Rebecca D. Butler, M.D., PLLC

New Patient Registration

Patient Legal Name: ______________________________________ Sex: ___ Date of Birth: ____________

Nickname: _____________________

Patient's Insurance Information

Policyholder: ____ DOB: ______________________

Insurance Company: ___________________________________ Insurance Phone #: _______________________

Policy #: ____ Group/Plan #: ___________________________

Parent/ Guardian Information

Parent:

Last Name: __________________________________ First Name: ___________________________________

DOB: ____________________ SS#: ________________ Relationship to child: ____________________________

Contact Preference: ____________________________ Email: _______________________________________

Cell Phone: ___________________________________ Alternate Phone: _______________________________

Street Address: ____

City: ____ State: _____________ Zip: ______________________

Parent:

Last Name: __________________________________ First Name: ___________________________________

DOB: ____________________ SS#: ________________ Relationship to child: ____________________________

Contact Preference: ____________________________ Email: _______________________________________

Cell Phone: ___________________________________ Alternate Phone: _______________________________

Street Address: ____

City: ____ State: _____________ Zip: ______________________

Step Parent/ Guardian (if applicable):

Last Name: __________________________________ First Name: ___________________________________

DOB: ____________________ SS#: ________________ Relationship to child: ____________________________

Contact Preference: ____________________________ Email: _______________________________________

Cell Phone: ___________________________________ Alternate Phone: _______________________________

Street Address: ____

City: ____ State: _____________ Zip: ______________________

Step Parent/ Guardian (if applicable):

Last Name: __________________________________ First Name: ___________________________________

DOB: ____________________ SS#: ________________ Relationship to child: ____________________________

Contact Preference: ____________________________ Email: _______________________________________

Cell Phone: ___________________________________ Alternate Phone: _______________________________

Street Address: ____

City: ____ State: _____________ Zip: ______________________

Children live with: Mother Father Guardian Other: ____________________

Emergency Contact (other than parents): __________________________ Phone: ___________________________

Confirmation Calls

Please check how you would like to be contacted for confirmation calls

- Call on cell phone

  Name ____________________________ Phone Number _________________

- Text

  Name ____________________________ Phone Number _________________

- Email

  Email Address: ____

To whom should billing statements be sent:

____

Authorization of Treatment and Assignment of Benefits

I authorize Lantana Pediatrics, Rebecca D. Butler, M.D., to treat my child. I further authorize payment directly to Lantana Pediatrics 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 charges whether or not paid by my insurance.

I authorize the use of this signature on all my insurance submissions. I permit a copy of this authorization to be used in place of the original.

Signature: ____ Date: _____________________

Authorization to Treat a Minor

Child's Name: ______________________________________ Date of Birth: ________________

Please list below anyone (besides parent or guardian) that is authorized to bring your child in the office and make medical decisions. (They will need to provide a photo ID with each visit).

Name: ____________________________________ Relationship: _______________________

Name: ____________________________________ Relationship: _______________________

Name: ____________________________________ Relationship: _______________________

Name: ____________________________________ Relationship: _______________________

Name: ____________________________________ Relationship: _______________________

Print: ____ Date: ___________________

Sign: ____ Relationship: ____________

Initial History Questionnaire

Name ______

ID NUMBER ______

FORM COMPLETED BY ______ DATE COMPLETED ______

BIRTH DATE ______ AGE ______ M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. ______

If mother and father are not living together or if child does not live with parents, what is the child's custody status? ______

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? ______

Birth History

Birth weight ______

Was the baby born at term? ______ Early? ______ Late? ______

If early, how many weeks' gestation? ______

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain ______

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What ______ When ______

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? ______

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain ______

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain ______

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain ______

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain ______

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain ______

Has your child had any surgery? ☐ Yes ☐ No Explain ______

Has your child ever been hospitalized? ☐ Yes ☐ No Explain ______

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain ______

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain ______

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain ______

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain ______

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 resource classes? ______

Family History

Have any family members had the following:

