ADVANCED PEDIATRIC CARDIOLOGY, PLLC
SHABIB A. ALHADHERI, M.D.

1478 W. Elliot Rd Ste 102 Gilbert, AZ 85233 T: 480-855-1339 F: 480-857-0313 Web: www.apcardio.com

NOTICE OF PRIVACY POLICIES

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

Introduction:

Here at **Advanced Pediatric Cardiology, PLLC**, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This is required by the Privacy Regulations created as a result of the Health Insurance Probability and Accountability Act (**HIPAA**). This notice applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information:

Each time you visit **Advanced Pediatric Cardiology, PLLC**, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Use and disclosure of your health information in certain special circumstances:

- To public health authorities and health oversight agencies that are authorized by law to collect information.
- Lawsuits and similar proceedings in response to a court or administrative order.
- If required by a law enforcement official.
- When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
- If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and national security activities authorized by law.
- To correctional institutions or a law enforcement official.
- For Workers Compensation and similar programs.
- To remind you of needed appointments in the future by way of mailed postcard or email.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of **Advanced Pediatric Cardiology, PLLC**, the information belongs to you.

You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

Advanced Pediatric Cardiology, PLLC is required to:
- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

FINANCIAL POLICY

Thank you for choosing **Advanced Pediatric Cardiology, PLLC** for your cardiac care. We are committed to providing you with the best care possible. Our goal is to provide and maintain a good physician-patient relationship. This Financial Policy helps our practice to provide quality care for our valued patients. In order to reduce potential misunderstandings, our office has clarified our Financial Policy. We require that you read our Policy carefully and agree to comply with it prior to beginning or continuing treatment.

INSURANCE:

We must emphasize that as a medical care provider; our relationship is with you, our patient, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from **THE DATE SERVICE IS RENDERED**. If there is a change with the insurance information, you must inform us immediately. Failure to do so may result in you owing the entire bill. The services generated during your visit are always **YOUR RESPONSIBILITY** to make sure they are paid for. Payment is due for your outstanding balance as well as co-pay before your visit. According to your insurance plan, you are responsible for any and all co-payments, deductibles and co-insurances. We reserve the right to deny your visit if you do not have payment. **Please check with your insurance to make sure we are "in network" with your plan.**

PAYMENT:

- For patients with ***private*** or ***no insurance***, full payment is required at the time of service.
- For patients with ***HMO plans***, co-payment is required at the time of service. The amount of ***co-payment*** varies with different plans. You are responsible for knowing the co-payment amount.
- For patients with ***PPO plan***, payment is required at the time of service until the new-year's deductible has been met. After that, we require co-payments or your liability to be paid at the time of service. •
- If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card to remain on file.
- For patients with ***AHCCCS:*** Please carefully read this review of our office policy on how we handle pending Medicaid applications:

  * We require that proof of application be presented to our office within 5 business days. Proof of application can be documented by official acknowledgment in writing from the Department of Social Services stating that your application has been received. If you have an upcoming appointment, we will need a copy of the letter noting your appointment date; we will then need the proof of application within the 5 working days from the date of appointment.

  * For accounting reasons, your medical charges will be listed as self-pay, but you will not be required to make payment on your account for the next 8 weeks. This is based on our understanding of the time it has been taking to receive a determination on your family's application. If the Department of Social Services indicates that it will need additional time, we will need that in writing.

  * If we have not received your Medicaid number for billing by 8 weeks or have not received an extension letter from the Department of Social Services, you will be required to set up a payment plan for services rendered. Extensions can only be given if you provide written proof of a continuing application.

* It is your responsibility to request that Medicaid go back to the date of your application to cover outstanding medical bills that your family may have incurred. We strongly suggest that you make that clear at the time of application because we can only bill Medicaid for services on or after the effective date of your coverage, once approved. Any medical charges incurred prior to the effective date of coverage will remain your responsibility.

* Our office cannot be responsible for speaking with social workers or for errors that may occur during your application process. This is a governmental process of benefit determination and approvals, between you and the Department of Social Services.

We are aware of how difficult and stressful this process can be for our families. Please contact our billing office if you have additional questions or concerns.

