Keiki Korner Pediatrics
Leila Agullana, M.D

NOTICE OF THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by federal law to maintain the privacy of your Protected Health Information, and to provide you with notice of our legal duties and privacy practices regarding Protected Health Information. "Protected Health Information" is information that we keep in electronic, paper or other form, including demographic information collected from you and is created or received by us and relates to your past, present or future physical or mental health or condition, the provision of health care services to you, or the past, present, or future payment for the health care services we deliver to you , and that identifies you or which we reasonably believe can be used to identify you.

We are required by federal law to comply with the terms of this Notice. We reserve the right to make changes in our privacy practices regarding your Protected Health information. If we change our privacy practices, that change will apply to all protected Health Information that we maintain about you. However, before we change our privacy practices, we will provide you with written notice of any changes.

We may use and disclose your Protected Health Information for a variety of purposes. For example:

1. **Treatment:** We may disclose your Protected Health Information to another physician, such as a specialist to whom we refer you for medical treatment.

2. **Health Care Operations:** We may disclose your Protected Health Information to a health plan, managed care plan, individual practice association or to a management services organization that analyzes our competence. We may also provide your Protected Health Information to other health care providers, such as laboratories or ambulance companies, for purposes of their health care operations.

3. **Payment:** We may disclose your Protected Health Information to obtain payments. Disclosures for "payment" include: A) disclosure to a health plan to determine your eligibility or coverage under the plan; b) disclosures to health plan to obtain reimbursement for delivering medical services to you; c) disclosures to billing services or collection agencies; d) disclosures for utilization management and determination of whether the medical services we deliver to you are necessary or appropriate; or e) disclosures to determine whether the amount we charge you for medical services are justifiable.

4. **Reminders and Treatment Alternatives:** We may contact you to provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and services that may be of interest to you. This communication may be by telephone call and/or an appointment reminder postcard.

We may use or disclose your Protected Health Information in connection with treatment, payment or health care operations if we deliver health care products or services to you based on the orders of another health care provider and we report the diagnosis or results associated with health care services directly to another health care provider, w ho provides the products or reports to you. We may use or disclose you Protected Health Information that was created or received in emergency treatment situations, to carry out treatment, payment or health care operations if we attempt to obtain your consent as soon as reasonably practicable after the delivery of such treatment.

We may disclose your Protected Health Information without your authorization in the following circumstances: (a) for public health activities, such as controlling communicable diseases, reporting child abuse or neglect, to monitor or evaluate the quality, safety or effectiveness of FDA-related products or services; (b) for reporting victims of abuse neglect or domestic violence; (c) for health oversight activities, such as overseeing government benefit programs; (d) in response to judicial or administrative orders, such subpoenas; e) for law enforcement purposes, such as mandatory reporting of certain types of wounds, or identifying or locating individuals; (f) for certain research purposes; g) to avert a serious threat to the health or safety of an individual or the general public; and h) for selected governmental functions such as national security. In each of these situations we will keep records t hat explain our attempt to obtain your consent and the reason why consent was not obtained.

We are required to disclose your Protected Health Information: (a) to you upon your request; and (b) to the U.S. Department of Health and Human Services ("DHHS") when DHHS investigates to determine whether we are complying with federal law.

We may disclose your name, your location in our facility, your general condition and your religious affiliation, if any, in our facilities directory, unless you object verbally or in writing.

In all other circumstances we must obtain your authorization to use or disclose your Protected Health information. You will be required to sign an authorization form which permits us to use and disclose your Protected Health Information for certain purposes, and we may not condition the delivery of medical treatment to you on your providing the requested written authorization. You have the right to revoke your authorization in writing as long as we have not acted in reliance on the authorization.

You have the following rights with respect to your Protected Health Information:

1. The right to request restrictions on our use and disclosure of your Protected Health Information for treatment, payment or health care operations. If we agree to any restriction, then we cannot violate that restriction except in the case of emergency treatment. However, we are not required to agree to any restrictions.

2. The right to request in writing and to receive confidential communications of your Protected Health Information by alternative means (such as by mail or e-mail) or at alternative locations (such as your office or business workplace).

