willamette falls pediatric group

1510 Division, Suite 280, Oregon City, OR 97045
p 503.905.3400 f 503.905.3399

200 Hazel Dell Way, Suite 202, Canby, Oregon 97013
p 503.266.8500 f 503.266.8585

PATIENT REGISTRATION

PATIENT'S NAME Last _____ First _____ Middle _____

Birth Date ___ / ___ / ___ Sex ❑ M ❑ F SSN _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ E-Mail Address _____

Preferred method of appointment reminder: _____Voice _____Text _____Email

Patient's Primary Care Physician (PCP) _____

Race _____ Ethnicity_____ Primary Language _____

Would you like secure online access to your health record? ____ Yes ____ No

Combine children on same account? ____ Yes ____ No If no, please list children to be on this account_____

_____

Siblings: Last _____ First _____ Middle _____ Birth Date ___ / ___ / ___

Last _____ First _____ Middle _____ Birth Date ___ / ___ / ___

Last _____ First _____ Middle _____ Birth Date ___ / ___ / ___

PATIENT'S PARENT'S OR GUARDIAN INFORMATION

PRIMARY GUARDIAN

_____ (Last Name) _____ (First) _____ (Middle) ___/___/___ (Birth Date) _____ (Social Security Number)

Address ❑ Same as Patient _____ Apt. # _____

City _____ State _____ Zip _____ Home Phone_____

Employer _____ Work Phone _____ Cell Phone _____

SECONDARY GUARDIAN

_____ (Last Name) _____ (First) _____ (Middle) ___/___/___ (Birth Date) _____ (Social Security Number)

Address ❑ Same as Patient _____ Apt. # _____

City _____ State _____ Zip _____ Home Phone_____

Employer _____ Work Phone _____ Cell Phone _____

EMERGENCY CONTACT *(Other Than Listed Above)*

Name _____ Relationship to Patient _____

Home Phone _____ Work or Cell Phone _____

PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

Name _____ Subscriber _____

Subscriber Birth Date ___ / ___ / ___ Relationship to Patient _____ Effective Date ___ / ___ / ___

SS # or ID # _____ Group # _____ Co-Pay Fee, if any _____

SECONDARY INSURANCE COMPANY

Name _____ Subscriber _____

Subscriber Birth Date ___ / ___ / ___ Relationship to Patient _____ Effective Date ___ / ___ / ___

SS # or ID # _____ Group # _____ Co-Pay Fee, if any _____

I hereby authorize Willamette Falls Pediatric Group to provide medical services to the above named patient and to use and release medical information as required for treatment, payment and health care operations. I also assign Willamette Falls Pediatric Group all payments to which I am entitled for medical and surgical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that failure to make insurance co-payments at the time of visit will result in additional charges. I have received a copy of the current Privacy Notice of Willamette Falls Pediatric Group.

Signature _____ Date _____

willamette falls pediatric group

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

OREGON CITY
1510 Division Street, Suite 280, Oregon City, OR 97045
T 503.905.3400 • F 503.905.3399

CANBY
200 Hazel Dell Way, Suite 202, Canby, OR 97013
T 503.266.8500 • F 503.266.8585

All sections of this form MUST be completed or the authorization will not be accepted.

I authorize: _____

_____

To use and disclose a copy of the specific health information described below regarding:

_____ _____
(name of individual) (date of birth)

Consisting of: ___ Physician Reports ___ X-rays ___ Labs ___ Other (specify) _____

To: **Willamette Falls Pediatric Group, 1510 Division St. Suite 280, Oregon City, OR 97045**

For the purpose of: ___ Continued Care ___ Other (specify) _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my initials in the space next to the type of information.

_____ **HIV/AIDS information** _____ **Mental Health information**

_____ **Genetic testing information** _____ **Drug/alcohol diagnosis, treatment, or referral information**

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to **Medical Correspondence, Health Information Services; WFPG, 1510 Division St. Suite 280, Oregon City, OR 97045,** and state that you are revoking this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to Redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure HIV/AIDS information, mental health information, genetic information, and drug/alcohol diagnosis, treatment, or referral information.

I have read this authorization and I understand it.

