Pediatric Associates of Alexandria

HealthPlex Office
6355 Walker Lane, Suite 401
Alexandria, VA 22310

Potomac Yard Office
3600 S. Glebe Rd., Suite 150
Arlington, VA 22202

Tel: (703) 924-2100
Fax: (703) 922-6067

www.pedsalex.com
www.healthychildren.org

Dear Parents,

We look forward to meeting you and your child(ren). 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 their 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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PATIENT INFORMATION

- **Office Hours**
  - **Monday- Thursday** **6:00 am - 8:00 pm**
  - **Friday** **6:00 am - 6:00 pm**
  - **Saturday** **8:00 am -12:00 pm (Healthplex office only)**
  - **Sunday** **8:00 am- 12:00 pm (Potomac Yard office only)**
- **Walk in hours: Monday-Thursday 6:00am-7:00pm Friday 6:00am-6:00pm**

All Day Walk In "SICK" Appointments are for Established Patients Only. If you have a specific provider that you would like to see, we ask that you call to schedule a sick visit with them. **Walk-in visits** are on a first come basis, with the next available provider.

- 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.

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. Missing three scheduled appointments may terminate your relationship from the practice.

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 6am-8pm, Friday 6am-6pm, Saturday and Sunday 8am-12pm 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)

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❒New Patient
❒ Updated Information Applies To All Children listed
❒Yearly Established Patient Update

PATIENT REGISTRATION

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

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

❒Address Update Only ❒Mother ❒Stepmother ❒Legal Guardian ❒Partner ❒Married ❒ Unmarried ❒ Divorced

If divorced, does child reside with you? YES / NO

Full Name	DOB	Social Security Number	Home Phone Number ( )
Home Address	City, State, Zip		Cell Phone Number ( )
Employer name & Address			Work Phone Number ( )

❒Address Update Only ❒Father ❒Stepfather ❒Legal Guardian ❒Partner ❒Married ❒ Unmarried ❒ Divorced

If divorced, does child reside with you? YES / NO

Full Name	DOB	Social Security Number	Home Phone Number ( )
Home Address	City, State, Zip		Cell Phone Number ( )
Employer name & Address			Work Phone Number ( )

Emergency Contact (Friend or Relative)

Name	Relationship to Patient	Home Phone Number ( )

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

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

PARENT: PLEASE MAKE SURE FORM IS COMPLETELY FILLED OUT
PAYMENT IS DUE AT TIME OF SERVICE

Read Conditions of Registration on the Back of this

(TURN OVER)

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/HEPATITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPATITIS 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 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, I (we) are financially responsible for; 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 a $25.00 Late Missed Appointment Fee for all scheduled appointments that I was more than 15 minutes late for. I also agree to pay a $50.00 Missed Appointment Fee for all Missed Appointments or that were not cancelled with at least 24 hours advance notice. I understand that missing three scheduled appointments may terminate my relationship from the practice. 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 primary 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.***

I agree to terms & conditions of registration. 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.

Signature of Parent/Guardian/Guarantor	Print Name-Relationship to Patient	Date

Updated:04/19

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Child's Name: _____ Birth Date: _____

DEMOGRAPHICS: Please list pertinent demographic information for legal parents.

	Name	Age	Occupation	Highest Education	Ethnicity
Mother/Parent					
Father/Parent					

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

FAMILY HISTORY FOR BIOLOGIC FAMILY: 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												

Turn over

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Child's Name:_____ Birth Date:_____

BIRTH HISTORY: Please fill in the blanks.

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

Type of Delivery:_____ **Complications:** _____

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?_____

_____

Does anyone in the household smoke? _____

If yes, outside or inside?_____

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

babysitter, nanny)?_____

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:

_____

_____

* All persons selected to bring your child to our office must be 18 years of age or older and 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: _____

Updated: 09/14

When you sign up for our Patient Portal you will be able to:

- View scheduled appointments, cancel appointments, re-schedule appointments & request new appointments
- Receive appointment reminders & confirmations
- Submit non-urgent questions for advise nurse or general messages
- Submit requests for referrals
- Prescription refills
- View immunization records & medical records
- View & update your child's personal information

All you have to do is provide us with your email and we will sign you up:_____

**You will receive an email with a link to the portal along with your log in and password.

Divorce, Separation, & Custody Agreements

- We believe that such matters should not enter into a child's medical treatment.
- The individual who is requesting the medical treatment is responsible for the payment of the medical bills. We are not a party to your divorce agreement, you are. We will collect co-pays and deductibles from the attending parent.
- "Joint Custody" means that each parent has equal access to the child's medical record. Without a court order, we will not stop either parent from looking at their child's chart or obtaining their child's test results.
- We will not call the other parent for consent prior to treatment.
- Unless stated in the court order both parents have equal rights and we can't get involved.
- We will discuss with the accompanying parent information pertinent to the child's history and/or present exam.
- Should the issues that come between parents become disruptive to our organization, we will discharge the patient from further treatment.

