PEDIATRIC CENTER AT RENAISSANCE
OFFICE INFORMATION AND POLICIES

OFFICE HOURS

We are open Monday-Friday from 8:00 am – 5:00 pm with a lunch closure from noon – 1:00 pm. Our phone lines open at 7:30 am and transfer to our after-hours call line at 5:00 pm. We are also open Saturdays from 8:00 am – 1:00 pm for acute illness and immunizations only.

WALK-IN CLINIC

Our walk-in clinic hours are as follows:

Monday – Friday	8:00 am – 11:30 am; 1:00 pm – 4:30 pm
Saturday	8:00 am – 12:30 pm

Patients that walk in for an appointment will be scheduled with a Physician Assistant. Walk in appointments are worked in after same day appointments.

AFTER HOURS

We offer after hours telephone triage through Tele-Nurse. Calls made outside of our standard business hours will be answered by a team of nurses that will direct patient care accordingly. This service is offered when the clinic is closed, including weekends and holidays.

BILLING AND ACCOUNT MANAGEMENT

We are partnered with PedsOne, Pediatric Billing Specialists, for our billing and account management services. They are not a collections agency, but rather specialize in pediatric billing and work exclusively with our electronic healthcare record vendor. Any issues regarding your bills or concerns regarding your financial account should be directed to our PedsOne billing account manager Donna Circe at 866-371-6118, ext 118. PedsOne will work with families to set up financial arrangements and budget plans for account balances and are available to take payments over the phone. For added convenience, balance payments can also be made on our patient portal, MyKids Chart.

SCHEDULING APPOINTMENTS

If your child needs to be seen because of an illness, same day appointments during office hours are always available. Please call ahead to obtain a time. Should your primary care physician be fully booked or out of the office, you will be seen by a Physician Assistant. When calling to make an appointment, please make sure to give accurate information to our schedulers so that they may assign the appropriate amount of time needed to address your child's illness. If more than one child needs to be seen, please let the front office know that at the time you are scheduling the appointment.

You will receive an appointment reminder notification from our automated reminder system to the email or phone number of your choice based on what we have on file. You will have the option to confirm or cancel your appointment at this time. Appointment reminders will be sent 2 days ahead of

any scheduled appointment. However, you are still responsible for keeping your appointment time even if we cannot reach you.

Updates to account demographics and patient information are required at every visit. Please help us keep your phone number, mailing address, and email address up-to-date in our system. Insurance and Medicaid cards, along with a valid ID, are required at every visit and will become a part of the patient's record. It is your responsibility to notify our office of any insurance change.

REFERRALS

If your child needs a referral to see a specialist, he/she must be up to date on well child check ups and have seen the physician for the concern in the last 6 months. When a referral recommendation is made, our office staff will work with the specialist's office to make the appointment for the patient; however, if the specialist is out-of-network with the patient's insurance plan, all out-of-pocket expenses are the responsibility of the policy holder. Many insurance plans require 3-5 days before an authorization can be obtained therefore we are not able to facilitate last minute requests. No retroactive referrals will be given.

LATE/CANCELED/MISSED APPOINTMENTS

If you are running late for your appointment, please notify our office so that we can see the next scheduled patient early if possible. Patients that arrive more than 15 minutes late for their appointment will have lost their place on the schedule and will be taken in as a walk in. The front office will accommodate your visit based on the availability of the providers in clinic that day. When possible, you will be fit in as a walk in and will be seen when a provider becomes available. You may have to wait until all scheduled patients are seen .

If you need to cancel or reschedule your appointment, we ask that you do so 24 hours in advance. You can do so by calling the office or when notified by our automated appointment reminder system.

Failure to cancel or reschedule an appointment will result in a MISSED appointment. After 3 missed appointments without notification, an account will be placed on a scheduling hold. A family account with such a hold can no longer schedule an appointment but can only be seen on a walk-in basis.

DUAL VISITS

We are a patient centered medical home with an emphasis on preventative care. Well child check ups are an essential part of your child(ren)'s overall health. We follow Bright Futures and Texas Health Steps guidelines to assess and evaluate development and growth. These services include vision and hearing screens, vaccines, dental varnish, and CHADIS questionnaires. Please be advised that your insurance may not cover all of these services, leaving you responsible for paying the balance. We encourage you to learn your plan's benefits and what will be covered.