NON-COVERED SERVICES:

Please be aware that some – and perhaps all – of the services you receive may be uncovered or not considered reasonable or necessary by insurers. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. If your health plan determines that a service is “not covered” you will be responsible for the entire charge. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. You are due for payment of these services in full at the time of visit.

PROOF OF INSURANCE:

We must obtain a copy of your valid driver’s license/photo ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information before your visit, you may be responsible for the balance of a claim. It is the patient’s responsibility to provide us with current insurance information and to present an active insurance card at each visit.

CLAIMS SUBMISSION:

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

PAST DUE PAYMENTS:

Just as we make every effort to accommodate you when you need medical care, we expect that you will make every effort to pay your bill promptly. If you have a financial hardship or if you are unable to pay your bill in its entirety, please contact our billing office to discuss payment options. **We reserve the right to report delinquent balances to credit bureaus, assess a collection fee, and/or take other collection action**. Therefore, if your account is over 60 days past due, you will receive a statement stating that your balance will go to collections. Please be aware that if a balance remains unpaid, we will then refer your account to a collection agency unless other arrangements have been made. Any fees imposed in the collection of your account are the guarantor’s responsibility and may be recovered in a courtroom, along with any associated court and attorney’s fees. Accounts that are turned over to collections may result in dismissal from our practice.

FORMS OF PAYMENTS:

We accept Visa, MasterCard and Discover Cards, as well as cash and personal checks.
WE DO NOT ACCEPT AMERICAN EXPRESS.

UNINSURED/SELF PAY:

We are happy to offer a discount to our patients who are uninsured. Payment is expected at the time of service if you are uninsured. If you find you need a payment plan, please feel free to discuss this with our staff, preferably before services are rendered to make the appropriate arrangement. **PLEASE BE ADVISED THAT A CREDIT CARD ON FILE WILL BE REQUIRED FOR ALL PAYMENT PLANS.**

RETURNED CHECKS:

A $20 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

NO SHOW/CANCELLATION POLICY:

We understand that situations may arise in which you must cancel your appointment. Therefore, we request **24 hours' notice** for appointment cancellations in order to give another patient who is waiting for an appointment to be scheduled in that appointment slot.

Cancellations that are made with less than 24 hours' notice make it difficult to offer that slot to other patients. Office appointments which are cancelled with **less than 24 hours'** notification may be subject to a **$35.00 cancellation fee**.

No Call No-Show Patients are considered patients who do not show up for their appointment without a call to cancel an office appointment. Patients who appointments are considered No-Show **three (3) or more times in a 12-month period, will then only be eligible for a same day appointment IF available.** Patients may also be subject to the above mentioned **$35.00** no call no-show fee. **Please note that we reserve the right to dismiss the patient from our practice**. We will notify your primary care provider (PCP) and provide information for other cardiology practices.

The cancellation and No-Show fees are the sole responsibility of the patient and must be **paid in full before the patient's next appointment.** We understand that special, unavoidable circumstances may cause you to be unable to cancel within 24 hours. Fees in this instance may be waived but **only** with provider/office manager approval.

We appreciate your continued support and confidence in our practice as we strive to put our patient's well-being and safety first and we look forward to providing the best care possible for all our patients and families.

REFERRALS:

Our practice must receive a referral from your Primary Care Provider before your appointment if required by your insurance, please note it is **YOUR** responsibility to know your insurance and whether a referral is required.

Outside Prescriptions/Specialist Referrals

Due to liability issues and wanting to make sure that both our office and you as the patient are protected, our providers will not fill/refill **ANY** prescriptions that are not prescribed by our office as it is the patient/parent responsibility to follow up with their providers in a timely manner to ensure outside prescription refills. Anything that is outside of our scope of practice will need to be directed to the appropriate provider/specialty and our office would be more than happy to provide recommendations. If a referral to another specialty is required, the patient's PCP will need to initiate it and we can provide recommendations and provide any notes from our office that may be needed.

CHILDREN OF DIVORCED/SEPARATED PARENTS

A parent and/or legal guardian should be present for each visit for all children under 18. If a parent and/or legal guardian is not able to be present, we must have a signed letter giving permission for another adult with a valid photo ID to be present and consent for the care of the minor child. The parent and/or legal guardian who brings the minor child in for medical service will be required to pay for the bill. We do not bill third parties regardless of what the decree or custody documents indicate. Please make appropriate arrangements prior to the office visit. "Joint Custody" means that each parent has equal access to the medical record. Without a court order, we will not stop either parent from looking at their child's chart, discuss what each parent told the doctor when they were here last, and notify the other parent when a child is being treated, or call the other parent for consent prior to treatment. Please note, if we feel this is becoming an issue and compromising the care of the minor child and/or if at any time a family OR non-family member becomes abusive with the staff, we have the right to discharge the family from the care of the practice.