This authorization expires one year from the date of signing unless revoked or otherwise specified below.

Signature _____ Date _____

Willamette Falls Pediatric Group

Patient Medical History Form

Date	Child's Name	DOB	M F
Mother's name	Occupation	Father's name	Occupation
Previous Physician/Office		Date of Last Physical/Well Child Checkup	
Allergies/Reactions (please state nature of reaction)			
Current Medicines			

Birth History

Were there any problems with pregnancy? ☐ No ☐ Yes (please specify) _____

Was baby full term? ☐ or premature? ☐ If so, how early_____

Delivered by ☐ vaginal birth ☐ caesarian (please explain why) _____

Birth weight _____ Birth length _____ Delivery Hospital_____

Current and Past Medical History

Has your child had any of the following conditions? Please circle all that apply:

Asthma/hay fever/eczema	Bronchiolitis/RSV	Pneumonia
Attention/Learning problems	Seizures	Developmental Delays
Broken bones/major injuries	Anemia/Bleeding Problems	Urinary Tract Infections
Hearth problem or murmur	Chickenpox	Other:
Frequent Ear Infections	Frequent Strep Infections	_____

Past Surgical History:

Has your child had any operations such as ear tubes, hernia repair, or tonsillectomy?

☐ No ☐ Yes (Please explain-type of surgery, location, dates) _____

_____

Safety:

Does your child use a car seat/seat belt?	☐ Yes ☐ No
Do you have a smoke detector at home?	☐ Yes ☐ No
Do you have the phone number for Poison Control?	☐ Yes ☐ No
Do you have guns at home?	☐ Yes ☐ No
If so, has your family had fire arm safety instruction?	☐ Yes ☐ No
Has your child been taught how to swim?	☐ Yes ☐ No
Does your child wear a bike helmet?	☐ Yes ☐ No
Does your child have access to the internet	☐ Yes ☐ No
How much time does your child spend watching TV or on the computer? _____	
Do you monitor his/her time, content?	☐ Yes ☐ No

(please turn over)

Social History

Please list all those living in the child's home

Name	Relationship to child	DOB/age

Child Care: _____

Smokers in household? ☐ Yes ☐ No Pets in household? _____

Are there siblings not listed? If so, please list names, 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?

_____

Family Medical History (Parents, Siblings, Grandparents, Aunts & Uncles)

Have any family members had the following:

Alcoholism/Drug Abuse	☐Y	☐N	Who _____	Comments _____
Allergies	☐Y	☐N	Who _____	Comments _____
Asthma	☐Y	☐N	Who _____	Comments _____
Attention Deficit Hyperactivity Disorder	☐Y	☐N	Who _____	Comments _____
Bleeding/clotting problems/anemia	☐Y	☐N	Who _____	Comments _____
Cancer (type)	☐Y	☐N	Who _____	Comments _____
Diabetes (Type 1 or Type 2)	☐Y	☐N	Who _____	Comments _____
Gastrointestinal (stomach, bowel, liver)	☐Y	☐N	Who _____	Comments _____
Genetic/Inherited disease/Birth Defects	☐Y	☐N	Who _____	Comments _____
Hearing Loss	☐Y	☐N	Who _____	Comments _____
Heart disease/Heart attack before age 50	☐Y	☐N	Who _____	Comments _____
High Blood Pressure	☐Y	☐N	Who _____	Comments _____
High Cholesterol	☐Y	☐N	Who _____	Comments _____
Hip Problems/dislocation	☐Y	☐N	Who _____	Comments _____
Kidney Disease	☐Y	☐N	Who _____	Comments _____
Learning Disabilities	☐Y	☐N	Who _____	Comments _____
Mental Illness/Anxiety/Depression	☐Y	☐N	Who _____	Comments _____
Seizures/Neurologic	☐Y	☐N	Who _____	Comments _____
Thyroid disease	☐Y	☐N	Who _____	Comments _____

Other (please explain) _____

Thank you for taking the time to fill out this form. It will be reviewed by your provider and become part of your record.

