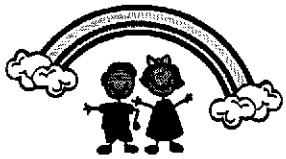


Decerina Uy MD, P.C.
649 Route 25A Suite 3 Rocky Point, New York 11778
Tel. No. (631) 509-0671 Fax No. (631) 509-0672

Record Release Authorization Form

Record release from:

_____
Doctor/Clinic/Hospital

Address:

_____
Street City Zip

Telephone No.: _____ Fax No.:_____

Patient Information:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Address:

_____
Street City Zip

Home Phone:_____ Work Phone: _____

I hereby authorize and request that you release my child(ren)'s **last wellcare, most recent bloodwork and lead test results, immunization record and any consultation letters regarding a chronic health issue** that you have in your possession to:

Decerina Uy M.D., P.C.
649 Route 25A
Suite 3
Rocky Point, NY 11778

Signature of Guardian:_____ Date:_____

******* PLEASE DO NOT SEND THE ENTIRE CHART - THANK YOU *******

DECERINA UY PEDIATRICS - PATIENT REGISTRATION FORM

CHILD / CHILDREN INFORMATION – Any additional children can be written on the reverse side

Child's Name _____ DOB: _____ [ ] Male [ ] Female

Child's Name _____ DOB: _____ [ ] Male [ ] Female

Child's Name _____ DOB: _____ [ ] Male [ ] Female

Child's Name _____ DOB: _____ [ ] Male [ ] Female

PARENT / LEGAL GUARDIAN #1 – Living in the same household as the patient(s) & Primary Contact

Name: _____ DOB: _____ Relationship to Patient _____

Address: _____ City/State/Zip _____

Primary Phone # _____ [ ] Cell [ ] Home [ ] Other _____

Alt. Phone # _____ [ ] Cell [ ] Home [ ] Other _____

Occupation; _____ Employer: _____

Email: _____ [ ] I agree to receive email notifications

PARENT / LEGAL GUARDIAN #2

Name: _____ DOB: _____ Relationship to Patient _____

Address: _____ City/State/Zip _____

Primary Phone # _____ [ ] Cell [ ] Home [ ] Other _____

Alt. Phone # _____ [ ] Cell [ ] Home [ ] Other _____

Occupation; _____ Employer: _____

Email: _____ [ ] I agree to receive email notifications

PARENT / LEGAL GUARDIAN (please circle one) **Married Living Together Single Widowed Separated Divorce**

If Divorced or Separated, who is the Custodial Parent? _____

If the Legal Guardian, what is the relationship to the patient (s)? _____

** **PLEASE NOTE: LEGAL DOCUMENTATION WILL BE REQUIRED FOR ANY CUSTODY ARRANGEMENTS** **

INSURANCE INFORMATION – **Billing Address & Responsible Party for Billing Issues [ ] Parent #1 [ ] Parent #2**

Plan Name: _____ ID# _____ Effective Date: _____

Subscriber Name: _____ Subscriber DOB: _____ Relationship: _____

PHARMACY INFORMATION

Primary Pharmacy _____ Address _____ Phone _____

Mail Away Pharmacy _____ Address _____ Phone _____

Decerina Uy Pediatrics will submit medical claims to the insurance company based on the information I have provided. I understand that I am responsible for updating insurance each time services are rendered. **If this insurance information is not correct, I understand that I will be responsible for any charges denied.** I further understand that Decerina Uy Pediatrics has privacy policies and office policies in place and I have been offered copies.

Parent/Guardian's Signature _____ Relationship:_____ Date:_____

HIPAA AUTHORIZATION STATEMENT and AUTHORIZATION TO ACCOMPANY MINOR

Newborn to Age 17

****** Patients age 18 and older must fill out their own individual HIPAA Form ******

Medical care or immunizations cannot be provided to a minor that is not accompanied by a parent or legal guardian unless permission is granted to another specified adult (18 years of age or older). Please list the fami members or other persons who may accompany your child so we can discuss your child's general medical condition and discuss diagnoses, treatment, healthcare concerns 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: _____ Relationship _____

Name: _____ Phone: _____ Relationship _____

Name: _____ Phone: _____ Relationship _____

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.