We thank you for understanding our policies. Our goal is to make your visit with us pleasant and professional.

For more information or to report a concern, you may contact our office directly at **480-855-1339** or email us at staff@apcardio.com

Thank you again for choosing Advanced Pediatric Cardiology for your heart care.

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Please fill out this form as completely and accurately as you can. All information will be treated confidentially.

FOLLOW UP VISIT INTAKE - PATIENT INFORMATION

Last Name: First Name: DOB:

Marital Status: ☐ Married ☐ Single ☐ N/A SSN: Gender: M ☐ F ☐ Age:

Address: City: State: Zip Code:

Email: Phone #:

Child's school: Grade:

Your Doctor: City: Phone:

Father's Name: Home phone: Work phone:

Mother's Name: Home phone: Work phone:

INSURANCE INFORMATION

Primary Insurance: ID/Policy #: Group #:

Subscriber Name: Relationship to Patient:

Secondary Insurance: ID/Policy #: Group #:

Subscriber Name: Relationship to Patient:

GUARANTOR INFORMATION (POLICY HOLDER)

Guarantor's Name: DOB: SSN:

Relationship to Patient: Home #: Cell #:

Address (if different from patient): Work #:

City: State: Zip Code: Employer:

PATIENT HEALTH HISTORY

Reason for your follow up visit:

CURRENT MEDICATIONS: (please list all prescription, non-prescription, vitamins and nutritional supplements)

Name	Dose	Times per day

YOUR PHARMACY (Name & Crossroads):

Phone/Fax:

DRUG ALLERGIES: ☐ **Yes** ☐ **No**

Name	Reaction

Other Allergies: (foods, adhesive tape, X-ray contrast dye, latex, etc.) ☐ Yes ☐ No

What/Reaction: _____

IMMUNIZATIONS: Up to date? ☐ Yes ☐ No ☐ Deferred/Refused

HOSPITALIZATIONS

Reason	Date	Hospital

ANY CHANGES SINCE LAST VISIT

☐ **Yes** ☐ **No**

Medical & Surgical History:

Family History:

Social History:

REVIEW OF SYSTEMS

Please check if patient has ever had any of the following:

GENERAL

- ☐ Feeling Down
- ☐ Unexplained Weight Loss
- ☐ Poor Exercise Tolerance
- ☐ Fever
- ☐ Failure to Thrive
- ☐ Chills
- ☐ Night Sweat
- ☐ Excessive Sweating
- ☐ Unexplained Weight Gain
- ☐ Weakness Fatigue/Lethargy

BEHAVIORAL/PSYCHOLOGICAL

- ☐ ADHD/ADD
- ☐ Decreased Energy
- ☐ Learning Disability
- ☐ Unusual Stress
- ☐ Depression
- ☐ Autism/Asperger's Syndrome
- ☐ Eating Disorder
- ☐ Anxiety
- ☐ Sleep Disturbances

BLOOD

- ☐ Anemia
- ☐ Petechiae/Purpura
- ☐ Easy Bruising
- ☐ Sickle Cell Disease
- ☐ Easy Bleeding Tendency

EYES

- ☐ Eye Irritation
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Eye Glasses/Corrective Lenses

GASTROINTESTINAL

- ☐ Poor Appetite
- ☐ Constipation
- ☐ Feeding Difficulties
- ☐ Diarrhea
- ☐ Black Stools
- ☐ Difficulty Swallowing
- ☐ Blood in Stool
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Ache/Abdominal Pain

DENTAL

- ☐ Bleeding Gums
- ☐ Dental Carries/Infection
- ☐ Last Dental Checkup Date:

CENTRAL NERVOUS SYSTEM

- ☐ Seizure
- ☐ Headache
- ☐ Abnormal Movements (Chorea)
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Stroke
- ☐ Dizziness
- ☐ Fainting
- ☐ Tremors
- ☐ Confusion
- ☐ Difficulty Walking
- ☐ Speech Difficulty