Condition	Yes	No	Who	Comments
Deafness	☐ Yes	☐ No	Who ______	Comments ______
Nasal allergies	☐ Yes	☐ No	Who ______	Comments ______
Asthma	☐ Yes	☐ No	Who ______	Comments ______
Tuberculosis	☐ Yes	☐ No	Who ______	Comments ______
Heart disease (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
High cholesterol	☐ Yes	☐ No	Who ______	Comments ______
Anemia	☐ Yes	☐ No	Who ______	Comments ______
Bleeding disorder	☐ Yes	☐ No	Who ______	Comments ______
Liver disease	☐ Yes	☐ No	Who ______	Comments ______
Kidney disease	☐ Yes	☐ No	Who ______	Comments ______
Diabetes (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who ______	Comments ______
Epilepsy or convulsions	☐ Yes	☐ No	Who ______	Comments ______
Alcohol abuse	☐ Yes	☐ No	Who ______	Comments ______
Drug abuse	☐ Yes	☐ No	Who ______	Comments ______
Mental illness	☐ Yes	☐ No	Who ______	Comments ______
Mental retardation	☐ Yes	☐ No	Who ______	Comments ______
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who ______	Comments ______

Additional family history ______________________________

____

____

Past History

Does your child have, or has he/she ever had:

Condition	Yes	No	Details
Chickenpox	☐ Yes	☐ No	When ______
Frequent ear infections	☐ Yes	☐ No	Explain ______
Problems with ears or hearing	☐ Yes	☐ No	Explain ______
Nasal allergies	☐ Yes	☐ No	Explain ______
Problems with eyes or vision	☐ Yes	☐ No	Explain ______
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain ______
Any heart problem or heart murmur	☐ Yes	☐ No	Explain ______
Anemia or bleeding problem	☐ Yes	☐ No	Explain ______
Blood transfusion	☐ Yes	☐ No	Explain ______
Frequent abdominal pain	☐ Yes	☐ No	Explain ______
Constipation requiring doctor visits	☐ Yes	☐ No	Explain ______
Bladder or kidney infection	☐ Yes	☐ No	Explain ______
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain ______
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When ______
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain ______
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain ______
Frequent headaches	☐ Yes	☐ No	Explain ______
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain ______
Diabetes	☐ Yes	☐ No	Explain ______
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain ______
Any other significant problem	☐ Yes	☐ No	Explain ______
Use of alcohol or drugs	☐ Yes	☐ No	Explain ______

Questions About Your Child and Tuberculosis (TB)

Childs Name: ____ DOB: _________________

Your Name: ____ Date: _________________

We need your help to find out if your child has been exposed to the disease tuberculosis, also known as TB.

TB is caused by germs. It is usually spread to another person by coughing or sneezing. A person can have TB germs in their body but not have active TB disease. TB can be prevented and treated. Your answers to the questions below will let us know if your child might have been exposed to TB. If your answers show your child might have picked up the TB germs, we will want to give him or her a tuberculin skin test (TST). The skin test is not a vaccination. It will not prevent TB. It will only let us know if your child has the TB germ.

Check the box that matches your answer:	Yes	No	Do Not Know
1. Has your child been tested for TB? If yes, when? Please tell us the date ___ /___ /___			
2. Have you ever been told that your child had a positive tuberculin skin test (TST)? If yes, when? Please tell us the date ___ /___ /___			
3. TB can cause fever that can last days or weeks. It can cause weight loss, a bad cough (lasting over two weeks), or coughing up blood.			
a. Has your child been around anyone with any of these problems?			
b. Has your child been around anyone sick with TB?			
c. Has your child ever had any of these problems or do they have them now?			
4. Was your child born in another part of the world like Mexico or Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
5. Has your child been to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than 3 weeks? Which country or countries did your child visit? ______________________			
6. Do you know if your child has spent more than 3 weeks with anyone who:			
Uses needles for drug use?			
Has AIDS?			
Was or is in jail or prison?			
Has just come to the United States from another country?			

