



Decerina Uy MD, P.C.

649 Route 25A Suite 3 Rocky Point, New York 11778
Tel. No. (631) 509-0671 Fax No. (631) 509-0672

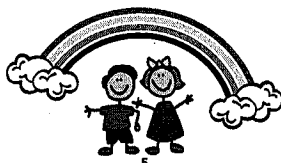
Welcome to Decerina Uy Pediatrics!!

This is our paperwork required for all new patients which contains:

- **Record Release** – Required for patient's chart – If more than one child, please write each child's name
- **Initial Patient History** – One for each child
- **Patient Registration Form** – One for each child
- **Consent Forms, Acknowledgement of Office Policies and Acknowledgement of Privacy Notice** – If more than one child, please write each child's name on each form, sign and date

If you have any questions, please feel free to ask the front desk.

If you are unable to print them, please arrive 15 minutes prior to your appointment time so you can complete the forms in the office.



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Record Release Authorization Form

Record release from:

Doctor/Clinic/Hospital

Address: _____
Street City Zip

Telephone No.: _____ Fax No.: _____

Patient Information:

Patient Name: _____ (M / F) Date of Birth: _____

Patient Name: _____ (M / F) Date of Birth: _____

Patient Name: _____ (M / F) Date of Birth: _____

Patient Name: _____ (M / F) Date of Birth: _____

Address:

Street City Zip

Home Phone: _____ Cell Phone: _____

I hereby authorize and request that you release my child(ren)'s wellcare, immunization record and growth charts only.

Decerina Uy M.D., P.C.

649 Route 25A, Suite 3

Rocky Point, NY 11778

Fax 631-509-0672

Signature of Guardian: _____ Date: _____

******PLEASE ONLY SEND LAST WELL VISIT, IMMUNIZATIONS & GROWTH CHART ONLY******



INITIAL HISTORY QUESTIONNAIRE

Patient Name: _____ Sex: ☐ Male ☐ Female DOB: ____/____/____
Form Completed By: _____ Relationship: _____ Date: _____

Family Information *Check all that apply.*

Are mother and father: ☐ married ☐ separated/divorced ☐ other?

If separated/divorced, what is the patient's custody status?

If one or both parents are not living in the home, how often does the child see that parent(s)? _____

Are there siblings living away from home? ☐ Yes ☐ No
If yes, give name, age, and where they live:

List all family members living in patient's home.

Name	Relation	DOB	Health Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History *Check all that apply. Specify affected family/household member & *note if it is maternal or paternal side. (M-Mother, F-Father, S-Sibling, *GM-Grandmother, *GF-Grandfather, *A-Aunt, *U-Uncle)*

☐ Problems similar to patient _____
☐ Birth defects _____
☐ Allergies / Asthma / Eczema _____
☐ Deafness / ENT problems _____
☐ Eye problems _____
☐ Mental illness / Mental retardation _____
☐ Learning problems / ADHD _____
☐ Abuse / Alcohol / Drug / Smoking _____
☐ Cancer _____

☐ Stroke / Heart attack / Sudden death _____
☐ Hypertension / High Cholesterol _____
☐ Thyroid problems / Diabetes / Obesity _____
☐ Seizures / Migraine headaches _____
☐ Anemia / Bleeding disorders _____
☐ Stomach / GI _____
☐ Infectious disease (Ex. TB) _____
☐ Other: _____

Pre Natal History *Check all that apply.*

Complications: ☐ Gestational Diabetes ☐ Preeclampsia ☐ Accident ☐ Surgery
Exposure to: ☐ Drugs / Prescription medications ☐ Alcohol ☐ Tobacco ☐ Illness / Infection

Birth History *Check all that apply.*

Was labor: ☐ Complicated ☐ Difficult ☐ Prolonged Explain: _____
Was baby born at: ☐ Term ☐ Early ☐ Late Baby was delivered by: ☐ Vaginal ☐ C-section ☐ Forceps
Apgar: _____ Birth weight: _____ Discharge weight: _____
Mom blood type: A / B / O / + / - Patient blood type: A / B / O / + / - Coombs: + / -

