Welcome to CCP Hamot Pediatrics West! We are honored that you have chosen us to care for your child. Given this privilege, we will work with you to provide the most compassionate pediatric care. As a means of introduction to our practice we have enclosed some materials so you know what to expect for your first and subsequent visits.

Please make note of the following **IMPORTANT REMINDERS** and **OFFICE POLICIES:**

- If you are unsure of your insurance coverage please call your insurance company prior to your appointment to verify that our office does participate in your insurance plan.
- If your insurance carrier requires that you select a Primary Care Physician (PCP) please do so and notify your insurance carrier by calling the member services number located on your insurance card. **If this is not done we will be unable to treat your child.**
- If you arrive more than 15 minutes late for an appointment you will be required to reschedule your visit.
- All sick appointments are made the day of your phone call only. No advance scheduling of sick visits is allowed.
- As a courtesy to our staff and physicians, we request that you **turn off all cellular devices** upon entering the office area.
- While we understand that there may be times you will not be able to make a previously scheduled appointment, we ask that you please give us at least a **24 hour notice prior to the appointment time. Failure to show for three appointments within a one year period may result in dismissal from the practice. Same day cancellations will result in a missed appointment.**
- Please call for prescription refills during regular office hours, **Monday through Friday 8:00 AM until 5:00 PM Requests for refills must be made seven days prior to the refill date. DO NOT** call or page the on-call pediatrician for prescription refills. **All refills will be handled during regular business hours only; no exceptions.**
- Please allow at least **48 hours** notice when requesting a referral.
- Our physicians are available after hours **FOR EMERGENCIES ONLY**. They are not to be called with routine questions, medication dosages or refills. Please call us with routine questions during normal office hours.
- ***We do not allow you to change physicians within our practice.***
- **We do not call in antibiotics without seeing the patient first.**

If you have any questions prior to your child's appointment please feel free to call our office at (814) 877-5424. We look forward to meeting you and partnering with you for the health of your child!

Sincerely,

The Physicians and Staff of CCP Hamot Pediatrics West

Patient Name_____ **D.O.B.**_____

Parent/Guardian Signature_____**Date:**_____

CHILDREN'S COMMUNITY PEDIATRICS
HAMOT PEDIATRICS WEST

PATIENT DEMOGRAPHICS

Name _____ **Birth Date** ____/____/_____
Last First M

Gender M F **Social Security Number:** _____ **Race:** _____

What language is spoken at home? _____ **Do you need an interpreter?** _____

Current Address _____
Street Apt City Zip

E-Mail Address: _____ **None** **Declined**

PARENT/GUARDIAN INFORMATION

Mother's/Guardian Name _____ **SS #:** _____ **Birth Date:** _____

Employer: _____ **Occupation:** _____ **Full/Part Time:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Father's /Guardian Name _____ **SS #:** _____ **Birth Date:** _____

Employer: _____ **Occupation:** _____ **Full/Part Time:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

EMERGENCY CONTACTS

Name _____ **Relationship to Patient:** _____

Home Phone: _____ **Mobile Phone:** _____

Name _____ **Relationship to Patient:** _____

Home Phone: _____ **Mobile Phone:** _____

INSURANCE INFORMATION

Primary Insurance: _____ **Effective Date:** _____

ID Number: _____ **Group Number:** _____

Primary Care Physician Co-Pay: _____ **Specialist Co-Pay:** _____

Subscriber Name: _____ **Date of Birth:** _____

Subscriber's Relationship to the Patient: _____

Secondary Insurance: _____ **Effective Date:** _____

ID Number: _____ **Group Number:** _____

Primary Care Physician Co-Pay: _____ **Specialist Co-Pay:** _____

Subscriber Name: _____ **Date of Birth:** _____

Subscriber's Relationship to the Patient: _____

CHILDREN'S COMMUNITY PEDIATRICS
HAMOT PEDIATRICS WEST

Name _____ **Birth Date** ____/___/_____ **Gender** M F
Last First M

Any special spiritual, religious, or cultural needs? ☐ yes ☐ no _____

Do you plan to immunize your children? (Reason) ☐ yes ☐ no _____

BIRTH HISTORY

☐ Term ☐ Premature by _____ weeks ☐ Late by _____ weeks

☐ Vaginal delivery ☐ Cesarean section **Birth Weight:** _____ **Birth Length:** _____