WFPG Financial Policy

Patient Name: _____ Date of Birth: _____

The primary goal of our practice is to provide the finest pediatric care to the children and young adults in our community. Since our practice has obligations that must be met, we ask that you agree to abide by our payment policies. Insurance coverage is an agreement between a patient and his/her insurance company for the payment of medical services. While we will attempt to assist you in obtaining payment from your insurance company, it is your responsibility to understand your coverage and to know your carrier's guidelines for obtaining medical services. You are ultimately responsible for full payment of charges incurred at the visit if your insurance carrier doesn't pay for any reason. For your convenience we accept cash, check, VISA and MasterCard.

- Insurance cards: Please come to each appointment with all the necessary forms and current insurance cards so that we may have the most updated information necessary to bill the insurance company in a timely and accurate manner.
- Name changes: In the case of a legal name change, proof of name change must be submitted to us so that the information we have matches the information your insurance carrier has. Please verify with your insurance carrier that they have the same patient name you provide us. Until proof of name change is provided, payment for visit is expected.
- Legal guardianship: Proof of legal guardianship must be submitted before treatment is provided to patients.
- Co-pays: If your insurance company requires a co-payment, payment of the co-pay is due at the time of service. If you fail to make a co-payment at the time of the appointment, a $10 billing fee will be added to your account.
- Non-insured patients: If you do not have insurance, payment is due at the time of service. We will give a 25% discount on the exam charge when payment is made in full at time of service. Established patients in good financial standing with the clinic have the option of paying a $100 deposit rather than paying in full, but there will be no discount available unless account is paid in full at time of service.
- No proof of insurance: See policy for non-insured patients above. The same policy will apply until proof of insurance is provided.
- Non-sufficient funds: When checks are returned to WFPG for non-sufficient funds, a $35 charge will be added to your account, and you will be asked to pay with cash or credit card for future visits.
- Non-covered services: OHP/Commercial insurance patients will be required to make payment in full at time of service for services not covered by insurance.
- Collections: In the unfortunate event that we need to assign an account to a collection agency, we will add a fee of $150 to the delinquent balance on the account.
- Missed appointments: Willamette Falls Pediatric Group has a policy of charging $50 for missed appointments. We may also choose to discharge a patient from care for repeated incidents of missed appointments. Please call 24 hours in advance to cancel or reschedule appointments.

As responsible patient or legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of Willamette Falls Pediatric Group as stated above.

Signature of Guarantor:_____Date:_____

willamette falls pediatric group

TERMS AND CONDITIONS OF SERVICE

HEALTHCARE CONSENT: Patient care provided at WFPG is directed by attending staff Providers. I understand that there may be risks and alternatives to a proposed treatment. I have the right to ask for detailed explanations of all aspects of my care and treatment. I consent to services rendered and provided under the instructions of attending staff physicians or other WFPG health care Providers who may be assisting in my care, as well as volunteers or courtesy physicians who may be associated for the purpose of consulting.

TEACHING INSTITUTION: I agree that persons who are students, resident physicians and post-graduate fellows or others involved in graduate medical education programs may participate in my care as a part of the educational programs of the institutions of which they are affiliated. I may be contacted by various healthcare providers or clinical researchers for voluntary participation in clinical research projects. However, I have the right to refuse to participate without jeopardizing future care in any way.

CONSENT FOR RETENTION OF GENETIC INFORMATION: I understand and consent that genetic information received or created in the course of the delivery of healthcare at WFPG will be entered into the routine patient medical record and maintained by WFPG. Should I wish to opt out regarding the use of my health information or biological samples being used for genetic research, I will complete and submit a *Notice of Your Right to Refuse Participation in Future Anonymous and/or Coded Genetic Research* form to WFPG.

CONSENT FOR RELEASE OF INFORMATION TO PRIMARY CARE PROVIDERS, REFERRING PROVIDERS, INSURERS, AND PROFESSIONAL REVIEW ORGANIZATIONS: I understand and consent that health information received or created in the course of the delivery of healthcare at WFPG will be used or released for treatment, payment and healthcare operations as described in the WFPG Privacy Practices. A copy of the *Notice of Privacy Practices* is available upon request.

