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millburn pediatrics

159 Millburn Ave.
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T (973) 912-0155
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www.millburnpediatrics.com

Summary of Notice of Privacy Practices

This Notice of Privacy Practices explains how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information
We will use and disclose your health information in order to treat you or assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process claims for services rendered to you by us or health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization
We will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization
In the following circumstances, we may disclose your health information without your written authorization:

1. To family members or close friends who are involved in your health care.
2. For certain limited research purposes.
3. For purposes of public health and safety.
4. To government agencies for purposes of their audits, investigations and other oversight activities.
5. To government authorities to prevent child abuse or domestic violence.
6. To the FDA to report product defects or incidents.
7. To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
8. When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights
As our patient, you have the following rights:

1. To have access to and/ or a copy of your health information.
2. To receive an accounting of certain disclosures we have made of your health information.
3. To request restrictions as to how your health information is used or disclosed.
4. To request that we communicate with your confidence.
5. To request that we amend/ correct your health information.

If you have a question, concern or complaint regarding our privacy practices, please request a Patient Complaint Form.

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Your Children *name(s) of all children*	**D.O.B.**	**M**	**F**	**Single/ Married**

Guarantor *Need SSN and DOB*

Name: _____ **D.O.B.:** _____

Address: _____

City, State, Zip: _____

Home Phone: _____ **Cell Phone:** _____

SSN: _____ **Work Phone:** _____

Occupation: _____ **Name of Employer:** _____

Partner *Need SSN and DOB*

Name: _____ **D.O.B.:** _____

Address: _____

City, State, Zip: _____

Home Phone: _____ **Cell Phone:** _____

SSN: _____ **Work Phone:** _____

Occupation: _____ **Name of Employer:** _____

Primary Insurance *All information must be filled in*

Insurance Company: _____

ID #: _____ **Group:** _____

Name of Insured: _____

D.O.B.: _____

Secondary Insurance *All information must be filled in*

Insurance Company: _____

ID #: _____ **Group:** _____

Name of Insured: _____

D.O.B.: _____

Is newborn child covered under mother's plan for first 30 days? If so:

Insurance Company: _____

ID #: _____ **Group:** _____

Authorization and Release

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/ or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents **not covered** by insurance.

Your Insurance Company may **not** reimburse the doctor for lab services done in the office. These include strep, lead, urine, mono, influenza, blood sugar, occult blood or specimen handling. They may have a contract that requires you to use Lab Corp or Quest Labs. If you would like the test done here, you will be charged.

I am also responsible for calling my Insurance Carrier and naming the doctor as my Primary Care Physician.

I have received the Millburn Pediatrics Privacy Standards Notice of Health Information Practices.

I understand that Millburn Pediatrics may disclose certain health information to a family member or caregiver because they are involved in my child's health care or payment relating to my health unless I specify their name in writing.

_____ _____

Signature of Parent/ Guardian **Date**

Please do not release any information regarding my child to:

_____