Oklahoma Kids Pediatrics
Sara Buntin, APRN, CPNP

HIPPA NOTICE OF PRIVACY PRACTICES

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

Authorization for Medical Treatment

Oklahoma Kids Pediatrics personnel are hereby authorized to administer any medical, diagnostic or therapeutic treatment as may be deemed necessary or advisable. I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent an emergency or extraordinary circumstances.

Disclosure of Medical Information

I understand that my medical records and billing information are made and retained by Oklahoma Kids Pediatrics and are accessible to office personnel. Oklahoma Kids Pediatrics may use and disclose medical information for operations, functions and to other physician or healthcare personnel involved in my continuum of care. Safeguards are in place to discourage improper access. Oklahoma Kids Pediatrics and its medical staff are authorized to disclose all or part of my medical records to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of Oklahoma Kids Pediatrics charges and to any healthcare provider who is or may become involved with my care. Oklahoma law requires that Oklahoma Kids Pediatrics advise you that the information authorized for use of disclosure may include information which may indicate the presence of a communicable or non-communicable disease, or related to mental health, or drug substance or alcohol abuse. We can share health information about you in response to a court or administrative order, or in response to a subpoena. We can share information with your family, close friends, or others involved in your care if given directions by yourself to do so. We are required by law to maintain the privacy and security of your protected health information. We must follow the duties and privacy practices described in this notice and give you a copy of it. By signing this agreement, you are attesting to the fact that you have received, read and consent to such disclosure.

Assignment of Insurance Benefits

I agree that physician benefits otherwise payable to the insured are to be made payable to the practitioner(s)/physician(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rule of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.

Pre-certification Policy

I understand that Oklahoma Kids Pediatrics will assist with insurance pre-certification requirements, but will not assume responsibility for pre-certification or any impact which it may have on insurance payment.

Financial Responsibility

As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by Oklahoma Kids Pediatrics.

Your Rights

You have several rights under HIPPA regarding your medical information. You have the right to request amendments be made to your records. You have the right to an accounting of disclosures. You have the right to

request confidential communications with the office. You have the right to a paper copy of this notice. You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you.

If you have further questions, please contact the office staff with your concerns. If you are concerned that your privacy rights are being violated, you may file a complaint directly with our office. You may also file directly with the Secretary of Department of Human Services by calling 1-877-696-6775. You will not be penalized for filing a complaint.

Certification

I hereby certify that I have read each of the above statements. I have had each item explained to me to my satisfaction, and have been offered a copy of Oklahoma Kids Notice of Privacy Practices. I further certify that I am the patient or duly authorized by the patient to accept the terms of this patient agreement.

Patient's Name:_____Patient's Date of Birth:_____

Signature of Patient or Legal Representative:_____

Relationship to Patient:_____ Date:_____