If a patient comes in for a sick visit and is due or overdue for a well child check up, the provider will take the additional time, as needed, to provide both the sick and well services. Likewise, if a patient comes in for a well child check up and symptoms of an illness or medical condition are brought to the provider's attention, he/she will take the additional time, as needed, to discuss and evaluate the illness for

treatment. In either case, we will bill and collect for both the sick and well visit. While many insurance plans do not require copayment for the well/preventive visit, many insurance plans do require a copayment for the sick visit. We are contractually required to collect any patient financial responsibility including, copayments, coinsurance, deductibles and any services not fully covered by your insurance.

INSURANCE VERIFICATION

Our front office staff will determine insurance eligibility in advance of the patient's appointment. Insurance must be active for a patient to receive medical benefits. If no active coverage is found at the time of service, the patient will be considered private pay for that visit and the account holder is responsible for paying for the visit in full at the time of service. If proof of insurance coverage is determined after the date of service, a full refund will be processed. If a patient is covered by more than one insurance, it is the policy holder's responsibility to provide that information up front so that we can update patient records accordingly. Please keep in mind that our providers must be in-network with your insurance plan in order to avoid out-of-network additional costs. It is the responsibility of the policy holder to confirm that information.

Acknowledgment of Office Policies

I acknowledge receiving Pediatric Center at Renaissance's Office Policies. By acknowledging this I am accepting the policies as stated. I have read this form and I have had an opportunity to ask questions about it.

Parent/Guardian's Signature: ____

Patient's Name: ______________________________Date of birth (MM/DD/YYYY):___________________

Patient's Name: ______________________________Date of birth (MM/DD/YYYY):___________________

Patient's Name: ______________________________Date of birth (MM/DD/YYYY):___________________

FAMILY REGISTRATION FORM

Today's Date___/___/___

CHILD'S NAME (First, Middle, Last)	SEX (circle)	Date Of Birth	Ethnicity	Race	PCP
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ Juan Saenz ☐ Jennifer Saenz
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ Juan Saenz ☐ Jennifer Saenz
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ Juan Saenz ☐ Jennifer Saenz
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ Juan Saenz ☐ Jennifer Saenz

	PARENT/GUARDIAN #1	PARENT/GUARDIAN #2
Name:		
Relationship to patient(s):		
Date of birth:		
Mailing address:		
Primary phone:		
Secondary phone:		
Alt phone:		
Email address:		
Employer:		
Occupation:		
Preferred language:		

Parents are: ☐Single ☐Married ☐Separated ☐ Divorced (if divorced, who is the custodial parent? ☐#1 or ☐#2)

PATIENT CONFIDENTIAL COMMUNICATION PREFERENCE

Consent to Contact for Appointment Reminders and Other Communications

Patients in our practice may be contacted via email, phone and/or text messaging for general information/communications related to Pediatric Center at Renaissance, including:

- Appointment reminders
- Well child check-up appointments
- Situational/seasonal service suggestions (ex. flu shot clinics, asthma follow up, weight checks)

We will send communications via your preferred method of contact. You may revoke this consent at any time.

How would you wish to be contacted? (choose only one)
☐Mailing Address ☐Cell Phone ☐Work Phone ☐Home Phone ☐Email ☐Text Message

By signing below, I consent to receiving this type of communications from Pediatric Center at Renaissance. I understand that this request to receive emails, phone calls and/or text messages will apply to all future communication from the office regarding the information above.

____ ___________________________________

Parent/Guardian Signature Date

Cell phone number that I authorize to receive text messages*:

____

Phone number that I authorize to receive phone calls and voicemails:

____

Email address that I authorize to receive emails:

____

**Pediatric Center at Renaissance does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details). You may opt-out at anytime by sending STOP to 622-622. If you change phone carriers, you will need to opt back in by texting MCALLENSAENZ to 622-622.*

Is it okay to leave a voicemail regarding labs/medical information: ☐ Yes ☐ No

If yes, who is the preferred contact? ______________________ Preferred Phone #: ________________

MEDICAL INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance company:		
Carrier phone #:		
Policy #:		
Group #:		
Policy holder:		
Date of birth:		
Relation to patient:		

Do you have Medicaid insurance? ☐ No ☐ Yes If yes, please complete the table below for any child on a Medicaid plan.

CHILD'S NAME	MEDICAID PLAN	CERTIFICATE NUMBER

Insurance Responsibility Letter to Patients

Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you as the patient, to please check with your insurance company prior to any procedures and / or tests. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred here. If your carrier requests other information from you such as evidence of other insurance, they will not provide reimbursement of your claim until you provide the requested information. If you fail to do so, you will be billed for any outstanding charges. Please remember, your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

It is your responsibility to update our clinic when there is a change in your insurance plan. If we cannot find active coverage at the time of service, you will be treated as private pay. Payment is expected up front; however, budget plans are available in the event the balance cannot be paid in full.