Post Natal History *Check all that apply.*

Feedings: ☐ Breast ☐ Formula Type: _____
Problems: ☐ Slow weight gain ☐ Bloody stools ☐ Jaundice ☐ Multiple formula changes ☐ Recurring diarrhea / vomiting
☐ Other: _____

Past Medical History/Review of systems *Check all that apply.*

Allergies: ☐ None ☐ Medicine _____ ☐ Environmental _____ ☐ Food _____

Immunizations: ☐ Up to date ☐ Not available to review ☐ Adverse reactions ☐ Refuse immunizations

Past Medical History/Review of systems (cont.) Check/circle all that apply & explain.

Does your child have or ever had:

- ☐ a serious medical problem? _____
- ☐ been hospitalized or had surgery? _____
- ☐ had a serious injury or accident? _____
- ☐ disabilities? _____
- ☐ chickenpox (Date: _____) or any other infectious disease? _____
- ☐ Pulmonary problems: allergies, asthma, bronchitis, respiratory infections _____
- ☐ ENT problems: repeated ear infections, tubes, difficulty with hearing _____
- ☐ Eye problems: problems with eyes or vision _____
- ☐ Cardiovascular problems: heart problems or a heart murmur _____
- ☐ Hematologic problems: anemia, bleeding problems, or blood transfusion _____
- ☐ GI problems: abdominal pain, constipation, recurrent vomiting, diarrhea, bloody stools _____
- ☐ GU problems: bladder or kidney infections, bed-wetting after 5 yrs _____
- ☐ Gynecological problems: _____ (if female, start of menstrual cycle: _____)
- ☐ Neurological problems: concussions, seizures _____
- ☐ Skin problems: acne, eczema, etc. _____
- ☐ Endocrinology problems: diabetes, thyroid, etc. _____
- ☐ Other: _____

Current Medications: ☐ Multivitamins ☐ Prescription Medications _____

Developmental History Check all that apply & explain.

Are you concerned about your child's...

- ☐ Physical or sexual development? _____
- ☐ Mental or emotional development? _____
- ☐ Behavioral development? (sleep / eating / toileting / social) _____
- ☐ Cognitive or learning development? _____

Is your child: ☐ in school ☐ home-schooled

If your child is in school:

- How is his/her behavior in school? _____
- Has he/she failed or repeated a grade in school? _____
- How is he/she doing in academic subjects? _____
- Is he/she in special or resources classes, or receiving tutoring? _____

Social History Check/Circle all that apply & explain.

- ☐ Smoke exposure _____ ☐ Gun exposure _____ ☐ Pets _____ ☐ Violence _____
- ☐ Sports _____ ☐ Media exposure (social media, TV, handheld/video games, computer) _____

Provider Comments



*** **PLEASE FILL IN ALL INFORMATION** ***

PATIENT INFORMATION FORM

revised Feb 2023

Patient:

Last Name:	First Name:	MI	Gender:	Date of Birth:
Address:		City:	State:	Zip:

Mother/Father/Guardian (Circle One)

Last Name:	First Name:	Date of Birth:	SS#
Address:	City:	State:	Zip:
Employer:	Occupation:	Home Phone:	Cell Phone:

Mother/Father/Guardian (Circle One)

Last Name:	First Name:	Date of Birth:	SS#
Address:	City:	State:	Zip:
Employer:	Occupation:	Home Phone:	Cell Phone:

Sibling:	Gender:	Date of Birth:
Sibling:	Gender:	Date of Birth:
Sibling:	Gender:	Date of Birth:
Sibling:	Gender:	Date of Birth:

Children Live With: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian		
Emergency Contact Person:	Relation:	Phone No:

