

Premier Care Pediatrics

16637 Fishhawk Blvd. Suite 101 • Lithia, FL 33547-3800

Phone (813) 657-7337 • Fax (813) 661-4702

<http://www.premiercareped.com>

Welcome to Premier Care Pediatrics!

Your Child's Premier Medical Home

What is a Patient-Centered Medical home?

- **Patient-centered:** Premier Care Pediatrics ensures that there is special relationship between the providers and the patients and their families. We respect the wants, needs and personal preferences of our children and their families, and we will supply you with the education and support to help with decisions in your child's care.
- **Comprehensive:** Premier Care Pediatrics provides a team of care providers who take responsibility for your child's physical and mental health care needs which include acute and chronic care, as well as preventative and wellness care. In order for us to provide comprehensive and quality care, please be prepared to provide a complete medical history including any new visits to specialists or recent hospitalizations so we may continue to deliver comprehensive care to your child.
Behavioral health concerns can be addressed at an individualized appointment with your child's selected personal clinician. Depending on your child's needs, further management and collaboration with outside services may be recommended.
- **Coordinated:** Premier Care Pediatrics organizes care across all health care systems, including specialty care, hospitals, community services and support groups. We strive to maintain a complete medical record for your child, therefore any of our new patients, or established patients that have seen or used services that also follow your child's care, please request a medical records release from our receptionist so that we may maintain continuity of care for your child.
- **Accessible:** Premier Care Pediatrics patients and their families are able to access services with shorter waiting times, access to "after hours" care at local facilities, 24/7 electronic (via patient portal) and telephone access.

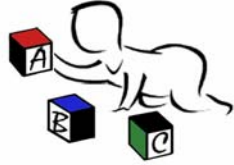
Premier Care Pediatrics gives equal access to all patients regardless of source of payment. (If you are currently looking for insurance coverage for your child, please contact our office manager for information about obtaining coverage.)

Dr. Minick and Dr. Pruitt have a rotating call schedule, and one of them is available after hours by calling the office phone number (813-657-7337) and leaving a detailed message.

- **Committed to quality and safety:** Premier Care Pediatrics care team guarantees that patients and families will have access to evidence based care, patient and family educational materials, and self-management tools. We seek quality improvement measures to enhance the care for your child.

Thank you for choosing Premier Care Pediatrics as your child's medical home!

Dr. Minick and Dr. Pruitt



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PATIENT PORTAL

As we continue in our efforts to provide you, our patients, with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of but also involved in the maintenance and improvement of your health.

To that end, we are proud to announce that our practice now offers you the opportunity to use the power of the web to track all aspects of your health care through our office. The Patient Portal enables our patients to communicate with our practice easily, safely, and securely over the Internet.

Our patient portal can be accessed from our website (<http://www.premiercarepeds.com>), directly by visiting <https://health.healow.com/premiercarepeds>, or via the Healow app from your phone

Through the Patient Portal, you will be able to

- View or download your medical records: This includes labs, imaging, visit summaries for each visit, personal health record, referrals, immunization history, growth charts
- View and/or update your personal information
- View your statements
- Send messages to our staff including refill requests, lab or referral requests, or ask a non-emergent question of your physician
- View your upcoming and past appointments
- Fill out certain questionnaires before your visit
- View educational handouts specific to your visit that have been provided by your physician or access the database to search for health information on your own

We ask that you please activate your account today so you can begin utilizing this free service to play an active role in your/your child's health. We will be utilizing the portal to send out reminders, post lab results, and provide you with easy access to your personal health record 24 hours a day. If you have any questions regarding this service, how to use the portal, or have any issues logging in, please contact our office at (813) 657-7337.

We look forward to helping you to participate in this great service.

Sincerely,

Dr. Minick, Dr. Pruitt, and staff



Premier Care Pediatrics
NEW PATIENT INFORMATION

PATIENT

Today's Date ____ / ____ / ____

Name: Last _____ First _____ Middle Initial _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) ____-____ Cell Phone (____) ____-____
 Work Phone (____) ____-____ Ext. _____
 Permission to Leave Message Home Yes No Work Yes No
 Current Pediatrician _____ School _____
 Date of Birth ____ / ____ / ____ Sex F M Social Security # ____ - ____ - ____
 Employer (if any) _____ Address _____