EMERGENCY CONTACT (Only in the event the Parent/Guardian cannot be contacted in the case of a dire emergency

Name: _____ Phone: _____ Relationship _____

Parent/Guardian/ Signature:_____ Relationship:_____ Date:_____

AUTHORIZATION of TREATMENT, ASSIGNMENT of BENEFITS 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(s), 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.

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 content

I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payme 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.

Parent/Guardian/ Signature:_____ Relationship:_____ Date:_____

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 of 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/Circe all that apply & explain.*

☐ Smoke exposure _____ ☐ Gun exposure _____ ☐ Pets _____ ☐ Violence _____

☐ Sports _____ ☐ Media exposure (social media, TV, handheld/video games, computer) _____

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

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 canceled or rescheduled 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 or 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): _____

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

Nondiscrimination Notice

Decerina Uy Pediatrics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Decerina Uy Pediatrics does not exclude people or treat them differently because of race, color, national orgin, age, disability, or sex.

Decerina Uy Pediatrics:

- Provides free aids and services to people with disabilities to communicate effectively with us such as:

- Qualified sign language interpreters via video

- Provides free language services to people whose primary language is not English, such as:

- Qualified Interpreters via telephone
- Information written in other languages

If you need these services, contact Cryacom Interpretation Services at #1-844-203-2025.

If you believe Decerina Uy Pediatrics has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age , disability, or sex, you can file a grievance in person, by mail, or fax with: Compliance Team at 649 Route 25A Suite 2 Rocky Point, NY 11778; Phone: 631-509-0671; Fax: 631-509-0672.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html or by mail, email, or phone at:
Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Indenpendence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
PH: 1-800-368-1019, 800-537-7697 (TDD)
Email: OCRComplaint.gov

649 Route 25A Suite 3 Rocky Point, NY 11778
PH: 631-509-0671 Fax: 631-509-0672

Informed Consent for Telemedicine Services

Patient: _____ Date of Birth: _____

Introduction:
Telemedicine involves the use of electronic communications; such live two-way audio/video and telephone conferences, to enable the health care provider to deliver medical services when an individual is located at a different site than the health care provider.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measure to safeguard the date to ensure it's integrity against intentional and unintentional corruption.

Patient Consent to the Use of Telemedicine

1. My health care provider has explained to me how the telehealth/telemedicine technology will be used to connect me with a provider. Telehealth/telemedicine appointments may be conducted by videoconferencing, video images, still (high quality photo) images, or by telephone conference. I understand that this appointment will not be the same as direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that the health care provider may use devices such as stethoscope, otoscope or other peripheral devices to assist in the examination.
2. I understand there will be potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time.
3. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine (ie. HIPAA).
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may be present during the appointment other than my health care provider in order to operate the equipment. The above mentioned people will all maintain confidentiality of the information obtained at all times and will comply with HIPAA. I further understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my/my child's medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination room; and/or (3) terminate the telehealth appointment at any time.

649 Route 25A Suite 3 Rocky Point, NY 11778
PH: 631-509-0671 Fax: 631-509-0672

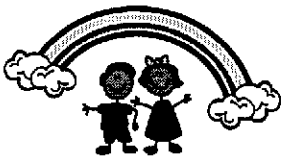
Informed Consent for Telemedicine Services (continued)

5. I have had the alternatives to telehealth/telemedicine appointment explained to me, an in choosing to participate in a telehealth/telemedicine appointment, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the primary care provider.
6. I understand that I will be responsible for any copayments, coinsurance, deductibles applied by my insurance carrier for the telemedicine/telemedicine visit. I understand that my insurance carrier will have access to my/my child's medical records for quality review/audit.
7. I understand that I have the right to withhold or withdraw my consent to the use of telehealth/telemedicine in the course of my/my child's care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Decerina Uy Pediatrics . As long as this consent is in force (has not been revoked), Dr. Decerina Uy may provide healthcare services to me/my child via telemedicine without the need for me to sign another consent form.
8. I have read this document carefully, and understand the risks and benefits of the telehealth/telemedicine appointment and have had my questions regarding the visit explained to me and I hereby consent to participate in a telehealth/telemedicine appointment under the terms described herein.

I hereby authorize Dr. Decerina Uy to use telehealth/telemedicine in the course of my diagnosis and treatment.