☐ Complications of pregnancy _____

_____

☐ Newborn/Delivery Complications _____

_____

☐ Special Needs? yes no _____

Was he/she discharged from the hospital at the same time as the mother? ☐ yes ☐ no

MEDICAL HISTORY

Any ALLERGIES to medications, x-ray dyes, foods, or other substances? ☐ yes ☐ no

_____

_____

_____

SURGERIES (Please Include Dates)

_____

_____

_____

_____

_____

MEDICATIONS (including prescription drugs, fluoride, vitamins and herbal products)

_____

_____

_____

_____

_____

DEVELOPMENTAL HISTORY

- ☐ Rolled over_____
- ☐ Sat unassisted _____
- ☐ Crawled _____
- ☐ Pulled to stand _____
- ☐ Stood alone _____
- ☐ Walked holding on _____
- ☐ Walked alone _____
- ☐ Spoke_____
- ☐ Potty trained_____
- ☐ Other_____

Any special equipment or assisted devices? ☐ yes ☐ no _____
Any specific developmental concerns? ☐ yes ☐ no _____

FAMILY MEDICAL HISTORY (Please Check All That Apply)

- ☐ Allergies_____
- ☐ Anemia
- ☐ Asthma
- ☐ Attention problems
- ☐ Bed wetting
- ☐ Behavior problems
- ☐ Bleeding disorder
- ☐ Blood disorder (other)
- ☐ Cancer_____
- ☐ Chronic lung disease (BPD)
- ☐ Congenital disorders
- ☐ Colic
- ☐ Constipation
- ☐ Cystic fibrosis
- ☐ Diabetes _____
- ☐ Epilepsy (seizures)
- ☐ Eating disorders
- ☐ Ear infections
- ☐ Eye problems
- ☐ Feeding problems
- ☐ Hearing problems
- ☐ Heart problems
- ☐ HIV
- ☐ Injuries
- ☐ Immune deficiency
- ☐ Kidney problems
- ☐ Lead Poisoning
- ☐ Learning disorder
- ☐ Meningitis
- ☐ Pain (chronic or unusual)
- ☐ Pneumonia
- ☐ Prematurity
- ☐ Immunization reaction _____
- ☐ Sickle cell anemia
- ☐ Tuberculosis (TB)
- ☐ _____
- ☐ _____
- ☐ _____

HEALTH PROMOTION & SAFETY

Are his/her immunizations up to date as far as you know?	☐ yes	☐ no	☐ not sure
Does he/she wear a safety belt in the car?	☐ yes	☐ no	☐ sometimes
Does he/she wear a bicycle helmet and/or other protective equipment?	☐ yes	☐ no	☐ sometimes
Are there any firearms in the home?	☐ yes	☐ no	
If so, are they loaded?	☐ yes	☐ no	
Is the gun unlocked?	☐ yes	☐ no	
Is the ammunition stored separately?	☐ yes	☐ no	
Does your home have a smoke detector?	☐ yes	☐ no	
Does your home have a fire extinguisher?	☐ yes	☐ no	
Does your home have a carbon monoxide detector?	☐ yes	☐ no	

Have you discussed any of the following with your child? (If age appropriate)

Abstinence, safe sex, condoms, HIV?	☐ yes	☐ no
Puberty, menstruation (periods), etc.?	☐ yes	☐ no
Drugs/alcohol/tobacco use?	☐ yes	☐ no

PARENT/GUARDIAN: _____ **DATE:** _____

UPMC

UPMC/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC) – CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO)

IMPRINT PATIENT IDENTIFICATION HERE

UPMC for the purposes of this Consent, includes all hospitals, physician offices and other facilities providing healthcare services which are part of the UPMC system.

I. CONSENT TO TREATMENT

This consent cannot be modified. Any handwritten changes to the form shall not be legally binding or enforceable.