CONSENT TO TREAT

Labs/Procedures/Immunizations/ Vaccines/Injectables

I voluntarily authorize and consent to the medical care, treatment, diagnostic tests, transfers, and referrals that the providers at Pediatric Center at Renaissance and their designated associates or assistants believe are necessary. I also consent to the taking of photographs related to the care and treatment of the patient and understand that such photographs may be made part of the medical record. l understand that by signing this form, I am giving permission to the doctors, physician assistants, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

List of Name of Patient(s):

____

____

At times you may not be able to bring your child in for treatment. Please specify any other adult 18 years or older that is able to act on your behalf in authorizing medical treatment: (i.e., grandparent, aunt, uncle, etc.). Please check next to the person that you want as the emergency contact in case we are not able to get a hold of either parent/guardian.

Name	Address	Phone #	Relationship

Permission to Treat Patients 16 Through 18 Years Old without Parent/Legal Guardian

Pediatric Center at Renaissance must receive permission, from a child's parent or legal guardian, prior to providing treatment(s) for preventative care, injury, or illness that is non-life threatening. This form provides the legal permission to treat your adolescent child without an adult present.

Patient's Name: ____ Patient's DOB: _____________

This form is specific to patients who are at least 16, but not 18 years old. In addition to giving permission to Pediatric Center at Renaissance to assess and treat the aforementioned minor without an adult present, I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

This authorization is valid until otherwise revoked or until date listed ___________________________.

Please note: insurance card(s) and co-pay amounts (if applicable) must be presented at each visit.

Authorized by: ____ Date: ______________________

(Parent/legal guardian signature)

PATIENT PORTAL REGISTRATION - MY KID'S CHART

You can access your child's medical records on your smartphone, computer, laptop, and/or tablet through Pediatric Center at Renaissance's secure patient portal at https://saenz.pcc.com/portal. You will need an email address in order to register for the portal.

Parent Email: ___________________________________

Parent Name: ___________________________________

Parent Phone: ___________________________________

Patients requested for portal access:

First Name	Last Name	Birthdate

Once your account is created, you will receive an email with a temporary password that is active for 1 week. You will need to sign into the portal in order to complete your account set-up. Be sure to verify that your name appears correctly and that the names of the patients you have requested access to appear on the screen.

Please be aware that when a patient turns 18, the record for that patient automatically becomes private. After the patient is 18, he or she may grant permission to a parent or guardian to have access to the chart by completing and signing a release form. This permission can be revoked at any time at the request of the patient or at the discretion of the physician.

Please note that messages sent through the portal will only be checked during normal business hours Monday-Friday 8am-5pm.

Signature____________________________________ Date_______________

I hereby avow that I am the authorized legal guardian for the aforementioned patients and give permission for Pediatric Center at Renaissance to enroll them in the patient portal.

Please allow 48 hours to receive your email from our office containing your temporary password to access the portal.

FINANCIAL POLICY

Pediatric Center at Renaissance is committed to providing optimal care to our patients and their families and feel that this goal is best achieved if everyone is aware of our financial policy. Changes in the health insurance industry have made the cost of healthcare challenging for both patients and healthcare providers. We've developed this policy to serve as a clear understanding of our billing practices and to help with any questions about your financial obligations. Our Billing Specialists at PedsOne are happy to answer any additional questions you may have. Our billing account manager Donna Circe can be contacted at 866.371.6118, ext 118.

Payment Procedures and Payment Options

Full payment is expected at the time of service, regardless of who brings the child to the office. This includes applicable deductibles and co-payments. We accept cash, personal checks and all major credit cards. A receipt will be provided to you for all payment transactions. As an added convenience, payment can be made for balances through our patient portal, MyKids Chart. Contractual obligations with your insurance plan require us to collect your co-payment in full at the time of service. We cannot reduce or waive co-payments, deductibles or other cost-sharing balances that are due following your insurance carrier's adjudication of your claim. The accompanying parent or other adult is responsible for full payment due at the time of service and for providing the proper insurance identification.

Insurance Coverage

We participate with several insurance plans. As insurance plan benefits vary, it is the policyholder/parent's responsibility to know the specific benefits of their plan. We will bill the insurance companies we participate with. If your carrier requests other information from you such as evidence of other insurance, they will not provide reimbursement of your claim until you provide the requested information. If you fail to do so, you will be billed for any outstanding charges.