INSURANCE INFORMATION

Insurance Carrier:	Policy ID:	Co-payment \$
Name of Insured:	Date of Birth:	Relationship:
Party Responsible for Payment of Medical Services: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian:		

PHARMACY INFORMATION

Local Pharmacy	Address	Phone
Mail Away Pharmacy	Address	Phone

Parent/Guardian/Patient's Signature _____ **Date:** _____
(Please circle one)

Print Name of Parent/Guardian/Patient _____ **Relationship:** _____
(Please print & circle one)

Patient Name: _____ **Patient Date of Birth:** _____

HIPAA AUTHORIZATION STATEMENT:
and
AUTHORIZATION TO ACCOMPANY MINOR:

Medical care or immunizations cannot be provided to a minor that is not accompanied by their parent or legal guardian unless permission is granted to another specified adult (over the age of 18). Please list the family members or other persons who may accompany your child so we can discuss your child's general medical condition and diagnoses (including treatment, health care operations and payment).

Please be made aware that any personal health information relating to the minor pertinent to the visit may be disclosed.

I (we) hereby authorize:

Name:	Phone:	Relation:
Name:	Phone:	Relation:
Name:	Phone:	Relation:
Name:	Phone:	Relation:

to accompany my/our child to the office of Decernia Uy M.D. PC in my absence. I (we) authorize Decerina Uy M.D and her personnel to deliver medical services to my child.

- Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

Address:	City:	State:	Zip:
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- Please print the telephone number where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than your home telephone number.

**** Please be aware that a cell phone is NOT a secure and private line.**

Telephone Number:

- Please indicate if confidential messages (i.e., appointment reminders) can be left on your telephone answering machine or voicemail.
☐ Yes ☐ No

Signature of Parent/Guardian/Patient: _____ **Date:** _____

Print Name of Parent/Guardian/Patient: _____ **Relation:** _____

AUTHORIZATION of TREATMENT, ASSIGNMENT of BENEFIT and CONSENT TO TREAT MINOR

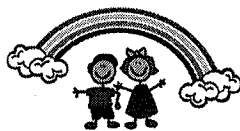
I authorize Decerina Uy MD PC FAAP and her personnel to treat my child. Being the parent /legal guardian of the above minor, I consent to the said procedures being performed whether I am present or not and this, my signature hereunder, shall be full and sufficient authority. Should the need arise to perform services not set out above, Decerina Uy MD aka Decerina Uy Pediatrics may obtain consent by telephone or by letter/fax granting such consent.

I hereby request and consent to diagnostic procedures, medical treatments, and immunizations deemed advisable by the professional staff of Decerina Uy Pediatrics. I acknowledge that I have read this consent form and understand its contents. I have had the opportunity to discuss it, and any questions have been answered to my complete satisfaction.

I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment made directly to Decerina Uy MD for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. I hereby authorize said assignee to release all information necessary to secure payment.

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian/Patient's Signature _____ **Relationship:** _____ **Date:** _____
(Please circle one)



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Vaccine Policy For All Patients

We at Decerina Uy Pediatrics, firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives. Since Dr. Uy is a sole practitioner, the office adheres to a vaccine schedule as mandated by the American Academy of Pediatrics. Because we are committed to protecting the health of your children through vaccination, **we require all of our patients to be vaccinated.**

If you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another healthcare provider who shares your views.

As medical professionals, we feel very strongly that vaccinating your child on schedule with currently available vaccines is absolutely the right thing to do to protect all children and young adults. Please feel free to discuss any questions or concerns you may have about vaccines with any one of us. Thank you for taking the time to read this policy.

Patient Name

Parent Signature

Date



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Cancellation and No-Show Policy

Decerina Uy Pediatrics understands that there are times when you must miss an appointment due to an emergency, unforeseen obligation for work or family or you may have simply forgotten. However, the result of a missed appointment affects other children within our practice who also need appointments.