Patient/Parent/Guardian Signature:_____ Date:_____

Relationship to patient:_____



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

GUARANTEE AGREEMENT

I. Individual's Responsibility for Non-Covered Services

In consideration of services rendered be Decerina Uy MD, P.C. to the undersigned patient, the undersigned promise(s) to pay Decerina Uy MD, P.C. any co-payment, deductible, coinsurance or other charges to be paid by my health insurance coverage. In addition, I promise to pay for services that are not covered by my health insurance plan provided I am informed of same prior to the rendering of said services.

I understand that I am responsible for your fees for services. I understand that your invoice terms are due upon receipt and that a service charge of $10.00 will be added to my account for any past due balance. A returned check fee of $25.00 will be added to my account for any returned checks. A service charge of $25.00 will be added to my account for any missed appointments. A service charge of $10.00 will be added to my account if I fail to pay my co-payment at the time of service.

I agree to reimburse Decerina Uy MD, P.C., the fees of any collection agency, which is based upon a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonably attorney's fees, we incur in such collection efforts.

II. Assignment of Benefit Proceeds

I hereby assign to Decerina Uy MD, P.C. all moneys and/or benefits to which I am entitled from my insurer/HMO/third party payer, government agencies, or those who are financially liable for my medical care.

III. Authorization to Release Records

I hereby authorize Decerina Uy MD, P.C. to release to my insurer/HMO/third party payer, government agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for pre-certification/prior approval purposes.

It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services, other than those services covered by Paragraph I above, which are not Medically Necessary or improperly billed.

_____ Date: _____
Signature of Patient or Authorized Representative

Account # _____

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

Office Policy Notice: Insurance Responsibility

Important Information Regarding Secondary Insurance

Office Policy on Insurance

Our practice does not accept secondary insurance plans. Only your primary insurance will be billed for services rendered at our office.

Patient Responsibility for Insurance Information

It is the patient's responsibility to provide accurate and up-to-date insurance information prior to receiving any services. If incorrect or outdated insurance details are given and a claim is denied as a result, the patient will be held financially responsible for all charges incurred.

- No secondary insurance will be billed by our office.
- Patients must provide correct insurance information before treatment.
- If incorrect insurance information is submitted, the patient assumes full responsibility for payment of all balances.

We encourage you to double-check your insurance details and notify our staff immediately of any changes. Your cooperation helps us process your claims efficiently and avoids unnecessary billing issues.
If you have questions regarding this policy or your coverage, please contact our office for assistance.

Thank you for your understanding and attention to this important matter.

_____ _____
Signature Date

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

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 ACCOMPANING 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.)

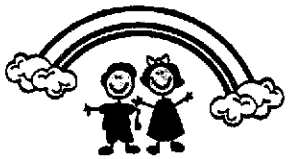
Co-payments: Please remember that your co-payments are a contractual obligation between you and your insurance carrier and is required at the time of service. A $10.00 service fee will be applied to your account for any co-payments not made by the end of the next business day. Kindly be aware of any 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.



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

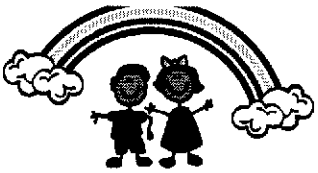
Acknowledgement of Office Policies

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

Date: _____

Patient Name(s): _____

Parent Signature : _____



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 IIHI 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 IIHI 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 IIHI for reasons other than treatment, payment, or healthcare operations. Use of your IIHI 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

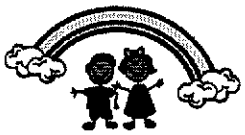
If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Decerina Uy Pediatrics Privacy Officer. All complaints must be submitted in writing. You will not be penalized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

CONTACT

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

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

This notice is effective as of June 1, 2024



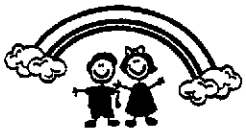
Decerina Uy MD, P.C.
649 Route 25A Suite 3 Rocky Point, New York 11778
Tel. No. (631) 509-0671 Fax No. (631) 509-0672

ACKNOWLEDGMENT OF PRIVACY NOTICE

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

SIGN: _____

DATE: _____, 20__



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

Vaccine Policy For All Patients

We at Decerina Uy Pediatrics, firmly believe in the effectiveness of vaccines to prevent serious ilness 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 Pedicatics. Because we are committed to protecting the health of your children through vaccinations, **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 absulutely 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 _____