3. The right to request in writing access to our office to inspect and copy your Protected Health Information. Except in cases where the Protected Health Information is not maintained or accessible onsite, we will act on a request for access no later than thirty (31) days after we receive your request.

4. The right to request in writing that we amend your Protected Health Information. Your request must contain the reasons to support the requested amendment. We will act upon your request within sixty (60) days after we receive your request.

5. The right to receive an accounting of all our disclosures of your Protected Health Information in the six years prior to the date of your request, except for disclosures: (a) to carry out treatment, payment and health care operations; (b) to you; (c) for our directory or to persons involved in your care; (d) for national security or intelligence purposes; (e) to correctional institutions or law enforcement officials; (f) pursuant to any written authorization that you give to us; or (g) that occurred prior to April 14, 2003.

6.The right to request and obtain from us a paper copy of this Notice.

If you believe t hat we have violated your privacy rights, then you may file a written complaint with Dr. Leila Agullana, who is our privacy officer. You may also file a complaint with the Office for civil rights of the DHHS. Your complaint must: (a) be in writing, either on paper or electronically; (b) name the Company and describe the acts or omissions you believed to be in violation of the Privacy Rules; (c) be filed within 180 days of when you knew or should have known that the act or omission complained for occurred, unless the time limit is waived by the DHHS for good cause shown. The complaint may be sent to: Office of Civil Rights, U.S. Department of health and Human Services, Region IX, 50 United Nations Plaza, Room 322, San Francisco, CA 94102. We will not retaliate against you for filing a complaint. If you wish to obtain additional information about any of the matters discussed in this notice you may contact Dr. Leila Agullana at 674-9600.

This Notice is effective as of April14, 2003

ACKNOWLEDGEMNT OF RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH

INFORMATION FOR
Keiki Korner Pediatrics
Leila Agullana, M.D

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice" that is posted in your office). I was informed that I may also obtain a printed copy of the Notice from your receptionist. I hereby acknowledge that I received from Keiki Korner Pediatrics, Leila Agullana M.D. a copy of the Notice.

Print Your Name:

Signed: _____

Date:

Patient Information

Patient Information

Last Name: **First Name:** **Middle Initial:**

Date of Birth: *(MM/DD/YY)* **SSN#:** **Gender:** ◯ MALE ◯ FEMALE

Street Address: **City:** **ZipCode:**

Mailing Address: *(if different from above)*

Home Phone Number: **Alternate Phone Number:**

Parent's Information

Mother's Name: **Date of Birth:** *(MM/DD/YY)* **SSN#:**

Employer: **Work Phone:** **Extension:**

Employer Address:

Father's Name: **Date of Birth:** *(MM/DD/YY)* **SSN#:**

Employer: **Work Phone:** **Extension:**

Employer Address:

Nearest Friend or Relative - *NOT LIVING WITH YOU*

Name: **Phone:** **Relationship:**

Address:

Insurance Information

Primary Insurance: **Member #:** **Group #:**

Subscriber Name: **Subscriber Date of Birth:** **Effective Date:**

PCP: **Coverage Code:**

Secondary Insurance: **Member #:** **Group #:**

Subscriber Name: **Subscriber Date of Birth:** **Effective Date:**

PCP: **Coverage Code:**

Person Responsible for Bill - *IF OTHER THAN PATIENT OR PARENTS OR NAME OF SOCIAL WORKER*

Name: **Date of Birth:** **SSN#:** **Relationship To Parent:**

Address: **Home Phone:** **Work Phone:**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION & ASSIGNMENT OF INSRUANCE BENEFITS:

I authorize **KEIKI KORNER PEDIATRICS, LLC** or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period if such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier.

FINANCIAL AGREEMENT: I understand that I am financially responsible for all charges whether or not paid by the said insurance. These include deductible, co-payment, co-share and/or non-covered benefits. I also agree to pay a late payment fee of 1% a month on any unpaid balance over 90 days old together with reasonable attorney's fees and collection expenses should the account be referred to an attorney or collection agency. I agree to pay a $10 processing fee for each returned check.