1. I, _____ **(print or type name)** on behalf of_____ (patient name and relationship) consent to the provision of treatment that may include diagnostic procedures, medical treatment by and/or admission to UPMC, including its hospitals, other health care facilities and physicians (all "affiliates"), which my physician or his/her authorized agent may consider necessary or advisable. I understand special consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided I may ask UPMC not to provide such care.
2. I understand that my care may include examinations, diagnostic tests, medical treatment, taking photographs/video and making audio recordings that may be used for my care and/or by UPMC for education.
3. I understand and agree that others, under the direction of a physician, may assist or participate in providing hospital and/or medical care to me at UPMC teaching facilities. These people may include but are not limited to residents, fellows, and medical/nursing students.
4. I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices.
5. If applicable, I give UPMC permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, specimens/tissue cannot be retrieved. I understand and agree that UPMC and its designees may use such specimens/tissue as part of its educational activities. I understand that state and federal law allows UPMC to use specimens/tissue for research purposes without my authorization if my identity is not linked to the specimens/tissue. I will be asked to provide authorization for use of my specimens/tissue in research if my identity is linked to the specimens/tissue.
6. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

II. MEDICARE CERTIFICATION (IF APPLICABLE)

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or entity to submit a claim to Medicare for payment to me.

III. MEDICAID CERTIFICATION (IF APPLICABLE)

I certify that the information given on this consent is true, complete, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statement, documents, or concealment of material facts, may be prosecuted under applicable federal and state laws. My signature at the end of this consent acknowledges my receipt of an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS / CHAMPVA) and does not waive any of my rights to request a review.

IV. RECEIPT OF NOTICE OF PRIVACY PRACTICES/RELEASE OF INFORMATION

1. I have been provided the *UPMC Notice of Privacy Practices*, which may have been provided to me during a previous visit. _____ **Patient Initials (required)**
2. I consent to access by any UPMC affiliate (including UPMC hospitals, staff, physicians providing services to me and other entities and programs) to my medical or other information maintained on electronic information systems or stored in various forms at individual UPMC affiliates related to my treatment and/or services. I also consent to UPMC providing such information to my primary care/family physician(s) and others as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to me. However, my specific consent to release behavioral health information will be obtained as required by law.
3. I understand that my information may be released if required by local, state or federal law.

V. FINANCIAL ARRANGEMENTS

I agree to the following terms related to payment for services provided by UPMC and affiliates.

1. I authorize UPMC to bill my insurance carrier and request such payments to be made directly to UPMC. I certify that the information I have given about my insurance coverage or other payment sources is correct.
2. I assign to UPMC all rights to insurance payments or benefits to which I may be entitled for services provided to me by UPMC. I authorize UPMC to act on my behalf and as my representative to request reconsideration (internal and/or external review process) by my managed care plan or utilization review entity for coverage or grievance review.
3. I authorize UPMC to release any medical or other information about UPMC services, or services provided by third parties, if required to obtain payment from my insurer or other payor and their agents to process payments. I also authorize UPMC to release any medical or other information required by my insurer, other payors and their agents. I also authorize UPMC to release medical or other information required by my insurer, other payors and their agents, government agencies or their designees for review of the care provided to me.
4. I assign all rights to benefits, insurance proceeds or other payments or judgments to which I may be entitled for hospital-based physician services (pathology, radiology, neurology, cardiology, anesthesiology, etc.) and/or emergency room services to the physician or organization providing the service. I also authorize submission of a claim for payment on my behalf to my insurance carrier.
5. I understand that any amounts not paid by my insurance are my responsibility.
6. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payor regarding those services, I understand that a separate financial agreement will be put into place regarding the self pay services and this section will not apply to such services.

VI. PATIENT VALUABLES

I relieve UPMC of any responsibility for loss of clothing, money, valuables, dentures, glasses, or any other items that I decide to keep with me while I am a patient. I further understand that UPMC will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

VII. AGREEMENT TO MEDIATE CLAIMS

I agree that any claim which may result from the care provided to me by the doctors, nurses and other health care providers in any UPMC facility shall be subject to the laws of Pennsylvania. I also agree that before any lawsuit is filed related to the care provided to me, I must attempt to resolve any claim through mediation, which must take place in the Commonwealth of Pennsylvania. I am not waiving my right to a jury trial. Mediation is a process in which a neutral third person tries to help settle a claim. This agreement is binding on me and any person making a claim on my behalf.