PARENT/GUARDIAN

Relationship to Patient _____ Email _____
 Name _____ Address _____
 City _____ State _____ Zip _____ Home Phone (____) ____-____
 Cell Phone (____) ____-____ Social Security # ____ - ____ - ____ Date of Birth ____ / ____ / ____
 Employer _____ Address _____
 City _____ State _____ Zip _____ Phone (____) ____-____ Ext. _____

EMERGENCY CONTACT

Relationship to Patient _____
 Name _____ Address _____
 City _____ State _____ Zip _____
 Home Phone (____) ____-____ Work Phone (____) ____-____ Ext. _____

AUTHORIZATION TO RELEASE INFORMATION TO:

Name _____ Relationship to Patient _____
 Home Phone (____) ____-____ Work Phone (____) ____-____ Ext. _____
 Address _____ City _____ State _____ Zip _____
 Name _____ Relationship to Patient _____
 Home Phone (____) ____-____ Work Phone (____) ____-____ Ext. _____
 Address _____ City _____ State _____ Zip _____

Pharmacy _____ Address _____
 Phone (____) ____-____ Fax (____) ____-____

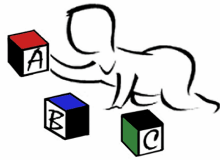
Primary Insurance _____
 Policy Holder Sex F M
 Policy Holder SSN # ____ - ____ - ____
 ID# _____
 Secondary Insurance _____
 Policy Holder Sex F M
 Policy Holder SSN # ____ - ____ - ____
 ID# _____

Policy Holder Name _____
 Policy Holder DOB ____ / ____ / ____
 Policy Holder Relationship to Patient _____
 Group # _____
 Policy Holder Name _____
 Policy Holder DOB ____ / ____ / ____
 Policy Holder Relationship to Patient _____
 Group # _____

 Patient or Guardian Signature

 Relationship to Patient

 Date



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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name: _____ DOB: _____ Phone #: _____

Street Address: _____ City, State, Zip: _____

PLEASE **OBTAIN** INFORMATION **FROM**:

PLEASE **SEND** INFORMATION **TO**:

Name of Provider/Clinic/Organization

Premier Care Pediatrics
Name of Provider/Clinic/Organization

Street Address

16637 Fishhawk Blvd. Suite 101
Street Address

City, State, Zip Code

Lithia, FL 33547
City, State, Zip Code

Phone: _____ Fax: _____

(813) 657-7337 (813) 661-4702
Phone: _____ Fax: _____

I AUTHORIZE the following information to be disclosed: (Please mark all that apply)

- | | | |
|---|---|--------------------------------------|
| <input checked="" type="checkbox"/> Complete Health Records | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Consult Notes | _____ |
| <input type="checkbox"/> Growth Charts | <input type="checkbox"/> Medication History | |
| <input type="checkbox"/> Well Child Visits | <input type="checkbox"/> Date(s) _____ | |

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

EXPIRATION of this Authorization:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

ADDITIONAL PATIENT INFORMATION:

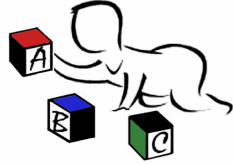
If I fail to specify an expiration date, event or condition, this authorization will expire in ninety days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Guardian Date

Signature of Witness Date

Name of Patient or Guardian Relationship

- Pick-Up Records Mail Records FAX Records



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AUTHORIZATION TO PROVIDE MEDICAL CARE

I, _____, being the parent/guardian of _____, authorize the following list of individuals to consent for treatment of my above mentioned child. I understand that by providing the following information about the individuals, I am allowing Premier Care Pediatrics to verify to the best of their ability the identity of the individual. If at any time I wish to remove a name from this list of persons authorized to consent for medical care of my child, I may do so by requesting a new form, filling it out, and signing again. I also understand that if there is any necessary treatment that requires a major decision be made, Premier Care Pediatrics will make every effort to contact me first. However, if no contact can be made with a parent, and I have authorized the individual to consent for treatment, the individuals listed below have my permission to make decisions for my child's medical care. This authorization will be indefinite and will only expire if I fill out a new form. All individuals listed below will be required to provide at least one form of identification that must include a photograph as well as the information provided below for verification purposes. I understand that this is being done to protect my child's well-being.