If you have failed to provide the correct insurance information, you must notify us immediately and we will attempt to submit a claim with the correct insurance company. However, if the claim is denied for any reason, or if it is past the timely filing limit per your insurance, you will be responsible for payment of all charges.

While many insurances cover preventative care in full, additional services may be rendered at a well child check up that may result in additional charges. Many insurances will not cover a well child check up and sick visit on the same day. If a problem or illness needs addressed during a well child check up, the check up may need to be rescheduled and/or there may be additional co-pays, co-insurances, or deductibles required by your insurance plan.

Non-covered Services

We will always provide your child with, what we consider the best and most up-to-date medical care. Some insurance plans limit coverage of procedures and services in order to control their costs. As a result, certain services we may provide for your child may not be reimbursed by your plan. Although we will submit a claim with your insurance, please be aware that some, and perhaps all, of the services

provided may be “noncovered” services or may not be considered reasonable and necessary by your insurance company. Except as provided by your insurance contract or by state law, you will be responsible for all charges not covered by your policy.

Secondary Insurance

If your child is covered under two insurance policies with which we are in-network with, we will submit claims to both plans. Once the primary insurance payer processes the claim, additional balances due may be submitted to the secondary insurance plan. There are guidelines that govern which plan is deemed primary and secondary. Please consult with your insurance plans for determination of such.

Newborn Enrollment

It is essential that you contact your insurance plan or the policy holder’s Human Resources department to enroll your newborn on your policy. We recommend doing this within the first few days of your baby being born as it often takes a few weeks for the baby to show up on the plan as a covered member. Delaying enrollment may result in us having to bill you directly.

Laboratory Services

We will send your lab work to the in-network or preferred laboratory based on the insurance information you have provided to our office. We are not liable for insurance billing and balances due from outside labs.

Referrals

Our providers will make referrals to specialists when clinically indicated. It is the responsibility of the policyholder to make sure the specialist is in or out of network with their insurance plan. Pediatric Center at Renaissance assumes no financial responsibility for any out of pocket expenses related to the care of the patient with the specialist. Any financial agreements related to account balances are between the policyholder and the specialist’s office.

Holiday Hours/Weekend Clinic

There may be an additional fee charged for visits occurring outside of routine office hours (holidays) and for visits to our Saturday clinic. We will bill this charge to the participating insurance plan. You may be responsible if your insurance carrier does not cover this charge. The Saturday charge for private pay patients is $15.

Medical Records

With the signed request from the patient, parent or legal guardian, we will provide you with a copy of your child’s medical record. There is a charge of $25 for the first 25 pages and $.50 for every page thereafter. Copies of medical records must be picked up and paid for by the patient’s guarantor. Our medical records release form is available on our website atwww.mcallenpediatrics.com.

Returned Checks

There is a $25.00 fee for any check returned to us from your banking institution.

Additional Fees

- Billing records/itemized receipt - $5.00
- New vaccine cards - $5.00
- Provider's signature for sports physical or daycare forms - $15.00
- Letter of medical necessity - $25.00

Past Due Accounts

Our office strives to assist you in every way possible to keep your account in good standing. When there is a balance due on an account, you will receive a billing statement from our Billing Specialists, PedsOne and payment is due in full within 30 days of receipt. While payment is always expected in full, please be assured, if there are financial circumstances that preclude you from settling your account promptly, we will be glad to work with you. Please contact Donna Circe from PedsOne Billing at 866-371-6118 so arrangements can be made and noted on your account. If an account has gone over thirty (30) days with no payment activity, a friendly reminder letter will be sent at the next billing cycle. If an account has gone over sixty (60) days with no payment activity, a second letter will be sent at the next billing cycle indicating that regular monthly payments are required in order to keep the account current. If an account has gone over ninety (90) days without regular, consistent monthly payments, a third letter will be sent at the next billing cycle indicating that action must be taken to avoid further consequence. Once an account has gone past ninety (90) days without regular, consistent monthly payments or some indication of a budget plan, we may put a scheduling hold on your account until the balance is settled.

I have read the above policy and agree to its terms.