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s) _____ _____, I am entitled under Pennsylvania Law to consent to medical, dental or other health services for myself, and if applicable, for my minor children without the consent of any other person.

_____ **Patient Initials (required if completing this section)**

I have read this Consent for Treatment, Payment and Health Care Operations form or have had it read to me, and it has been explained to my satisfaction. I understand that this Consent for Treatment, Payment and Health Care Operations form is valid for one (1) year from the date that I sign it and applies to all UPMC facilities (such as physician practices, hospitals, clinics, etc.) except for behavioral health facilities, where a separate consent may be required for an encounter.

Patient Signature	Date	Time	Signature of UPMC Representative
Signature/Identity on behalf of patient/relationship Name	Date	Time	Signature of UPMC Representative

FOR OFFICE USE ONLY

Patient Name _____ Account Number _____ MRN _____

☐ Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices _____

Reason given for refusal: ☐ Previously received ☐ Patient did not specify ☐ Other: _____

Children's Hospital of Pittsburgh of UPMC Health System (CHP)
Children's Community Pediatrics (CCP)

Notice of Privacy Practices - Summary

Attached to this paper is CHP/CCP's "Notice of Privacy Practices." The Notice explains how CHP and CCP use and share your (your child's) health information and other private information. The Notice also explains what rights you (your child) may have about this information. This Summary tells you in brief what the Notice says – IT IS NOT A COMPLETE LIST OF HOW WE USE AND SHARE YOUR HEALTH INFORMATION. CHP/CCP has the right to change this Summary and the Notice without first notifying you.

HOW WE MAY USE AND SHARE YOUR HEALTH INFORMATION

Without your specific written authorization, CHP/CCP can use and share your health information to:

- Provide you with medical treatment and other services
- Receive payment from you, an insurance company, or someone else for services we provide to you
- Operate our hospital and offices
- Comply with the law
- Meet special situations as described in the Notice, such as public health, safety, and research.

Exception: This does not include behavioral health, drug and alcohol and AIDS/HIV information

With your verbal agreement, We can:

- Include your name and other information in the hospital directory as described in the Notice
- Share your health information with the family and friends you agree can have this information.

ALL OTHER USES AND SHARING OF YOUR HEALTH INFORMATION WILL BE DONE ONLY WITH YOUR SPECIFIC WRITTEN PERMISSION OR AS REQUIRED BY LAW.

YOUR LEGAL RIGHTS ABOUT YOUR HEALTH INFORMATION

- **Right** to ask to see and request a copy of your medical record
- **Right** to ask that incorrect or incomplete information in your medical record be corrected
- **Right** to ask for a list of parties with whom we have shared your health information in certain cases.
- **Right** to ask us to limit how we use and share your health information without your consent.
- **Right** to ask for confidential communications
- **Right** to ask for a paper copy of the Notice of Privacy Practices

Please note: In many of the above cases, we are not required to agree to your requests in whole or in part

VIOLATION OF PRIVACY RIGHTS

If you believe your privacy rights have been violated, you have a right to file a complaint. Please see the attached Notice for more details. Questions? Please call 412-692-7842 or have the CHP Hospital Operator page the Privacy Officer (Operator: dial "O" while in CHP, from outside: 412-692-5325.)

CHILDREN'S HOSPITAL OF PITTSBURGH OF UPMC HEALTH SYSTEM

CHILDREN'S COMMUNITY PEDIATRICS

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED (SHARED) AND HOW YOU CAN GET ACCESS TO (SEE AND COPY) THIS INFORMATION.

PLEASE REVIEW THIS CAREFULLY.

What is a Notice of Privacy Practices?