Parent/Legal Guardian Signature:_____ Date:_____

Pediatric Associates of Alexandria
Vaccine Policy 01/01/2016

Pediatrics Associates of Alexandria (PAA) is a large practice, caring for thousands of children. Every day, we have hundreds of children coming in and out of our office. Some are too young to be vaccinated and are therefore vulnerable to severe, potentially life-threatening infection. It is our duty to protect each of our patients to the best of our ability from any infection that could be contracted in our office.

Due to recent concern of highly contagious, vaccine-preventable illnesses in our region, PAA is revising our vaccine policy. This is being done to better protect all our patients, as well as their caregivers and our greater community.

Effective January 1, 2016, patients at PAA will be REQUIRED:

1. To start required* childhood immunizations at 2 months of age, unless there is a medical contraindication.
2. To complete required* childhood immunizations no later than 2 years of age, unless there is a medical contraindication.
3. To complete immunization boosters required* after the fourth birthday by 6 years of age, unless there is a medical contraindication.
4. To complete immunization boosters required* after the tenth birthday, within 1 year after the latest recommended date for administration, unless there is a medical contraindication.
5. Children who are behind in their vaccines will have 30 days to initiate the catch-up process, and 6 months in which to receive all needed additional vaccines.

Immunization status will be reviewed and discussed at office visits with a provider.

This policy will be updated should any new recommendations/requirements arise as determined by authorities including the CDC, AAP, ACIP, or the State of Virginia.

Legal guardians who are not able to abide by the above guidelines will be asked to find a medical practice that is able to comply with their beliefs.

Pediatric Associates has no greater responsibility than to protect each and every one of our patients. Having a fully immunized patient population is essential to our providing this protection.

*Required vaccines are those required by the State of Virginia for school entry. These include DTaP, HIB, IPV, Prevnar, Hepatitis B, MMR and Varicella. See http://www.vdh.virginia.gov/epidemiology/Immunization/requirements.htm for details.

AAP 2015 immunization schedule:
http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

A Commitment to Our Patients about Antibiotics

Antibiotics only fight infections caused by bacteria. Like all drugs, they can be harmful and should only be used when necessary. Taking antibiotics when you have a virus can do more harm than good: you will still feel sick and the antibiotic could give you a skin rash, diarrhea, a yeast infection, or worse.

Antibiotics also give bacteria a chance to become more resistant to them. This can make future infections harder to treat. It means that antibiotics might not work when you really do need them. Because of this, it is important that you only use an antibiotic when it is necessary to treat your illness.

How can you help? When you have a cough, sore throat, or other illness, tell your doctor you only want an antibiotic ıf it is really necessary. If you are not prescribed an antibiotic, ask what you can do to feel better and get relief from your symptoms.

Your health is important to us. As your healthcare providers, we promise to provide the best possible treatment for your condition. If an antibiotic is not needed, we will explain this to you and will offer a treatment plan that will help. We are ***dedicated*** *to prescribing antibiotics* ***only*** *when they are needed, and we will avoid giving you antibiotics when they might do more harm than good.*

If you have any questions, please feel free to ask us.

Sincerely,

GET SMART
Know When Antibiotics Work

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS270414

Pediatric Associates of Alexandria Privacy Practices

Effective Date: November 1, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AT PEDIATRIC ASSOCIATES OF ALEXANDRIA (PAA) AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
If you have any questions about this notice, please contact Pediatric Associates of Alexandria's Chief Privacy Officer by calling the Compliance Department at 703-924-2100.

Each time your child visits a hospital, physician, or other health care provider, a record of their visit is made. Typically, this record contains the child's symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This information is considered protected health information (PHI). The Health Insurance Portability and Accountability Act (HIPAA) requires that we provide you, the parent with a notice regarding how your child's PHI may be used or disclosed and your rights concerning that information. This notice applies to all of the records of your child's care generated by and as part of the care furnished in one of Pediatric Associates of Alexandria facility, doctor's office or clinic.

Pediatric Associates of Alexandria Responsibilities
We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised copy by accessing our website www.pedsalex.com, calling 703-924-2100 and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. If any major change is made to this Notice, it will automatically be provided to you at the time of your next visit to a PAA facility. It will also be posted on our website at the time of the change.