___________________________________	_____________________	___________________________
Signature of Responsible Bill Payer	Print Name	Relationship to Patient

CODE OF CONDUCT FOR PATIENTS AND PARENTS

In an effort to provide a safe and healthy environment for staff and patients, Pediatric Center at Renaissance expects patients, parents and accompanying family and friends to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are prohibited and may result in your immediate dismissal from the practice:

- Physical assault or inflicting bodily harm.
- Rude behaviors in person or through written, verbal or electronic communication, including but not limited to the following: Profanity, harassment, offensive or intimidating statements or gestures and threats of violence.
- Racial or cultural slurs or other derogatory remarks associated with race, language, or sexual orientation.
- Requests that would constitute illegal or unethical behavior on the part of Pediatric Center at Renaissance.

PLEASE BE COURTEOUS WITH THE USE OF CELL PHONES AND OTHER ELECTRONIC DEVICES. WE RESPECTFULLY ASK THAT YOU PUT YOUR DEVICES AWAY WHILE INTERACTING WITH THE STAFF, MEDICAL ASSISTANTS, AND PROVIDERS. VIDEO AND/OR SOUND RECORDING AND PHOTOGRAPHS ARE PROHIBITED UNLESS PERMISSION IS GRANTED.

WE ARE MAKING EVERY EFFORT TO REDUCE WAIT TIMES AND MAKE ALL OF OUR PATIENTS' VISITS AS STRESS FREE AND ENJOYABLE AS POSSIBLE. TO ASSIST IN THAT GOAL, WE HAVE THE FOLLOWING EXPECTATIONS:

- Please communicate all issues that you wish to discuss with the doctor at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all of their patients the time and quality of care they deserve.
- Please arrive on time for your appointment. When you arrive late you are taking up someone else's designated time. This has a domino effect on every subsequent visit and is a contributing factor in long wait times. Arriving more than 15 minutes late may result in having to reschedule your appointment. At that point, you have given up your scheduled appointment and will be seen as soon as a provider becomes available.
- Please provide 24 hours notice of cancellation whenever possible. We understand that last minute situations arise. Any notification, even late notice is appreciated. You are also given the option to cancel your appointment when contacted by our automated appointment reminder system.
- MISSING your appointment without prior notification will result in a no show on your account. After 3 MISSED appointments, you can only be seen on a walk in basis, you can no longer schedule an appointment with a provider. Failure to give prior notice if you are unable to keep your appointment prevents someone else from being scheduled.

- Please ensure a parent or responsible adult attends all appointments with patients that are 17 years and below. This is necessary to obtain legal consent for all procedures and treatments, including vaccinations. A form to designate a responsible party to give consent in a parent's absence must be completed. This form is available online or from front office staff.
- Please do not leave your children unattended. To ensure your children's safety, we ask that you not allow your children to climb on the furniture in the waiting area or play at the water fountain.
- If your child has any of the following symptoms at the time of service, we ask that you remain in the sick lobby: rash (of any kind), fever, cough (slight or mild), congestion, sore throat, ear infection, diarrhea, vomiting, and/or stomach ache. Our well lobby is intended for patients without any sick symptoms who are in clinic for check ups, immunizations, ear piercings, or any other non-contagious condition (are asymptomatic).
- Please take all wet or soiled diapers with you when you leave. Bags are available upon request.

NOTICE OF PRIVACY PRACTICES

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record or health and claims record.** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or summary of your health information, usually within 30 days or your request. We may charge a reasonable, cost-based of fee.
- **Ask us to correct your medical record or your health and claims record.** You can ask us to correct health information about you that you think is incorrect or incomplete. We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- **Request confidential communications.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.
- **You can ask us to limit what we share.** You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
- **Get a list of those with whom we have shared information.** You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **A copy of this notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take this action.
- **File a complaint if you feel your rights are violated.** You can complain if you feel we have violated your rights by contacting us and asking for the Privacy Officer. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health and safety.

In these cases we never share your information unless you give us written permission: Marketing purposes, sale of your information, or most sharing of psychotherapy notes. We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

- **Treat you.** To treat you, run our organization, and bill for services. We can use your health information and share it with other professionals who are treating you. Ex. A doctor treating you for an injury asks another doctor about your overall health condition. We can use and share your health information to run our practice, improve your care, and contact you when necessary. Ex. We use health information about you to manage your treatment and services.
- **Payment.** We can use and share your health information to bill and get payment from health plans or other entities. Ex. We give information about you to your health insurance plan so it will pay for your services.

We are allowed to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues.** We can share health information about your for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.
- **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests.** We can use or share health information about you: For workers compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized

by law, and for special government functions such as military, national security, and presidential protective services.

- **Respond to lawsuits and legal actions.** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We will not sell your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Please let us know in writing.