Children's Hospital of Pittsburgh of UPMC Health System (CHP) and Children's Community Pediatrics (CCP) understands that your health information is personal. We create and maintain a record with information about the care and services you receive at our facilities. We need this information to provide you with quality care and to comply with the law. This Notice of Privacy Practices (Notice) applies to all information about your care that CHP, CCP and the UPMC Health System (UPMC) (and all of the people and places that make up these groups) may create, maintain or receive. This includes information that we receive from other doctors and medical facilities that are not part of CHP, CCP or UPMC, but that all of us keep to help give you better care. The Notice tells you about the ways we may use and share your health information, as well as the legal duties we have about your health information. The Notice also tells you about your rights under federal (United States) and state laws. In this Notice, the words "we", "us" and "our" mean CHP, CCP, UPMC and all the people and places that are part of us.

Who Follows This Notice of Privacy Practices

All of the people and places that make up CHP, CCP and UPMC follow this Notice, such as our hospitals, doctors, rehabilitation services, skilled nursing services, home health services, pharmacy services, laboratory services and other related health care providers. This also includes departments, units and staff within our health care facilities, health care professionals permitted by us to provide services to you and students, residents, trainees, volunteers and others involved in providing your care. We may share your health information with each other for the treatment, payment, or health care operations that this Notice describes.

This Notice does not apply to the UPMC Health Plan or CHP, CCP or UPMC as an employer. Additionally, if your doctor is not a member of a physician practice that is owned by us, they may have different policies about how they handle your information and will have their own Notice.

This is not meant to be a complete listing of all the CHP, CCP or UPMC people and places that may provide you with care. If you have any questions as to whether care you receive is covered under this Notice, please contact the CHP and CCP Corporate Compliance and Privacy Officer at 412-692-7842.

Our Duty to Protect Your Health Information

We are required by law to:

- make sure that information that identifies you is kept private
- make available to you this Notice that describes the ways we use and share your health information as well as your rights under the law about your health information
- follow the Notice that is currently in effect.

How We May Use and Share Your Health Information with Others

The law permits us to use and share your health information in certain ways. The list below tells you about different ways that we may use your health information and share it with others. The list also includes some examples of what we mean. When sharing this information with others outside of CHP or CCP, we share what is reasonably necessary, unless we are sharing information to help treat you, in response to your written permission, or as the law requires. In these three cases we share all information that you, your health care provider or the law has asked for. We will use health information that does not identify you whenever possible. Every possible example of how we may use or share information is not listed below, however, all of the ways we are permitted to use and share information fall into one of the groups below.

A. Ways We Are Allowed To Use and Share Your Health Information With Others Without Your Consent or In Accordance with Our General Consent Form.

1) Treatment. We may use your health information to give you medical treatment or services. We may share your health information with people and places that provide treatment to you. For example, if you have diabetes, the doctor may need to tell the dietitian about your diabetes so that you get the kind of meals you need. We may share health information about you with people outside of UPMC who provide follow-up care to you, such as nursing homes and home care agencies.

2) Payment. In order to receive payment for the services we provide to you, we may use and share your health information with your insurance company or a third party. We may also share your health information with another doctor or facility that has treated you so that they can bill you, your insurance company or a third party. For example, some health plans require your health information to pre-approve you for surgery and require pre-approval before they pay us.

3) Health Care Operations. We may use and share your health information so that we, or others that have provided treatment to you, can better operate the office or facility. For example, we may use your health information to review the treatment and services we gave you and to see how well our staff cared for you. We may share your health information with our researchers so they can develop plans to conduct research. We may share information with our students, trainees and staff for review and learning purposes.

4) Business Associates. We may share your health information with others called "business associates", who perform services on our behalf. The Business Associate must agree in writing to protect the confidentiality of the information. For example, we may share your health information with a billing company that bills for the services we provided.

5) Appointment Reminders. We may use and share your health information to remind you of your appointment for treatment or medical care. For example, if your doctor has sent you for a test, the place where the testing will be done may call you to remind you of the date you are scheduled.

6) Treatment Options and Other Health Related Benefits and Services. We may use and share your health information to tell you about possible treatment options and other health-related benefits and services that may interest you. For example, if you suffer from an illness or condition, we may tell you about a special treatment or research study that is being offered.

7) Fund-Raising Activities. We may use and share with a Business Associate or a foundation that is related to us your name, address, phone number and other such information (called "demographic information") and dates that health care was provided to you. You may then be asked for a donation to CHP,CCP or UPMC. For example, you may receive a letter from the CHP foundation asking for a donation to support cancer research at CHP. Any fund-raising materials will explain how you can tell us, a Business Associate or a foundation that you do not want to be contacted in the future, and we will use reasonable efforts to avoid contacting you in the future.