The following individuals are authorized by me to consent for treatment:

_____ Name of Individual	_____ Relationship to Patient	_____ Date of Birth
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_____ Name of Individual	_____ Relationship to Patient	_____ Date of Birth
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_____ Name of Individual	_____ Relationship to Patient	_____ Date of Birth
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_____ Name of Individual	_____ Relationship to Patient	_____ Date of Birth
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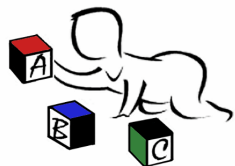
_____ Name of Individual	_____ Relationship to Patient	_____ Date of Birth
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_____ Name of Individual	_____ Relationship to Patient	_____ Date of Birth
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Signature of Parent

Name of Parent

Date



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PARENT'S ACCEPTANCE OF POLICIES

Patient Privacy Practices

By signing here, I am acknowledging that I have received a copy of Premier Care Pediatrics' Patient Privacy Policy. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

Parent or Patient Signature

Date

Patients' Bill of Rights

By signing here, I am acknowledging that I have received a copy of Premier Care Pediatrics' Patients' Bill of Rights. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

Parent or Patient Signature

Date

Patient Responsibilities

By signing here, I am acknowledging that I have received a copy of Premier Care Pediatrics' Patient Responsibilities. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

Parent or Patient Signature

Date

Financial Responsibilities

I understand that I am responsible for payment of this account, and hereby assume and guarantee prompt payment of all expenses occurred. I am also aware that certain services provided may not be covered by my insurance carrier. I understand that Premier Care Pediatrics will make every effort to notify me if services are known to be non-covered, but in the event that services performed are not covered, I will be responsible for payment of these services. I further understand that payment is due at the time of service, including co-payments. I give Premier Care Pediatrics permission to bill my or my child's insurance company on my behalf, and understand that any outstanding balance after my insurance company has paid in full will be my responsibility. If my account becomes past due and has to be turned over to collections, I will be responsible for additional fees to cover agency's fees.

Parent or Patient Signature

Date

Consent to Treat

By signing here, I am consenting to treatment of myself or my dependent by the physicians of Premier Care Pediatrics. I understand that my medical information may be viewed or shared amongst the staff of Premier Care Pediatrics and that every effort will be made by Premier Care Pediatrics to protect my health information as is required by HIPAA regulations.

Parent or Patient Signature

Date

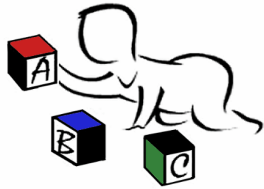
Permission to Release Medical Information

By signing here, I authorize Premier Care Pediatrics to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, third-payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. **This authorization is valid for every visit to Premier Care Pediatrics until written notice revoking this authorization is provided by the patient or patient's legal representative.**

Parent or Patient Signature

Date

If you are signing for the patient, please indicate your relationship here: _____
Relationship to Patient



Premier Care Pediatrics

Patient Privacy Practices

Created on 12/16/2006
Modified on 1/15/2007

Premier Care Pediatrics (the "Practice")

NOTICE OF PRIVACY PRACTICES:

The privacy of your personal and health information is important.

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.

No action on your part is required, unless you have a request or complaint.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. You may call the office and request that a revised copy be sent to you in the mail or request a current copy at the time of your next appointment.

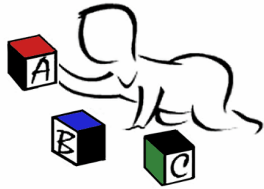
I. HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

A. Uses and Disclosures for Treatment, Payment and Health Care Operations: We collect health information from you and store it in an electronic chart. This is your medical record. The medical record is the property of the practice, but the information in the medical record belongs to you. We protect the privacy of your health information. The law permits us to use or disclose your health information for the purposes of treatment, payment and health care operations. Following are examples of the types of uses and disclosures of your PHI that the physician's office is permitted to make:

Treatment. We may use or disclose your PHI to physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment. We may use or disclose your PHI to obtain payment for your health care services. For example, obtaining approval for services may require that your PHI be disclosed to your health plan.

Health Care Operations. We may use or disclose your PHI or a limited data set in order to operate our practice. For example, we may use your PHI in order to evaluate the quality of health care services that you receive or to evaluate the performance of those who provide health care services to you. We may also provide your PHI to consultants in order to make sure we are complying with the laws that affect us. We may ask you to sign in at our front desk, and also call you by name when your physician is ready to see you.