EAR/NOSE/THROAT

- ☐ Nasal Congestion
- ☐ Ear Pain
- ☐ Sinus Problems
- ☐ Frequent Strep throat
- ☐ Nosebleeds
- ☐ Tonsil Infections
- ☐ Hoarseness
- ☐ Speech Problems
- ☐ Swollen Lymph Nodes

ENDOCRINE

- ☐ Swollen neck glands
- ☐ Heat/Cold Intolerance
- ☐ Frequent Thirst

GENITO-URINARY

- ☐ Bed-wetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Pain/Burning with Urination

MUSCLE/JOINT/BONE

- ☐ Joint Pain & Swelling
- ☐ Muscle Pain/Weakness
- ☐ Scoliosis
- ☐ Lupus (SLE)/Sjögren's Syndrome
- ☐ Pectus Deformity
- ☐ Stiffness
- ☐ Muscle/Bone Disease
- ☐ Arthritis

CARDIOVASCULAR

- ☐ Syncope (Passing Out/Fainting/loss of consciousness)
- ☐ Cyanosis (Bluish discoloration of lips, hands or feet)
- ☐ Pain in legs with walking
- ☐ Trouble lying flat in bed
- ☐ Rapid Heart Beats
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Pallor
- ☐ Palpitations
- ☐ Easy Fatigability
- ☐ Shortness of breath with Exercise
- ☐ Difficulty Breathing/Shortness of Breath
- ☐ Fluttering feeling in the chest
- ☐ Irregular heart beat/Skipped beat
- ☐ Dizziness/Lightheadedness
- ☐ Diaphoresis (excessive perspiration/sweating)
- ☐ Swelling in Ankles/feet
- ☐ Skin Mottling
- ☐ Cold Hands or Feet
- ☐ Poor Circulation of Limbs

RESPIRATORY SYSTEM

- ☐ Wheezing/Asthma
- ☐ Persistent Cough
- ☐ Chest Tightness
- ☐ Coughing up Sputum
- ☐ Bronchitis/Bronchiolitis
- ☐ Frequent Pneumonia
- ☐ Difficulty Breathing
- ☐ Stridor
- ☐ Bronchopulmonary Dysplasia (BPD)
- ☐ Apnea (Stop breathing)
- ☐ Obstructive Sleep Apnea

SKIN

- ☐ Hair Loss
- ☐ Itching
- ☐ Rash
- ☐ Hives
- ☐ Scars
- ☐ Bruising
- ☐ Sores that won't heal
- ☐ Eczema
- ☐ Lesions
- ☐ Nail Changes

Other Symptoms:

healthcurrent

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?
The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?
Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?
Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.

2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.

3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

healthcurrent

Notificación de Prácticas de la Información de la Salud

Usted está recibiendo esta notificación porque su proveedor de salud médica participa en una organización no gubernamental, sin fines de lucro, de intercambio de información de salud (HIE - por sus siglas en inglés) llamada Health Current. No le costará nada y podrá ayudar a su médico, proveedores de salud médica y sus planes de salud mejor coordinar su atención médica compartiendo de una manera segura su información de salud. Esta notificación explica cómo funciona el HIE y le ayudará a entender sus derechos respecto al HIE conforme las leyes estatales y federales.

De qué manera Health Current le ayuda a obtener mejor cuidado?
En un sistema de registro basados en papel, su información médica se envía por correo o fax a su médico, pero a veces estos registros se pierden o no llegan a tiempo para su cita. Si usted permite que su información de salud sea compartida mediante el HIE, sus médicos podrán acceder a su información electrónicamente de una manera segura y oportuna.

Qué información de salud está disponible mediante Health Current?
El siguiente tipo de información de salud se podrá disponer:

- Registros hospitalarios
- Antecedentes medicos
- Medicamentos
- Allergias
- Resultados de laboratorio
- Informes radiologicos
- Información de las consultas clínicas y médicas
- Inscripción y elegibilidad en los planes de salud
- Otra información útil para su tratamiento

Quién podrá ver y cuándo se podrá compartir su información de salud mediante Health Current?