8) Marketing Activities: We may use or share your health information for marketing purposes without your permission when we discuss such products or services with you face to face or to provide you with an inexpensive promotional gift related to the product or service. For example, you may receive samples of products or drugs during a visit to CHP or a UPMC hospital or facility. For other types of marketing activities we will obtain your written permission before using or sharing your health information. We will not sell your name to others.

9) Research: We may use and share your health information for research 1) if our researcher obtains permission from a special committee that decides if the request meets certain standards required by law or 2) if you provide us with your written permission to do so. You may participate in a research study that requires you to obtain hospital and other health care services. In this case, we may share the information that we create 1) to our researcher who ordered the hospital or other health care services; and 2) to your insurance company in order to receive payment for services that your insurance will pay for. We may also use and share with one of our researchers your health information if certain parts of your information that would identify you, such as your name and other items that the law describes are removed before we share it with the researcher. This will be done when the researcher signs a written agreement with us that the researcher will not share the information again, will not try to contact you and will obey other requirements that the law provides. We may also share your health information with a Business Associate who will remove information that identifies you so that the remaining information can be used for research.

10) Special Situations In the following situations, the law either permits or requires us to use or share your health information with others. Pennsylvania law may further limit these disclosures; for example, in cases of behavioral health information, drug and alcohol treatment information and HIV status:

(a) As Required By Law. We will share your health information when federal, state or local law requires us to do so.

- If we believe that you have been a victim of abuse, neglect (except child abuse or neglect) or domestic violence, we may share your health information with an authorized government agency. We will do so either if you agree to our sharing this

information or if the law allows us to do so and we believe that we need to share the information in order to protect you or someone else. If we decide to share your health information for this purpose, we will tell you unless we believe that telling you would put you at risk of harm or you are a personal representative of the victim and may be involved in the abuse, neglect or injury.

- We may share your health information in response to an administrative or court order, a subpoena, a discovery request or other legal process if we are advised that you have been made aware of the request or we receive notice either that you agree or, if you disagree with the request, that you are taking action to prevent the disclosure.

- We may share your information with a law enforcement official or other authorized individual 1) to comply with laws, including laws that require the reporting of injury or death suspected to have been caused by criminal means, 2) in response to a court order, warrant, subpoena or summons.

(b) To Prevent a Serious Threat to Health or Safety. We may use and share your health information with persons who may be able to prevent or lessen the threat or help the potential victim of the threat when doing so is necessary to prevent a serious threat to the health and safety of you, the public or another person. Pennsylvania law may require such disclosure when an individual or group has been specifically identified as the target or potential victim, or in an emergency situation.

(c) Organ and Tissue Donation. In the event of your death, we may share your health information with organizations that obtain, store or transplant organs, eyes or tissue, to assist in the process of eye, organ or tissue transplants.

(d) Special Government Purposes. We may use and share your health information with certain government agencies such as:

- Military and Veterans. We may share your health information with military authorities as the law permits if you are a member of the armed forces (of either the United States or a foreign government)

- National Security and Intelligence. We may share your health information with authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law

- Protective Services for the President and Others. We may share your health information with authorized federal officials to protect the President of the United States, other authorized persons, or foreign heads of state. We may also share your health information for purposes of conducting special investigations as authorized by law.

(e) Workers' Compensation. We may share your health information for Workers' Compensation or similar programs that provide benefits for work-related injuries or illness.

(f) Public Health. We may share your health information with public health authorities for public health purposes to prevent or control disease, injury, or disability. This includes, but is not limited to, reporting disease, injury and important events such as birth or death and conducting public health monitoring, investigations or activities. For example, we may share you health information to 1) report child abuse or neglect, 2) collect and report on the quality, safety and effectiveness of products and activities that are regulated by the Food and Drug Administration (FDA) such as drugs and medical equipment (which could include product recalls, repairs and monitoring) or 3) notify a person who may have been exposed to or is at risk of spreading a disease.