We kindly request your help in providing the highest quality and most efficient care possible for all of our children. Therefore, please notify our office as soon as possible if you are unable to keep any scheduled appointments.

Please be made aware that any appointment that is not canceled within 24 hours prior to the scheduled appointment time will be subject to a \$25.00 fee per child. This fee is not billable to your insurance carrier and must be paid in full prior to scheduling any further well exams, vaccine appointments, or the release of school/camp forms.

Please understand that in order to keep fairness within our patient population, this fee will **not** be waived.

Please call our office at 631-509-0671 to cancel your appointment. If you are calling outside of regular business hours, we ask that you wait until the office re-opens to reschedule your appointment.

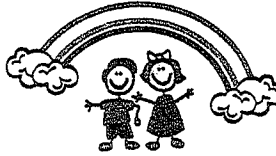
We greatly appreciate your cooperation in this matter. Thank you.

I have read the above policy and understand that I will pay Decerina Uy Pediatrics the sum of \$25.00 per child per missed appointment in the event that I fail to cancel or reschedule any appointment within 24 hours prior to my scheduled appointment time.

Signed: _____ Date: _____

Printed Name of Parent or Legal Representative: _____

Patient Name (s): _____



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Co-Payments

Co-payments are a contractual obligation with your insurance company. You are required to pay your co-payment, and we are required to collect your co-payment, at the time of each visit.

You have advised us that you are unable to make your co-payment today.

We ask that you pay your co-payment by the end of the next business day. For your convenience, payment can be made over the phone using a credit card. We accept Visa, MasterCard or Discover.

In the case of an unaccompanied minor, it will be the parent's responsibility to pay the co-payment within the next business day. The parent is aware the minor should come to the visit prepared to pay the co-payment.

Please understand that if your co-payment is not made by the end of the next business day, there will be an additional fee of \$10.00 posted to your account.

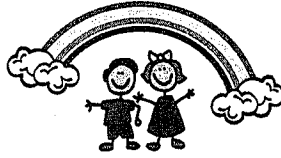
By signing below, you acknowledge and agree to the above terms.

Parent/Guarantor Signature

Date

Child's Name

Account Number



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Acknowledgement of Office Policies

I have read and have received a copy of the Office Policies for Decerina Uy Pediatrics.

Date: _____

Patient Name: _____

Parent Signature : _____

ACKNOWLEDGMENT

I, _____ acknowledge that I have been provided with a copy of Decerina Uy Pediatrics, P.C. privacy notice.

SIGN: _____

DATE: _____, 20__



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Office Policies

Parent Copy – Please print and keep for your records

ALL CHILDREN UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN FOR WELL EXAMINATIONS.

ALL OTHER VISITS REQUIRE **A WRITTEN AUTHORIZATION AND A PHOTO ID** TO BE BROUGHT IN BY THE CHILD FOR THE PERSON OTHER THAN THE PARENT OR LEGAL GUARDIAN THAT WILL BE ACCOMPANYING THE CHILD.

PLEASE UNDERSTAND THAT IF YOUR CHILD IS NOT PROPERLY ATTENDED, WE WILL NOT BE ABLE TO ADMINISTER TREATMENT AND THE VISIT WILL NEED TO BE RESCHEDULED.

Prescription Refills: Please allow 1 week processing of your prescription refill request. Exceptions will be considered for emergencies only. Please call the office directly, we will not honor requests submitted by the pharmacy.

Referrals: Your child will first need to be evaluated by Dr. Decerina Uy for the issue at hand before a referral will be issued by our office. Please keep in mind that obtaining a referral is the responsibility of the patient. Check with your insurance company if you need a referral to see a specialist. If so, you must first make your appointment with the specialist. Please contact our office with the following information in order for us to process your request:

Specialist Name/Address/Phone and Fax number

Specialist Insurance Carrier Provider Number

Diagnosis Code (reason for visit)

Appointment Date/Time

*** We require at least one week notification to our office in order to process your referral request. Please note that we can not accommodate any requests that are not given in advance unless it is considered an emergency.