Las personas que participan en su atención médica tendrán acceso a su información médica. Esto podría incluir a sus médicos, enfermeras, otros proveedores de salud médica, planes de salud y cualquier organización o persona trabajando en nombre de sus proveedores de salud y plan de salud. Ellos podrán acceder a su información para tratamiento, coordinación del cuidado, administración de casos o cuidados, transición de la planificación del cuidado, pagos de su tratamiento, conducir evaluaciones de calidad y actividades de mejora, desarrollar normas y protocolos clínicos, ejercer actividades de seguridad de los pacientes, y servicios de salud poblacional. Los examinadores médicos, las autoridades de salud pública, organizaciones de adquisicion de organos, y otros podran acceder la información de salud para ciertos fines aprobados, tales como investigaciones de muerte, investigaciones de salud pública, y la donación y el trasplante de órganos, ojos y tejidos según sea permitido por las leyes vigentes.

Health Current también podrá usar su información de salud según lo requiere la ley como sea necesario para llevar a cabo los servicios para los proveedores de salud, planes de salud y otras personas participando con Health Current.

La Junta Directiva de Health Current podrá ampliar las razones por las que los proveedores de salud y otros podrán acceder a su información de salud en el futuro mientras lo permita la ley. Esa información está en el sitio web de Health Current healthcurrent.org/permitted-use.

Usted podra autorizar a otros acceder a su información de salud mediante la firma de un formulario de autorización. Ellos sólo podrán acceder a la información de salud descrita en la forma de autorización para los fines indicados en el formulario.

Recibe Health Current información de la salud conductual y si es así, ¿Quién la puede acceder?
Health Current recibe información de la salud conductual, incluyendo los registros médicos de tratamiento de abuso de sustancias. La ley federal otorga protección especial de confidencialidad a los registros médicos de tratamiento para algunos programas de abuso de sustancias. Health Current mantiene los registros médicos protegidos del tratamiento de abuso de sustancias aparte del resto de su información de salud. Health Current solamente compartirá los registros médicos protegidos de tratamiento de abuso de sustancias que reciba de estos programas en dos casos. Uno, el personal médico podrá acceder a esta información en caso de una emergencia médica. Dos, usted podrá firmar un formulario de consentimiento para dar a su proveedor de salud médica u otros acceso a esta información.

Cómo se protege su información de salud?
Las leyes federales y estatales, tales como HIPAA, protegen la confidencialidad de su información de salud. Se comparte la información mediante una transmisión segura. Health Current toma medidas de seguridad para evitar que alguien no autorizado tendrá acceso. Cada persona tiene un nombre de usuario y contraseña, y el sistema registra todos los accesos a su información.

Sus derechos respecto al Intercambio Seguro de Información Electrónica
Usted tiene el derecho a:

1. Pedir una copia de su información de salud que está disponible mediante Health Current. Para hacer esta petition, llene el Formulario de Solicitud de Información de Salud y entregarlo a su proveedor de salud médica.

2. Pedir corregir toda información en el HIE. Si alguna información en el HIE esta incorrecta, usted puede pedirle a su proveedor de salud médica que corrija la información.

3. Pedir una lista de las personas que han visto a su información mediante Health Current. Para hacer esta petición, llene el Formulario de Solicitud de Información de Salud y entregarlo a su proveedor de salud médica. Favor de notificar a su proveedor de salud médica si usted cree que alguien que no debería ha visto a su información.

Usted tiene derecho según el artículo 27, sección 2 por la Constitución de Arizona y los Estatutos Revisados de Arizona título 36, sección 3802 para prevenir que su información médica sea compartida electrónicamente mediante Health Current:

1. Salvo que se provea según leyes estatales o federales, usted puede optar por la exclusión de tener su información compartida mediante Health Current. Para excluir su participación, pídale a su proveedor de salud médica por el formulario para optar por la exclusión. Su información no estará disponible para compartir mediante Health Current dentro de los treinta (30) días de cuando Health Current reciba el formulario para optar por la exclusión de su proveedor médico.
   Precaución: Si usted se excluye, sus proveedores de salud médica no podrán acceder a su información de salud — incluso en una emergencia.

2. Si usted se excluye hoy, puede cambiar de opinión en cualquier momento completando el formulario para la inclusión y entregarlo a su proveedor de salud médica.