(g) Health Oversight. We may share your health information with a health oversight agency for purposes of 1) monitoring the health care system, 2) determining benefit eligibility for Medicare, Medicaid and other government benefit programs and 3) monitoring compliance with government regulations and civil rights laws.

(h) Coroners, Medical Examiners, and Funeral Directors. We may share your health information with a coroner or medical examiner in order to identify a deceased person, determine the cause of death or for other reasons allowed by law. We may also share your health information with funeral directors, as necessary, so they can carry out their duties.

(i) Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may share your health information with the correctional institution or law enforcement official. This would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

B. Ways We Are Allowed to Use and Give Your Health Information to Others With Your Verbal Permission:

1) Hospital Directory. We may include limited information about you in the hospital directory while you are a patient at CHP or a UPMC hospital or other facility. The information may include your name, location in the building, general condition, such as "stable", "serious", "critical" and your religious affiliation. Except for your religious affiliation, the directory information may be released to

people who ask for you by name. We may give your religious affiliation to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This helps your family, friends and clergy who visit you to know how you are doing. You have the right to ask that all of your information not be given out. If you do so, we will not be able to tell your family or friends your room number or that you are in the hospital or facility.

2) People Involved in Your Care or Payment for Your Care. We may share your health information with a friend, family member or other person identified by you who is involved in your medical care or the payment of your medical care. We may also share your health information with these persons if you are present or available prior to our sharing your health information with such family, friends or other persons and you do not object to our sharing your health information with them, or we reasonably believe that you would not object to this. If you are not present and certain circumstances are present that in our judgment it would be in your best interests to do so, we will share information with a friend or family member or someone else identified by you, to the extent necessary. This could include sharing information with your friend so that they could pick up a prescription or a medical supply. We may tell your family or friends that you are in a UPMC hospital and your general condition. We may share medical information about you with an organization assisting in a disaster relief effort.

Exception to 1 and 2 above: If you are a patient in behavioral health facility or a drug and alcohol facility, none of the above information will be given to anyone outside of the UPMC facility unless you give your written permission. If you are under 14 years of age, this permission must come from your parents or legal guardians. If you are 14 years or older, and an inpatient at a behavioral health facility or under involuntary outpatient behavioral health treatment, this permission must come from you.

C. IN ALL OTHER WAYS, WE WILL REQUIRE YOUR WRITTEN PERMISSION BEFORE YOUR HEALTH INFORMATION IS USED OR SHARED WITH OTHERS.

Except as stated above, your written permission is required before we can use or share your health information with anyone outside of CHP, CCP or UPMC. This permission is provided through a form. If you give us permission to use or share health information about you, you may cancel that permission, in writing, at any time. If you cancel your permission, we will no longer use or share your health information for the reasons you have given us in your written permission. However, we are unable to take back any information that we have already shared with your permission.

Your Rights Concerning Your Health Information

The law gives you the following rights about your health information:

1. **Right to Ask To See and Copy**. You have the right to ask to see and copy the health information we used to make decisions about your care. Your request must be in writing and given to your doctor or the place where you were treated. You can call your doctor's office or the place where you were treated to find out how to do this. If you ask to see or copy your health information, you may have to pay for costs for copying, mailing or other costs. We may tell you that you cannot see or copy some or all of your health information. If we tell you this, you may ask that someone else at CHP or CCP review this decision. A licensed health care professional chosen by CHP/CCP will review those that can be reviewed. This person will not be the same person who refused your request. Whatever this person decides we will do.

2. **Right to Ask for a Correction**. If you feel that health information we have about you is incorrect or incomplete, you may ask us to correct the information. You have the right to ask for a correction for as long as the information is kept by or for CHP or CCP. You must put your request in writing and give it to your doctor or the place where you received care. If you do not ask in writing or give your reasons in writing, we may tell you that we will not do as you have asked. We have the right to refuse your request if you ask us to correct information that 1) was not made by us, unless the person or place that originally made the information is no longer available to make the correction; 2) is not part of the health information kept by or for CHP/CCP; 3) is not part of the information you are permitted by law to see and copy; or 4) we decide is correct and complete.