FOR THE PROVIDER:

If the prior test was negative and the answer to #4 is yes, the child does not need a repeat skin test.

If the prior test was negative and occurred at least 8 weeks after the situation described in #3a, 3b, 5, or 6, the child does not need a repeat skin test.

If the prior test was positive, the child does not need a repeat skin test; but a positive answer to #3c would indicate a chest x-ray as soon as possible.

TST administered: Yes _____ No _____

If yes, Date administered ____ /____ /______ Date read ____ /____ /______ TST reaction ________mm

TST provider signature: ____________________________ Printed: ______________________________

If chest x-ray done, date: ____ /____ /______ and results ______________________________________

Provider phone number: ________________________ City ______________ Country _______________

If positive, referral to local/regional health department/specialist? Yes _____ No _____

If yes, name of health department/specialist: ____

Contact your local or regional health department if assistance is needed.

Rebecca D. Butler, M.D., PLLC

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about my child by releasing a copy of the medical records, or a summary or narrative of their protected health information, to the person (s) or entity listed below.

Release protected health information from the health records of:

Name: ____ DOB: ______________________

Release protected health information from:

Physician/Hospital/Clinic: ____

Address: ____

Phone: ____ Fax: _______________________________________

WHAT INFORMATION CAN BE DISCLOSED?

Complete the following by indication those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ○ All health information
- ○ Physicians Orders
- ○ Progress Notes
- ○ Pathology Reports
- ○ History/Physical Exam
- ○ Patient Allergies
- ○ Discharge Summary
- ○ Billing Information
- ○ Past/ present medications
- ○ Operation Reports
- ○ Diagnostic Test Reports
- ○ Radiology Reports & Images
- ○ Lab Results
- ○ Consultation Reports
- ○ EKG/ Cardiology Reports
- ○ Other

Your initials are required to release the following information.

___ Mental Health Records (excluding psychotherapy notes) ___ Genetic Information (including Genetic Test Results) ___ Drug, Alcohol, Substance Abuse Records ___ HIV/AIDS test results/treatment

Release my protected health information to:

Lantana Pediatrics

Rebecca D. Butler, M.D.

74 McMakin Road, Suite 100

Bartonville, TX 76226

940-455-7200 (phone) 940-455-7214 (Fax)

Patient Signature (or parent, guardian, or legal representative):

Name (print): ____ Date: __________________________

Signature: ____

PLEASE MAIL ALL RECORDS

Privia Medical Group North Texas

Consent for Treatment

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injection, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. ____,

With Privia Medical Group of North Texas unless revoked by me in writing

Patients Name: ____ DOB: _____________________

Date: ____________________ ____

Patient/Parent/Guardian signature

HIPPA Authorization for Release of Patient Health Information

In general, HIPPA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: ________________________________
  - ☐ OK to leave a message with detailed information
  - ☐ Leave name and doctor with call back number only
- ☐ Work Telephone: ___________________________________
  - ☐ OK to leave a message with detailed information
  - ☐ Leave name and doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address
- ☐ Other: ____

I consent and authorize the release of NORMAL test results to the following

- ☐ Only myself
- ☐ Telephone answering machine/voicemail
- ☐ My spouse: ____
- ☐ My children: ______________________________________
- ☐ My parents: _______________________________________
- ☐ Other: ____

I consent and authorize the release of ABNORMAL test results to the following:

- ☐ Only myself
- ☐ Telephone answering machine/voicemail
- ☐ My spouse: ____
- ☐ My children: ______________________________________
- ☐ My parents: _______________________________________
- ☐ Other: ____

I consent and authorize your office or a facility on my behalf, to conduct benefit

verification services. ___ yes ___ no

I hereby give my physician permission to discuss all diagnostic and treatment details

with my other physician(s) and pharmacist(s) regarding my use of medications prescribed

by my other physician(s). ___ yes ___ no

Do you have an advanced directive (living will)? ___ yes ___ no

I consent and authorize your office or facility to make calls and/or send text messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system. ___ yes ___no

____ ___________________________

Patient/Parent/Guardian Signature Date

Rebecca D. Butler, M.D., PLLC

Office Policies

Thank you for choosing Rebecca D. Butler, M.D., for your primary care!