3. Si usted no hace nada hoy y permite que su información de salud sea compartida mediante Health Current, usted puede optar por la exclusión en el futuro.

SI USTED NO HACE NADA, SU INFORMACIÓN PUEDE SER COMPARTIDA DE MANERA SEGURA MEDIANTE HEALTH CURRENT.

Advanced Pediatric Cardiology, PLLC

Shabib A. Alhadheri, M.D.

1478 W Elliot Rd Ste 102 Gilbert, AZ 85233 T: 480.855.1339 F: 480.857.0313 Web: www.apcardio.com

Paperwork Requests & Guidelines Acknowledgment & Agreement

In light of the increasing number of requests for letters and paperwork, we feel it necessary to clearly state our guidelines and limitations. We appreciate your understanding that we are a small specialist office and there are things that fall outside of Dr. Alhadheri's scope of practice.

That being said, going forward, any paperwork or letters requested must have a formal request from the establishment you are requesting the letter for (i.e.: college, school, place of work). Only the information requested in the documentation will be included. Anything "extra" or that you may not agree with can be supported with the patient's records upon your request but we will not change or modify any letters or paperwork after completion. Current good standing with our office is required in order to request any paperwork; good standing meaning **no outstanding balances or recently missed appointments.** If your child has not been seen within the past 3 months, you will need to schedule an appointment and bring the paperwork you are requesting for review to the appointment in order for Dr. Alhadheri to review and approve.

Regarding new patients: Our office is more than happy to have Dr. Alhadheri review your chart and any specialist notes available in the effort to make a recommendation as to what he feels would benefit the patient however, we will not provide any letters or paperwork at the first visit.

Requests for Paperwork NOT accepted: Our office will no longer fill out anything related to disability or homebound/homeschooling unless under special circumstances which will be reviewed and approved by Dr. Alhadheri. **We will not accept or fill out anything related to service and or emotional support animals.**

Any paperwork requested requires at least 5 business days turn around time. **Paperwork will not be completed the same day.**

Effective 2/13/23 any paperwork requested will require a $25 fee for completion at the time of request.

We appreciate your continued support and confidence in our practice as we strive to put our patient's well-being and safety first and we look forward to providing the best care possible for all our patients and families.

Patient/Parent/Guardian **PRINTED NAME**: _____

Relationship: _____

Signature: _____

Date: _____

ADVANCED PEDIATRIC CARDIOLOGY, PLLC

SHABIB A. ALHADHERI, M.D.

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Authorization to Release Patient Health Care Information

Patient Name: _____

Social Security Number: _____ D.O.B.: _____

I hereby request and authorize the following release of information:

Information to be released by:	Information to be released to:
Name:_____ Address: _____ _____ Fax:_____	**Shabib A. Alhadheri, M.D.** **Advanced Pediatric Cardiology, PLLC** **1478 W. ELLIOT RD SUITE 102** **GILBERT, AZ 85233** **Phone: 480-855-1339** **Fax: 480-857-0313**

Purpose of Disclosure: ◯ Continuing Care ◯ Legal ◯ Insurance ◯ At patient request

Other (please explain): _____

GENERAL MEDICAL INFORMATION

Dates: From:_____ To: _____

- ☐ All Medical Records
- ☐ Lab Results
- ☐ Radiology Reports
- ☐ Other: (please specify)
- ☐ This request and authorization also applies to all information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

_____ _____

Signature of Patient/Parent, Guardian or Personal Representative Date

_____ _____

Please Print Name Relationship to Patient

FOLLOW UP PATIENT PACKET - AGREEMENT

Please review , initial and sign the form below.

_____ **VERIFICATION**

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to the patient's health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if the patient ever has a change in health.

_____ **FINANCIAL POLICY**

I have read and understood Advanced Pediatric Cardiology's financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined on the financial policy. I understand that I have online access to a copy of the financial policy at anytime.

_____ **ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to **Advanced Pediatric Cardiology, PLLC** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named entity may use my health care information and may disclose such information to the above name Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

_____ **NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT**

I have read and understood Advanced Pediatric Cardiology's notice of privacy practice, containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I have online access to a copy of the Notice of Privacy Practices at anytime.

_____

Signature of Patient/Parent, Guardian or Personal Representative **Date**

Please Print Name **Relationship to Patient**