including insufficient funds on my account I will be assessed and responsible for a $50.00 Returned Check Fee in addition to ALL original fees for services. Interest of one and one-half percent per month, eighteen percent per annum, will be charged on all accounts over 30 days. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collection, I agree to pay one-third of the unpaid principal and interest as a collection fee, plus court costs and interest in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed interest, shall become an additional liability for which I (we) assume full responsibility. PAA is required to report all services rendered, to your insurance carrier; even those that occur outside of normal business hours (M-F 8am-4:50pm). I understand that I am responsible for and agree to pay all balances rendered patient responsibility by my insurance carrier.

COPY OF SIGNATURE

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CERTIFICATION

I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing and as the parent/guardian/guarantor understand and fully accept the terms therein.

Information *Insurance info and copy of insurance cards needed to file for benefits*

In accordance with Virginia law, any patient to whose body fluids a healthcare worker has been exposed, will be deemed to have consented to HIV/HEPITITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPITITIS B & C TESTING. We do not randomly test for HIV.

PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

Pediatric Medical History Form

www.pedsalex.com
Phone: (703) 924-2100 Fax: (703) 922-6067

Child's Name: _____ Birth Date: _____

DEMOGRAPHICS: Please list pertinent demographic information.

	Name	Age	Occupation	Highest Education	Ethnicity
Mother					
Father					

	Name	Age		Name	Age
Sibling 1			Sibling 3		
Sibilng 2			Sibling 4		

FAMILY HISTORY: Please indicate with a check (√) the specified relatives with 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
ADHD												
Anemia												
Autism												
Asthma												
Autoimmune Disease												
Birth Defect (type?)												
Bleeding Problems												
Cancer (type?)												
Depression												
Diabetes												
Eczema												
Endocrine Disease												
Food Allergy (which foods?)												
Genetic Disorder												
Heart Attack/Heart Disease												
Hearing Disorder												
High Cholesterol												
High Blood Pressure												
Immune Disorder												
Kidney Disease												
Learning Disability												
Liver Disease												
Mental Health Problems												
Neurologic Problems												
Seasonal Allergies												
Seizures												
Stroke												
Substance Abuse												
Thyroid Disorders												
Death before age 50												
Other												

PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

Pediatric Medical History Form

www.pedsalex.com
Phone: (703) 924-2100 Fax: (703) 922-6067

Child's Name:_____Birth Date:_____

BIRTH HISTORY: Please fill in the blanks.

Hospital:_____ Birth Weight (If known):_____(lbs)_____(oz)

Type of Delivery:_____ Complications with Delivery:_____

Term:_____(wks) Jaundice: (yes / no) Phototherapy: circle one (yes / no)

CHRONIC MEDICATIONS: Please list the child's dose and frequency of chronic medications.

_____

_____

_____

ALLERGIES: Please list any drug and/or food allergies, reaction if ingested, and date first noted.

_____

_____

PAST MEDICAL HISTORY: Please indicate any chronic conditions or problems of the child.

_____

_____

SURGERY: Please list any past surgeries and dates.

_____

_____

HOSPITALIZATION: Please list any past hospitalizations and dates.

_____

_____

SOCIAL HISTORY: Please answer the following questions.

Who lives in the household?_____

_____

Are there any pets in the home? If yes, what kind?

_____

Does anyone in the household smoke? _____

If yes, outside or inside?_____

Are there any guns in the home? _____

If yes, are they locked?_____

Are your child's parents married? If not, what is the custody arrangement?_____

Lead risk**: What year was your home/apartment built?**_____

TB risk**: Has the child traveled or lived outside of the U.S. for longer than 2 weeks? If so, what country?**_____

Is your child in daycare? If so, what kind (in-home, group, babysitter, nanny)?_____

Languages spoken at home?_____

Does your child visit the dentist every 6 months?_____

PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

Authorization for Treatment and/or Immunization of Minors

In absence of parents or guardians

Today's Date:_____

Patients' Names: Date of Birth

_____
_____
_____
_____

I hereby authorize treatment of the above child(ren) and give permission for treatment during my child's preventive medical examination or sick examination. This form remains in full effect until rescinded in writting by parent/legal guardian.