3. **Right to Ask for an "Accounting of Disclosures".** You have the right to ask us for an "accounting of disclosures." This is a list of those people outside of CHP, CCP or UPMC that have received your health information. This right does not include information shared for treatment, a payment or health care operation, when you have provided us with permission to do so or as the law otherwise requires. You must put your request in writing and give it to your doctor or the place where you received care. You can call your doctor's office or the place where you received care to find out how to ask for the list. You must include in your written request how far back in time you want us to go. It may not be longer than six (6) years and may not include dates before April 14, 2003, which is the date by law we are required to begin keeping track of the disclosures.

4. **Right to Ask for Limits on Use and Sharing**. You have the right to ask us to limit the health information we use or share with others about you for treatment, payment or health care operations. You also have the right to ask us to limit health information that we share with someone who is involved in your care or payment for your care, like a family member or friend. You can call your doctor's office or the place where you received your care to get instructions on how to submit such a request. In your request, you must tell us 1) what

information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) the person or institution the limits apply to (for example, your spouse). For example, you could ask that we not use or share information about a surgery you had. You must put your request in writing and give it to your doctor or the place where you received your care. **We are not required to agree to your request.** If we do agree to your request, we will not follow your request if the information you asked us to limit is needed to give you emergency treatment.

5. **Right to Ask for Confidential Communications**. You have the right to ask that we contact you about your health information in a certain way or at a certain location that you believe provides you with greater privacy. You can ask that we contact you at work or by mail. Your request must state how or where you wish to be contacted. You must make your request in writing to your doctor or the place where you received care. You do not need to provide a reason for your request. We will comply with all reasonable requests.

6. **Right to Ask for a Paper Copy of This Notice**. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically (for example, through the computer), you still have the right to a paper copy of this Notice. You can get a copy of this Notice at our website at http://www.chp.edu To obtain a paper copy of this Notice, contact your doctor's office or the registration department of the place where you received care.

Violation of Privacy Rights

If you believe your privacy has been violated by us, you may file a complaint directly with us. You can do this by contacting the CHP/CCP Corporate Compliance and Privacy Officer at 412-692-7842 or by calling the CHP/CCP Compliance HelpLine at 1-800-542-4841.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary of Health and Human Services, you must 1) name the CHP, CCP or UPMC place or person that you believe violated your privacy rights and describe how that place/ or person violated your privacy rights, and 2) file the complaint within 180 days of when you knew or should have known that the violation occurred. All complaints to the Secretary of the U.S. Department of Health and Human Services must be in writing.

You will not be penalized for filing a complaint.

Changes to This Notice

We reserve (have) the right to change this Notice. We reserve (have) the right to make the revised or changed Notice effective for health information we already have about you and for any future health information. We will post a copy of the revised Notice in the places where we provide medical services. The Notice will contain the effective date on the first page, in the top right-hand corner. We will provide to you, if you ask us, a copy of the Notice that is currently in effect each time you register at CHP, CCP or UPMC as an inpatient or outpatient for treatment or health care services.

If You Have Questions About This Notice

If you have any questions about this Notice, please contact your doctor or the place where you received care. You may also contact the CHP/CCP Corporate Compliance and Privacy Officer at 412-692-7842.

CCP HAMOT WEST
NEW PATIENT SCREEN

DATE: _____

LEONARD FADRIGO

PATIENT NAME: _____

DOB: _____

ADDRESS: _____

_____

_____

PHONE #:_____ CELL#: _____

INSURANCE: _____

PREVIOUS PHYSICIAN: _____

REASON FOR LEAVING: _____

HAVE YOU EVER BEEN DISCHARGED FROM A CCP OFFICE? _____

WHO REFERRED YOU TO OUR OFFICE? _____

CHRONIC MEDICAL PROBLEMS	ACUTE MEDICAL PROBLEMS
_____	_____
_____	_____
_____	_____
_____	_____

MEICATIONS: _____

_____

_____

HAS PT BEEN IMMUNIZED? YES NO

WILL PT BE IMMUNIZED? YES NO

APPOINTMENTS TO BE SCHEDULED: _____

DATE NOTIFIED: _____STAFF INITIALS: _____