Privacy Practices

You will be asked to read and sign notification of our Privacy Practices. We also have another form for communication with another person regarding your health or messages, e.g. husband/wife, mother, father, etc. and gives us a phone number and/or email where messages can be left/sent.

General Office Policies:

Appointments: Patients are seen by appointment only. We pride ourselves in being able to offer same-day sick visit appointments, if requested early in the day. Patients who appear in the office requesting to be seen will be given the next available appointment that day if the doctor's schedule permits.

We try our best to run on time. Therefore, if you are more than 15 minutes late, it is up to the discretion of the doctor whether we will be able to see you at your time slot. You may be asked to reschedule. **There is a $30 charge for patients cancelling an appointment with less than 2 hour notice for sick appointments, and $50 for well and ADHD appointments with less than a 24 hour notice.**

We will call one day in advance and can email you appointment reminders. This allows us to see all the patients who have requested appointment times that day

Office Hours: Our office hours are 7:30 to 6pm Monday, Tuesday, Thursday, 7:30 to 1 pm Wednesday and 7:30 to 5pm Friday. We are open 9-12pm on Saturdays for sick appointments only. We are closed for the usual holidays.

After Hours: We do provide 24-hour triage. A doctor is available 24 hours a day for urgent situations. Just call the office phone and follow the directions to reach the doctor on call. **Please leave a number that will accept blocked-number calls.** If you have a routine question, please call during office hours. If you need medication dosages, please call your local 24-hour pharmacy or your insurance nurse line.

Saturday Clinic: We will be open Saturdays 9-12pm. Our Saturday clinic is for emergent sickness only. This clinic is **not** for chronic problems. If symptoms have been ongoing for several days, this should be addresses during our weekday office hours.

Telephone Calls: We ask that you make all non-emergency calls during regular business hours, when we have your child's medical record available. We will return your call as quickly as possible in the order it was received, and generally within the same half-day in which you call. If you leave a message after hours, these messages will be returned at the beginning of the next business day.

New Patients: We welcome new patients to our practice. It is a good idea to verify the doctor's name as a provider on your insurance web site. We. However, are not accepting new patients 17 years of age or older. We feel an internist would be a specialty better suited to their needs.

New Babies: Upon discharge, please contact our office to schedule a visit 24-48 hours after discharge. You may be given a summary of the hospitalization, which you should bring with you at your first appointment.

Your baby should have the first Texas Department of Health Newborn Screen and Hepatitis B vaccine in the nursery. Your second screen will be done either in the office or back at the nursery 1 week to 10 days later.

Immunizations: Our doctor follows the AAP guidelines and requires her patients to be vaccinated. Unfortunately, we cannot accept the responsibility for the care of patients who are refusing to vaccinate.

Terminating Relationship: Unfortunately, it is sometimes necessary to terminate the patient/physician relationship. If this does happen, any other physician in our practice will also not be able to see you.

Financial Policies:

Your Insurance:

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. **This office's policy is to collect this co-pay when you arrive for your appointment.** If co-payments are not paid at the time of service, a $10.00 fee will be assessed to your account. For your convenience, we accept Mastercard, Visa, cash, or check. A $25 fee will be assessed to your account for all returned checks.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Insurance Cards: You will be asked to present your insurance card at every visit. Although this might be inconvenient, it is necessary. Insurance plans and ID numbers are changing in order to keep social security numbers off the ID card. If you do not have your insurance card with you, you will be expected to pay for the visit until the information is provided.