The following person(s) listed below are authorized to bring my child(ren):

Name: Relationship:

_____
_____

* Any person selected to bring your child to our office will be required to show a current photo ID.

- ☐ Pediatric Associates of Alexandria follows the recommended immunization schedule of the American Academy of Pediatrics. I give permission for the administration of the recommended vaccines.
- ☐ I hereby request no immunizations be given to my child at their examination.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Printed Name:_____

- ☐ My child is 16 years of age (or older) and has a current driver's license. I give Pediatric Associates of Alexandria authorization to treat my child for; preventive medical examination, vaccine administration, and/or sick visits.

If a provider needs to call me while my child is being seen you can contact me at:( )_____.

This form remains in full effect until rescinded in writting by parent/legal guardian.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Printed Name:_____

Policies and Procedures for HIPAA

Health insurance Portability and Accountability Act

All patients of ***Pediatric Associates of Alexandria*** have the right to receive a paper copy of our Notice of Privacy Practices.

Procedures

1. A patient will be given a paper copy of the Notice of Privacy Practices when they request it.
2. A copy of the Notice will be provided even if they have previously received a copy.
3. A copy of the Notice of Privacy Practices will be provided even if it is available electronically or a patient has received the Notice in an electronic format.
4. The Notice of Privacy Practices will be posted in a prominent location within our office and is also posted on our web site (www.pedsalex.com)

Received by **(Relationship)** **Date**

PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC. NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD (CHILDREN) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Pediatric Associates of Alexandria, including staff, physicians and other healthcare providers on our staff use and share health information about you or your child (children) for treatment, administrative purposes and to evaluate the quality of care you receive. We are committed to protecting health information about you or your child (children). Your or your child's health information contained in a medical record is the physical property of Pediatric Associates of Alexandria, Inc.

HOW WE MAY USE YOUR HEALTH INFORMATION

FOR TREATMENT: We may use your or your child's health information to provide, coordinate or manage medical treatment or related services. Information obtained by a nurse, physician or other member of the healthcare team will be recorded in the medical record and used to determine the course of treatment that will work best for you or your child.
FOR PAYMENT: We may use and disclose health information to bill and collect payment for treatment and services that are received. For example, a bill may be sent to you or to your insurance company that will contain information that identifies you or your (children) as well as the diagnosis, procedures and supplies used in the course of treatment.
FOR HEALTH CARE OPERATIONS: We may use and disclose health information about you and your child (children) for office operations. For example, you or your child's health information may be disclosed to other staff members to:

- Evaluate the performance of our staff
- Assess the quality of care
- Learn how to improve our facilities and services; and
- Determine how we can make improvements in the care and services we provide

APPOINTMENT/FOLLOW-UP CALLS: We may use your or your child's information to contact you as a reminder that you have an appointment for treatment or to follow-up regarding medical care.
INDIVIDUALS INVOLVED IN YOUR CARE: We may share information with a family member or other persons identified by you or who is involved in your or your child's care or payment related to that care. We may tell a family member or friend about your child's condition. If you do not want information released to those involved in the care, see instructions for requesting a restriction under **YOUR HEALTH INFORMATION RIGHTS.**

HOW WE MAY DISCLOSE YOUR OR YOUR CHILD'S (CHILDRENS) HEALTH INFORMATION OUTSIDE OF PEDIATRIC ASSOCIATES OF ALEXANDRIA.

REQUIRED BY LAW/PUBLIC HEALTH: We may disclose information about you or your child (children) when required to do so by federal, state or local laws. For example, we may disclose information for the following purposes:

- To respond to a court order, subpoena or deposition.
- To assist law enforcement officials in their duties to locate a suspect, fugitive or missing person.
- To report information related to victims of child abuse or neglect
- To report reaction to medication or recall of products
- To federal and state agencies for oversight activities authorized by law such as investigation, inspections, audits, surveys and licensing. (Examples may include organizations that ensure the quality/safety of the care we provide).