Uses and Disclosures

How we may use and disclose Medical Information about your child.
The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about your child to provide them treatment or services. We may disclose medical information about your child to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of them at PAA. For example, we may provide a physician at one of PAA's facility locations with information regarding your child's prior treatment at a different PAA facility location. Different PAA departments also may share medical information about your child to coordinate the different things they may need, such as prescriptions, lab work, meals, and x-rays. We may disclose medical information about your child to people outside of PAA who provide services that are related to their care. We may also provide their physician or a subsequent health care provider with copies of various reports that should assist him or her in treating them.

Payment: Your child's PHI will be used, as needed, to obtained payment for health care services provided to your child. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for your child such as; making a determination of eligibility for coverage for insurance benefits, reviewing services provided to your child for medical necessity, and undertaking utilization review activities. For example, obtaining approval for an MRI may require that relevant protected health information be disclosed to the health plan obtain approval for the MRI.

Pediatric Associates of Alexandria Privacy Practices

Healthcare Operations: We may use or disclose your child's PHI in order to support the business activities of PAA. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fund raising activities, and conducting or arranging for other business activities.

For example, we may disclose your child's PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your/your child's name. We may call your child by name in the waiting room when we are ready to assist you. We may use or disclose your child's PHI as necessary to contact you to remind you of your appointment.

We may use or disclose your child's PHI as necessary to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your child's PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about the services we offer or to send you information about products or services that we believe may be beneficial to you. These activities are not considered to be marketing under the HIPPA Privacy Rule.

Use of your child's PHI for activities that would be considered marketing or disclosures that would constitute the sale of PHI may not be made without a signed authorized from you.

We may combine the medical information we have with medical information from other health care entities to compare how we are doing and see where we can make improvements in the care and services we offer.

If you do not want to receive the materials described above, please contact our Chief Privacy Officer by calling our Compliance Department at 703 924-2100 and request that these marketing materials not be sent to you.

Business Associates: Some of the services provided by PAA are provided through contracts with business associates. Examples may include transcription services or outside billing services with which we may contract. When these services are contracted, we may disclose your child's health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard the information, PAA requires a Business Associate Agreements with each such entity. In addition, all business associates are subject to oversight by the Secretary of Health and Human Services (HHS) and must adhere to all requirements of the HIPPA Privacy and Security Rules.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our facilities are participating.

Health Information Data Exchange: We may make your child's protected health information available electronically through a secure information data exchange service to other health care providers that request their information. Participation in information exchange services also lets us see health care information about your child from other health care providers who participate in the exchange.

Single Covered Entity: For purposes of HIPPA only, all covered entities that are owned or controlled by PAA shall be considered to be a Single Covered Entity. PHI will be made available to personnel at other facilities included in this Single Covered Entity, as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to PHI at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Chief Privacy Officer for further information on the specific sites included in this affiliated covered entity.

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As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or legal authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensations agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners and medical directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes:

- In response to a court order, subpoena, warrant, summons or similar process;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at a PAA facility; and
- About wounds made by certain weapons.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If Virginia Law is more stringent than Federal privacy laws, Virginia law preempts the Federal law.
Uses or disclosures of PHI not described in this notice will be made solely upon written authorization from you or your personal representative. Written authorizations may be revoked by contacting the department originally authorized to use/disclose the information.

Your Child's Health Information Rights:
Although your child's health record is the physical property of the health care practitioner or facility that compiled it, you have the **Right to:**

- **Inspect and Copy:** You as parent/legal guardian have the right to inspect and copy medical information in our possession that may be used to make decisions about your child's care. As a rule, this includes medical and billing records, but does not include psychotherapy notes. You may request an electronic copy of your child's PHI maintained in PAA electronic health record (EHR). Access to your records must be provided within 15 days of the receipt of your request. We may deny your request to inspect and copy your child's records in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. A licensed health care professional not involved in the original denial of your request will be chosen by PAA to review your request and the denial. We will comply with the outcome of the review.

- **Request an Amendment of Your Child's Information:** If you feel that your child's medical information we have on file is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as PAA retains the information. We may deny your request for an amendment and, if this occurs, you will be notified of the reason for the denial and will be provided with your options as defined in the HIPPA Privacy Rule.

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- **Request an Accounting of Disclosures:** You have the right to request an accounting of any disclosures we make of your child's medical information for purposes other than treatment, payment or health care operations.

- **Right to Restrict Release of Information For Certain Services** You have the right to request a restriction on disclosure of health information about services you paid for out of pocket in full. This request should be made prior to the service being provided and applies only if the disclosure is to a health plan for purposes of payment or health care operations.