Benefits: Insurance benefits can be very confusing. Each company has many different types of policies. Our office will try to help you as best we can. However, ultimately, it is your responsibility to know your benefits, including limitations and exclusions, as you are responsible for payment. If you have any questions regarding any of this, including covered services, deductibles, maximum benefits, please contact the insurance administrator of your employer or your insurance company.

New Insurance: If you have a new insurance, please let us know at the time you schedule an appointment in order that we can verify benefits prior to your appointment. If we are unable to verify, you will be responsible for the total allowable charges. When your insurance company does pay, we will refund your overpayment.

Co-Pay: Co-payment will be collected at check in unless you have a co-insurance plan (e.g. 80/20). If this is your plan, we will try to calculate as best we can your estimated co-insurance after you have seen the doctor. This may take a little extra time, as we will look up the allowable charges from your insurance company. If you have a deductible, insurance companies require you to meet this before they make payment. Some PPO plans have a co-pay only for sick visits, and a deductible for other services, e.g. labs, immunizations, procedures.

HMO/POS: You are required to select your respective physician, Rebecca D. Butler, MD, as your primary care physician(PCP) with your insurance company before your appointment. If you have not done this, your insurance will not pay for your visit and you would be responsible for payment in full.

Insurance Payments: We will sometimes ask your assistance to get the insurance company to pay the submitted charges. If they request some information from you, it is extremely important that you get them the information they request in a prompt manner. Always keep a copy of what you sed them, along with the person's name to send it to. Please follow up with that person within 24 hours to verify that they have received the information you sent and will be processing your claims. Ultimately, it is your responsibility for payment of the services provided.

Responsible Party: The adult patient is the responsible party for services rendered. If the patient is a child, the parent bringing the child to the appointment is responsible for all co-payments, co-insurances, and outstanding balances. We will provide a receipt of payment in order that retrieval for payment can be refunded to the paying parent.

Self-Pay: Payment is required in full at the time of service.

Treatment:

Antibiotics are NOT prescribed by telephone. Dr. Butler prefers to examine your child and tailor treatment to the specific diagnosis. Medication refill requests should be made during regular office hours or left on the non-urgent message line.

Your treatment will be based on medical necessity. Some procedures and labs may not be covered under your particular plan. It is not our responsibility to verify that everything is covered before treatment is provided.

Medication: We prescribe the medication that we feel is best suited to your condition. If this medication is not covered, or has a high co-pay, we would need to be provided with alternatives that are financially acceptable to you.

Refills: Please plan ahead for your prescription refills. If your prescription says no refills, please call your pharmacy. They will process an electronic or fax request to us. We need at least 24 hour notice to process authorization.

Referrals: Sometimes it is necessary to refer you to a specialist for your condition. We will give you a list of doctors that we know and would recommend. When you call to schedule an appointment, you would need to verify that the specialist is part of your network. If the specialists we give you are not in your insurance network, please find a physician and let us know their name, phone, and fax number in order for a referral to be done, if needed. We require at least 48 hours for referrals.

Thank you for choosing Lantana Pediatrics. We appreciate your confidence in choosing this office for your pediatric needs. We are dedicated to providing the best healthcare possible for your children. We look forward to caring for your family.

If you would like a copy of this for your records, please let the staff know.

____ ____________________

Patient/Parent/Legal Guardian Signature Date

____

Print Name

Rebecca D. Butler, M.D., PLLC

Notice of Patient Rights and Responsibilities

This document is meant to inform our patients of their rights and responsibilities while undergoing medical care. To the extent permitted by law, patient rights may be delineated on behalf of the patient to his or her guardian, next of kin, or legally authorized responsible person if the patient:

a) has been adjudicated incompetent in accordance with the law,
b) is found to be medically incapable of understanding the proposed treatment or procedure,
c) is unable to communicate his or her wishes regarding treatment, or
d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

Patient Rights:

1. Access to Care. You will be provided with impartial access to treatment and services within this practice's capacity, availability, and applicable law and regulation. This is regardless of race, creed, sex, national origin, religion, disability/handicap, or source of payment for care/services.