HEALTH RISK: You or your child's health information may be released for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability. We may disclose you or your child's health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease.
HEALTH AND SAFETY: We may disclose health information about you or your child (children) to avert a serious threat to the health or safety of yourself, another person or the public. Any disclosure would only be to someone able to help prevent the threat.
DECEASED: Health information may be disclosed to funeral directors, medical examiners or coroners to enable them to carry out their lawful duties.
ORGAN/TISSUE DONATION: If you or your child(children) are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplant or to an organ donation bank.
RESEARCH: We may disclose information for research purposes when Pediatric Associates of Alexandria has reviewed and approved research proposals. Medical record information that identifies you or your child (children) will only be used when given permission for us to do so. Additionally, when given permission PAA may contact you regarding research purposes.
NATIONAL SECURITY: We may disclose your or your child's health information to federal officials for intelligence, counter-intelligence and national security activities authorized by law.
TREATMENT ALTERNATIVES: We may disclose health information to tell you about or recommend possible treatment options or other health-related benefits and services that may be of interest to you.
WORKERS' COMPENSTATION: Your or your child's health information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

YOUR HEALTH INFORMATION RIGHTS

In accordance with federal regulations and Pediatric Associates of Alexandria's policies and procedures, you have the right to:

- Request a restriction on certain uses and disclosures of your or your child's health information. We will make every effort to honor your request. However, in some situations, we may be required by law to share the health information. For example, tuberculosis (TB) results are required by law to be reported to the Health Department. Pediatric Associates of Alexandria is not required to agree to all requested restrictions.
- Request to inspect and/or obtain a copy of your or your child's health record. You have the right to request to inspect and/or obtain a copy of the health information and billing records. We may charge a fee for the cost associated with copying and/or mailing the information.
- Request to correct/amend information in your or your child's health record. If you feel the health information that we have is incorrect or incomplete, you may ask us to correct/amend the information. If the health information is determined to be incorrect or incomplete, we will revise the record.
- Request confidential communications. You have the right to request that we communicate with you about health information in a particular manner or at a location other than your permanent address. For example, you may ask that we contact you by mail rather than by telephone or at work rather than at home. It is your responsibility to insure we have your correct address and contact information.
- Receive a listing of how your or your child's information has been shared. You have a right to receive a listing of disclosures of the health information for purposes of outside treatment, payment or office operations (not including disclosures made prior to April 14, 2003).
- Receive a paper copy of this notice. You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

In order to request a restriction on how your or your child's health information is used or to request confidential communication, you must complete a "Restriction of Health Information Form."

In order to request a copy, inspection, a correction/amendment or a listing of disclosures you must submit a request in writing to the Medical Records Department.

OBLIGATIONS OF PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

We are committed to:

- Make sure that medical information that identifies you, your child(children) is kept private.
- Provide you with this notice of our legal duties and privacy practices with respect to you or your child' health information.
- Follow the terms of this notice.
- Notify you, after management's review, if we are unable to agree to a requested restriction on how health information is used or disclosed.
- Accommodate reasonable requests for communications of health information in a particular manner or to a location other than your permanent address.
- Obtain your written authorization to disclose health information for reasons other than those listed above and permitted.

Pediatric Associates of Alexandria reserves the right to change the terms of this notice and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by posting them in our office, posting them on our website at www.pedsalex.com and upon your request, we will provide you with a copy of the most recent copy of our Notice of Privacy Practices.

CONTACT INFORMATION

You may file a complaint to Pediatric Associates of Alexandria or to the United Sates Secretary of the Department of Health and Human Services if you believe your or your child's privacy rights have been violated. You will not be penalized for filing a complaint.