Form Requests:

Address Confirmation/IRS requests: A \$25.00 service fee will be required in advance for any Address confirmation for tax/legal purposes.

Camp Forms: A \$15.00 service fee will be required in advance for any Camp/Daycare form request. Please allow 10 Business days preparation time. **If you would like your form expedited, please allow 48 hours. You will be expected to pay an additional \$25.00 service fee in advance for this request. You will be notified via phone when your form is ready for pick up. If you would like to have your school forms mailed to you, please supply us with a self addressed stamped envelope. Please be made aware that we do not fax forms to Camps/Daycare.

School/Daycare Forms: In order to complete any school forms, your child will need to have a well visit exam within the current school year. School forms may be brought in at the time of your child's well exam. As we have limited staff and do not charge a fee for this service unless an expedited request is made, please allow 10 Business Days preparation time for processing. You will be notified via phone when your form is ready for pick up. If you would like to have your school forms mailed to you, please supply us with a self addressed stamped envelope. Please be made aware that we do not fax forms to schools.

****If you would like your form expedited, please allow 48 hours. You will be expected to pay a \$25.00 service fee in advance for this request.**

Medical Records: If you would like your child's full medical chart copied, please allow 1 to 2 weeks processing time. A processing fee of \$0.75 per page for each chart requested will be due at the time of your request. Please note that we will be unable to begin processing your request unless the fee is paid in full. Cash or Credit Card will only be accepted. Unfortunately, we will not accept checks for this service. We will provide your new physician with your child's growth chart and vaccination record free of charge.

Financial Policies

We strive to make the billing aspect of your visits the least problematic for you. We appreciate your cooperation when dealing with insurance matters and ask that you use the following tips:

First, please make sure that our practice accepts your Insurance Plan. If you have an HMO/Managed Medicaid plan you must select Dr. Decerina Uy as your child's PCP (Primary Care Physician) prior to being seen for your visit.

Kindly inform our receptionist if you have had a change in your insurance plan, co-pay amount, or any other changes (such as custody, change of address, etc.)

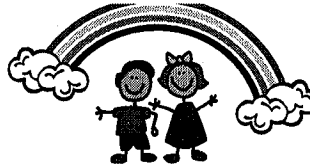
Co-payments: Please remember that your co-payments are a contractual obligation between you and your insurance carrier and is required at the time of service. A \$10.00 service fee will be applied to your account for any co-payments not made by the end of the next business day. Kindly be aware of any changes regarding your insurance plan's co-pay requirements. Some insurance companies charge an additional co-pay for certain office procedures, such as Hearing tests, Strep tests, Tympanograms, Urinalysis, Vision tests, etc.

Forms Fees: School, Day Care and Medication forms are free of charge for standard 10 business day processing time. Camp forms require a \$15.00 fee and IRS forms require \$25.00 fee to be paid in advance for standard 10 day processing time. Expedited requests: \$25.00 fee per form is to be paid in advance for 48 hours processing time. This charge is in addition to any other standard form fees.

Late Fees: Our invoice terms are "Due upon Receipt". If you disagree with the statement that you have received, please contact our office immediately to discuss the issue so that you may avoid any late fees. A \$10.00 Late Fee will be applied to your account for any past due amount.

Missed Appointments: We kindly ask that you notify our office at least 24 hours in advance if you can not keep your appointment. In the event that our office does not receive notification, your account will be charged a "Missed Appointment" fee in the amount of \$25.00 per child per missed appointment.

Returned Checks: There will be a service fee of \$25.00 placed on your account for any checks that are returned.



NOTICE OF PRIVACY PRACTICES

Effective January 1, 2016

Parent Copy – Please print and keep for your records

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU (OR A MINOR CHILD UNDER YOUR CARE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information, also known as your "PHI". In conducting our business, we will create records about you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in regard to your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location, and you may request a copy of our most current Notice at any time.

B. WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS:

1. Treatment means the provisions, coordination or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another.
2. Payment means the activities we undertake to obtain reimbursement for health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage.
3. Health care operations our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may also disclose PHI for review and learning purposes.

X. OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

- Appointment reminders
- Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
- Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member who is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for treatment of a cold. In this example, the babysitter may have access to this child's medical information to the extent necessary.
- We will allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, and similar forms of PHI, when we determine, in our professional judgment that it is in your best interest to make such a disclosure.
- Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

Δ. USE AND DISCLOSURE OF YOUR PHI IN SPECIAL CIRCUMSTANCES

The following categories describe special scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks Our practice may disclose your PHI to public health authorities who are authorized by law to collect information for the purpose of:
 - maintaining vital records, such as births and deaths
 - reporting child abuse or neglect
 - preventing or controlling disease, injury, or disability
 - notifying a person regarding potential exposure to a communicable disease
 - notifying a person regarding a potential risk for spreading or contracting a disease or condition
 - reporting reactions to drugs or problems with products or devices
 - notifying individuals if a product or device they may be using has been recalled
 - notifying appropriate government agency(ies) and authority(ies) regarding potential abuse or neglect
2. Health Oversight Activities We may disclose PHI to federal or state agencies that oversee our activities.
3. Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.
4. Law Enforcement We may release PHI if asked to do so by a law enforcement official.
5. Deceased Patients Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation If you are an organ donor, we may release PHI to organizations that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation and transplantation.
7. National Security and Intelligence Activities We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law or to authorized federal officials.
8. Serious Threats Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Research Our practice may use and disclose your PHI for research purposes in certain limited circumstances.
10. Worker's Compensation We may release PHI about you for programs that provide benefits for work related injuries or illness

E. YOUR RIGHTS REGARDING YOUR PHI

1. You have the right to request that you receive communications regarding your PHI in a certain manner or at a certain location. For example, you may request that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request
2. You have the right to request additional restrictions on the PHI that we may use for treatment, payment, and health care operations. You may also request additional restrictions on your disclosure of PHI to certain individuals involved in your care that otherwise are permitted by the Privacy Rule. *We are not required to agree to your request.* If we do agree to your request, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you in case of an emergency. To request restrictions, you must make your request in writing to our Privacy Officer.
3. You have the right to inspect and copy. You have the right to request the opportunity to inspect and receive a copy of PHI about you in certain records that we maintain. This includes your medical and billing records but does not include psychotherapy notes or information gathered or prepared for a civil, criminal, or administrative proceeding. We may deny your request to inspect and copy PHI only in limited circumstances. To inspect and copy PHI please contact our Privacy Officer. If you request a copy of PHI about you we may charge you a reasonable fee for copying, postage, labor, and supplies used in meeting your request.
4. You have the right to request that we amend PHI about you as long as such information is kept by or for our office. To make this type of request you must submit your request in writing to our Privacy Officer. You must also give us a reason for your request. We may deny your request in certain cases, including if it is not in writing or if you do not give us a reason for the request.
5. You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you for the six years prior to your request. An accounting of disclosures is a list of certain non-routine disclosures our practice has made of your PHI for reasons other than treatment, payment, or healthcare operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented. To request an accounting of disclosures of your PHI you must submit your request in writing to our Privacy Officer. Your request must state a specific time period

- for the accounting. The first accounting you request within a twelve month period will be free. For additional accountings, we may charge you for the costs of providing the list.
6. You have the right to receive a notification in the event that there is a breach of your unsecured PHI, which requires notification under the Privacy Rule.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Decerina Uy Pediatrics Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

CONTACT

You may contact our Privacy Officer at the following address and phone number:

Privacy Officer
Danielle Anderson
Decerina Uy Pediatrics
649 Route 25A Suite 3
Rocky Point, NY 11778
(631) 509-0671

This notice is effective as of January 1, 2016