2. Respect and Dignity. You have the right to considerate, respectful care/services at all times and under all circumstances. This includes recognition of psychosocial, spiritual, and cultural variables that may influence the perception of your illness.

3. Privacy and Confidentiality. You have the right, within the law, to personal and informational privacy. This includes the right to:

    - Be interviewed and examined in surroundings that assure reasonable privacy.
    - Have a person of your own sex present during physical examination or treatment.
    - Not remain disrobed any longer than is required for accomplishing treatment/services.
    - Request transfer to another treatment room if a visitor is unreasonably disturbing.
    - Expect that any discussion or consultation regarding care will be conducted discreetly.
    - Expect all written communications pertaining to care will be treated as confidential.
    - Expect medical records to be read only by individuals directly involved in care, quality assurance activities, or processing of insurance claims. No other persons will have access without your written authorization.

4. Personal Safety. You have the right to expect reasonable safety insofar as the office practices and environment are concerned.

5. Identity. You have the right to know the identity and professional status of any person providing services and which physician or other practitioner is primarily responsible for care.

6. Information. You have the right to obtain complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis. This information should be communicated in terms that you understand.

7. Communication. If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.

8. Consent. You have the right to information that enables you, in collaboration with the physician, to make treatment decisions.
    - Consent discussions will include explanation of the condition, risks, and benefits of treatment, as well as consequences of no treatment.
    - You will not be subjected to any procedure without providing voluntary, written consent
    - You will be informed if the practice proposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most effective care the practice otherwise provides.

9. Consultation. You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice.

10. Charges. Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services.

11. Rules and Regulations. You will be informed of practice rules and regulations concerning your conduct as a patient at this facility. You are further entitled to information about the initiation, review, and resolution of patient complaints.

Patient Responsibilities:

1. Keep us Accurately Informed. You have the responsibility to provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health, including unexpected changes in your condition.
2. Follow Your Treatment Plan. You are responsible for following the treatment plan recommended by the physician. This may include following the instructions of health care personnel as they carry out the coordinated plan of care and implement the physician's orders and as they enforce the applicable practice rules and regulations.
3. Keep Your Appointments. You are responsible for keeping appointments and, when unable to do so for any reason, for notifying this practice.
4. Take Responsibility for Noncompliance. You are responsible for your actions if you do not follow the physician's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.

5. Be Responsible for Your Financial Obligations. You are responsible for assuring that the financial obligations of health care services are fulfilled as promptly as possible, and for providing up-to-date insurance information.
6. Be Considerate of Others. You are responsible for being considerate of the right of other patients and personnel, and for assisting in the control of noise, smoking, and the number of visitors. You also are responsible for bring respectful of practice property and property of other persons visiting the practice.
7. Be Responsible for Lifestyle Choices. Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.

Lantana Pediatrics
Rebecca D. Butler, MD, PLLC
940-455-7200

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the wat that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if that would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operation with your health u=insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've share information.

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-277-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary

Example: we use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hippa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Other Instructions for Notice

Under the Texas Rules, consumers have a right to file a complaint with the Texas agencies that regulate Covered Entities as well as with eh Texas Attorney General. The Texas Attorney General maintains a Consumer Information Website, which provides the contact information and complaint process for the state agencies, Texas Medical Board, the Department of Insurance and U.S. Department of Health and Human Services.

Question or concerns should be addressed to Gus Farr/Privacy Officer (940) 455-7200 or email to gus@lantanapediatrics.com ATTN: Privacy Officer

Effective revised date: 10/30/2017

Lantana Pediatrics

Rebecca D. Butler, MD, PLLC

(940) 455-7200

Rebecca D. Butler, MD, PLLC

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

____ ____________________

Patient Name (Print) Date

____

Patient/Parent/Guardian Signature

____

Relationship to patient