I certify that the insurance information I have provided is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

Parent/Legal Guardian Signature: _____ Date:

KEIKI KORNER PEDIATRICS
PATIENT MEDICAL HISTORY

Patient Name: _____ **Birthday:** *(MM/DD/YY)* _____

Current Medications: Please list all medications your child is on currently

_____

Allergies: Please list all allergies

Medications: _____ Reaction: _____

Food: _____ Reaction: _____

Medical History: Check all boxes that apply

☐ Asthma	☐ Eczema	☐ Diabetes
☐ Frequent ear infections	☐ Heart defects	☐ Leukemia
☐ Learning disorders	☐ Eating disorders	☐ Downs syndrome
☐ Kidney Disease	☐ Bleeding problems	☐ Anemia
☐ Thyroid problems	☐ Seizures	☐ Developmental delays
☐ Speech disorder	☐ Cerebral palsy	☐ Cystic fibrosis
☐ Depression	☐ ADHD/ADD	☐ Hearing problems
☐ Anxiety	☐ Hepatitis	

Surgical History:

_____

Family History: Please check all boxes that apply to family members with...

☐ Asthma	☐ Eczema
☐ Diabetes	☐ Heart defects
☐ Learning disabilities	☐ Kidney disease
☐ Hearing loss	☐ High blood pressure
☐ High cholesterol	☐ Psychiatric disorder
☐ Tuberculosis	☐ Cancer
☐ Sudden death	☐ Hepatitis

Hospitalization:

_____

Reason:

_____

Social History:

Lives with _____ Smokers at home: ◯ Yes ◯ No Excessive alcohol or substance abuse: ◯ Yes ◯ No

Please list the name of your child's last physician: _____

KEIKI KORNER PEDIATRICS

1001 Kamokila Blvd. suite 197, Kapolei, HI 96707, #808-674-9600 fax: 808-674-9700

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I authorize * _____ to release the protected health information of:

*Patient Name: _____ Date of Birth: _____

Phone Number: _____

To: Keiki Korner Pediatrics, LLC
Kapolei Building, Campbell Square
1001 Kamokila Blvd. suite 197
Kapolei, HI 96707

* Information to be disclosed:	*Purposes for Use and/or disclosure (check as many as apply)
☐ All medical records ☐ Lab/Imaging Reports ☐ Clinical Notes ☐ X-ray Film(s) ☐ HIV test results specify ◯ Yes ◯ No ☐ Restrict to the following dates/conditions: _____ ☐ Restrict to information necessary to complete for provided ☐ Other (specify) _____	☐ At the request of the individual ☐ Legal Purposes ☐ Insurance ☐ Physician follow-up ☐ Other: _____

(initial) _____ **I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services. If do not specifically agree, this information will not be disclosed.**

*** Unless otherwise revoked, this authorization will expire on the following date or event:** _____

If a date or event is not specified, this authorization will expire one year from my date of signature below.

This authorization is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Leila Agullana M.D. at Keiki Korner Pediatrics, nor will it affect my eligibility for benefits.

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (e.g., a letter) addressed to Leila Agullana M.D. at Keiki Korner Pediatrics. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations.

I hereby release Leila Agullana M.D. at Keiki Korner Pediatrics, from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Leila Agullana M.D. at Keiki Korner Pediatrics, LLC. I certify that I have received a signed copy of this authorization.

* Requestor Signature: _____ * Print Name: _____

* Relationship: _____ * Date: _____

(Relationship to Patient) (complete only if Requestor is not patient)

* Items that MUST be completed for authorization to be valid.

KEIKI KORNER PEDIATRICS

1001 Kamokila Blvd. suite 197, Kapolei, HI 96707, #808-674-9600 fax: 808-674-9700

I authorize the following individual(s) to bring in _____

Patient's Name

for a medical evaluation and treatment and I give them the right to make medical decisions on my behalf.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

If an individual is not listed above, I understand that they may not be seen or evaluated here if I am not present.

Parent/Guardian: _____ Date: _____

Signature: _____