SOCIAL SECURITY NUMBERS: WFPG collects administrative and nonmedical patient data including social security numbers for the purpose of patient identification, compliance with federal and state agency reporting requirements, billing to insurance carriers and collections needs, as authorized by ORS 351.070 or 353.050. Disclosure of the social security number information is voluntary. I have provided this information and authorize WFPG to use this information for the purposes stated above.

STATEMENT OF FINANCIAL RESPONSIBILITY: Financial Agreement: The undersigned, jointly and severally, in consideration of services to be rendered to patient, agrees to pay each provider of service, in accordance with their regular rates and terms, for services rendered. The undersigned further agrees to pay reasonable attorney fees and expenses incurred in collecting all sums not paid when due, whether or not litigation is actually commenced, as well as all attorney fees and expenses and cost on appeal. The undersigned assigns to each provider of service all insurance benefits available for the professional and institutional services rendered. The assignment is irrevocable, and the undersigned authorizes carriers of such benefits to make payment directly to WFPG. Payments received from insurers will be applied to the patient's account balance obligation. The undersigned agrees to promptly pay any charges not immediately (within 30 days) covered by insurance(s).

Social Security Programs: I certify that the information given by me in applying for payment under Titles V.XVIII or XIX of the Social Security Act is correct. Should benefits be required to be terminated by Peer Review Organization, I understand I will be notified and I will become responsible for payment of non-covered hospital care if I elect to remain in the hospital. I request that payment of authorized benefits be made on my behalf directly to the provider.

PATIENT CARE: I agree that the above consent for treatment, consent for release of information and agreement of financial responsibility apply to services provided at WFPG.

I HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE ABOVE STATEMENTS.

Patient's Name, Signature and Date

Patient's Parent or Guardian's Name, Signature and Date

Witness Name, Signature and Date

1510 Division St, Suite 280, Oregon City, OR 97045. 503 905 3400
200 Hazel Dell Way, Suite 202, Canby, OR 97013. 503 266 8585

NOTICE OF PRIVACY PRACTICES

1510 Division Street, Suite 280
Oregon City, Oregon 97045
503-905-3400
www.wfpeds.com

I acknowledge I have received the current Notices of Privacy Practices for Willamette Falls Pediatric group.

Patient Name_____

Date of Birth _____

Patient/Guardian Signature_____

Relationship to Patient_____

Witness_____

Date_____

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

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.

If you have any questions about this notice, please contact the practice manager at 503-905-3400

willamette falls pediatric group
a doernbecher teaching affiliate

1510 Division Street, Suite 280
Oregon City, Oregon 97045
www.wfpeds.com

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from Willamette Falls Pediatric Group. Your health information may include information created and received by Willamette Falls Pediatric Group, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

  Different personnel in our organization may share information about you and disclose information to people who do not work for Willamette Falls Pediatric Group in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

- **For payment.** We may use and disclose health information about you so that the treatment and services you receive at Willamette Falls Pediatric Group may be billed to and payment may be collected from you, an insurance company or a third party.

  For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run Willamette Falls Pediatric Group and make sure that you and our other patients receive quality care.

  For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse/parent when you bring your spouse/parent with you into the exam room or the hospital during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as substance abuse information for purposes such as treatment, payment and healthcare operations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the practice manager in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

  If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to the practice manager. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Willamette Falls Pediatric Group.

  To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to the practice manager.

  We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete

  If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be 1-2 pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

  To obtain this list, you must submit your request in writing to the practice manager. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to with draw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

  To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to the practice manager.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to the practice manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to 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 it electronically, you are still entitled to a paper copy. (You may also find a copy of this Notice on our web site www.wfpeds.com.)

  To obtain such a copy, contact the practice manager.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice at our location(s) with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at: Office for Civil Rights Region (*Region Covered Entity is located in*)
U.S. Department of Health & Human Services
(*Address, phone number and other related contact information for the OCR office in the region the Covered Entity is located in*)

To file a complaint with Willamette Falls Pediatric Group, contact the manager at 1510 Division Street Suite 280, Oregon City, OR 97045. 503-905-3400.
You will not be penalized for filing a complaint.

U.S. Department of Health and Human Services
2201 Sixth Avenue -M/S:RX-11
Seattle, WA 98121-1831