- **You have the right to request a restriction or limitation on the medical information we use or disclose about your child for treatment, payment or health care operations.** You also have the right to request a limit on the medical information we disclose about your child to someone who is involved in your care or the payment for their care, like a family member or friend. For example, you could ask that we not disclose information about a surgical procedure. Restrictions should be requested in writing at the time you register for service.

- **With the exception of restrictions regarding services or procedures that you pay for out of pocket, we are not required to agree to your request.** Requests for restrictions or limitations on the medical information we use or disclose about your child for treatment, payment or health care operations must be forwarded to the Privacy Officer. Only the Privacy Officer or his/her designee can agree to such restrictions or limitations. If we do agree, we will comply with your request unless the information is needed to provide your child emergency treatment.

- **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 may ask that we contact you at a location other than your home or by U.S. Mail. Such request must be made in writing and must include a mailing address where bills for services and related correspondence regarding payment for services will be received. It is important that you note that PAA reserves the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

- **Breach Notification:** You have a right to be notified following a breach of your child's unsecured PHI.

- **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 may obtain a copy of this notice at our website www.pedsalex.com.
To exercise any of your rights under this notice, please obtain the required forms from the Registration Department in the facility where you received your services and submit your request in writing. You may also access these forms at our website www.pedsalex.com.

Pediatric Associates of Alexandria Privacy Practices

CHANGES TO THIS NOTICE
We reserve the right to change this notice at any time. The revised or changed notice will be effective for information we already have about you as well as any information we receive in the future.

The current notice will be posted in PAA facilities and will include the effective date. In addition, each time you register at PAA for treatment or health care services, we will provide access to the most recent version. You may always access the most recent version at our website www.pedsalex.com or may call 703-924-2100 and request that a copy of the most recent version is mailed to you.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with PAA by contacting the Compliance Department at 6355 Walker Lane Suite 401, Alexandria, Virginia 22192 Attention: Tiffany Johnson, Privacy Officer. You may file a complaint with the Secretary of the Department of Health and Human Services. Instructions for filing a complaint with the Secretary are found at www.hhs.gov/ocr/privacy.

All complaints must be submitted in writing. **You will not be penalized for filing a complaint about PAA Privacy practices.**

OTHER USES OF MEDICAL INFORMATION
We are required to retain our records of the care that we provided to your child(ren). PAA will make other uses and disclosures of medical information not covered by this notice or the laws that apply to us only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If we receive written revocation of your permission, we will cease the use or disclose medical information you originally authorized. We would not be able to take back any disclosure we had already made with your permission.

PRIVACY OFFICER
Tiffany Johnson
Telephone Number: 703-924-2100

Pediatric Associates of Alexandria Privacy Practices

I certify that I have been made aware of Pediatric Associates of Alexandria's Notice of Privacy Practices and that I have been given a copy to review.

This Notice describes the type of uses and disclosures of my child's protected health information that might occur during their treatment, to facilitate the payment of my child's bills or in the performance of Pediatric Associates of Alexandria's operations.

The Notice also describes my rights and Pediatric Associates of Alexandria's duties with respect to my child's protected health information.

I understand that copies of the Notice of Privacy Practices are available in the registration areas of each office location and on Pediatric Associates of Alexandria's web site at www.pedsalex.com. I may request that a copy be mailed to me by calling 703-924-2100.

Pediatric Associates of Alexandria reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by calling the above number and requesting a copy be mailed to me; by asking for a copy at the time of my next appointment or by accessing Pediatric Associates of Alexandria's website listed above to view the most current version.

Signature of Parent / Personal Representative Date

Name of Parent / Personal Representative (print) Relationship to Patient

Patient's Name (print) Date of Birth

Pediatric Associates of Alexandria, Inc.

Patient Survey

Patient's Name: _____ Date Of Your Visit:_____
(optional)

1. Customer service is very important to PAA, how do you feel you and your family were treated today?_____
   _____

2. How would you compare PAA to other pediatric practices?
   (Circle One) Better Worse Same _____
   _____

3. What could we have done to make your visit more pleasant?
   _____
   _____

4. Have you had any interaction with our billing department?
   (Circle One) Yes No
   Was it (circle one) Good Bad Indifferent
   _____
   _____

5. Would you recommend PAA to a friend/family?
   (Circle One) Yes No
   _____
   _____

6. Did any staff member(s) exceed your expectation today?
   (Circle One) Yes No If so who? _____
   _____

7. Did you have a scheduled appointment or did you walk in to be seen?
   (Circle One) Walk in Appointment

Comments/Suggestions:

_____

_____

----------(FOLD)----------

Patient Survey

---------- (FOLD)----------

Place
Stamp
Here

Pediatric Associates of Alexandria
6355 Walker Lane, Suite 401
Alexandria, Virginia 22310

ATTN: Practice Administrator