Patient Privacy Practices

Created on 12/16/2006
Modified on 1/15/2007

B. Others Involved In Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

C. Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

D. Other Permitted and Required Uses and Disclosures that may be made without your authorization or opportunity to object: We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required by law, legal proceedings, or law enforcement. We make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with crime; or when ordered in a judicial or administrative proceeding.

Public Health. As required by law, we may release PHI or a limited data set to public health authorities for purposes related to preventing or controlling disease, injury or disability; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. We are required to report all births and deaths to the office of vital statistics for certificate purposes.

Health Oversight Activities. We may disclose your health information to assist the government when it conducts an investigation or inspection of a health care provider or organization. We are required to disclose PHI, upon request, to the Secretary of the Department of Health & Human Services so they can determine our compliance with privacy laws.

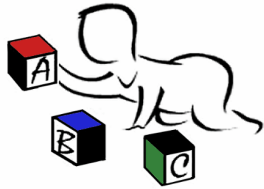
Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or Privacy Board.

Public Safety. We may disclose your health information or limited data set to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specific Government Functions. We may disclose your health information for military, national security, and prisoner purposes.

Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or to give information about other treatments or health-related benefits



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Patient Privacy Practices

Created on 12/16/2006
Modified on 1/15/2007

and services that may be of interest to you. For example, your name and address may be used to send you a newsletter.

Florida State Specific Requirements. When Florida's laws are more stringent than federal privacy laws, the state law preempts the federal law.

Diagnostic and therapeutic information regarding psychiatric, drug/alcohol abuse or sexually transmitted diseases (including HIV status) will not be disclosed without your specific permission, unless required by law.

II. WHEN WE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If we obtain an authorization from you to use or disclose your health information for other purposes, you may revoke your authorization in writing at any time except to the extent that your physician or your physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

III. YOUR HEALTH INFORMATION RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

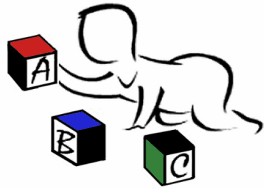
You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Your request for a copy must be in writing and you may be assessed a charge to cover the expenses related to providing the information.

You have the right to request restriction on certain uses and disclosures of your protected health information. We will consider your request, but are not required to accept it. These requests must be in writing.

You have the right to obtain a paper copy of this notice from us, upon request.

You have the right to choose how you receive your health information. You have the right to ask that we send information to you at an alternative address (for example e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. These requests must be in writing. You may be assessed a charge for this accommodation.

You have a right to request that we correct or update information that is incorrect or incomplete. We are not required to change your health information. If we deny your request, we will provide you with information about our denial and how you can disagree with the denial. These requests must be in writing.



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Patient Privacy Practices

Created on 12/16/2006
Modified on 1/15/2007

You have a right to receive a list of disclosures we have made, such as disclosures required by law, disclosures to government officials, and disclosures for workers' compensation. This request must be in writing and must state the time period. The time period requested may not be longer than six years. We may charge you for the costs of providing the list. 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.

IV. QUESTIONS

If you have questions about any part of this notice, or if you want more information about our privacy practices, please contact the office manager at Premier Care Pediatrics.

V. INCIDENTAL DISCLOSURES

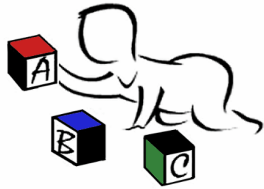
We make reasonable efforts to avoid incidental disclosures of your protected health information. An example of an incidental disclosure is conversations that may be overheard between you and our team members.

V. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the President/Vice President of Premier Care Pediatrics. To file a complaint with us, contact our office at (813) 657-7337, or premier@premiercareped.com. **You will not be penalized for filing a complaint.**

VI. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to change this Notice of Privacy Practices at any time in the future. We reserve the right to make the changed notice effective for health information we already have about you as well as any we receive in the future. We will post a current copy of the Notice. In addition, you may obtain a copy of the current notice in effect upon request.



Premier Care Pediatrics

Patients' Bill of Rights

Created on 12/16/2006
Modified on 1/15/2007

I. Information Disclosure

You have the right to receive accurate and easily understood information about your health plan, health care professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, assistance will be provided so you can make informed health care decisions.

II. Choice of Providers and Plans

You have the right to a choice of health care providers that is sufficient to provide you with access to appropriate high-quality health care.

III. Access to Emergency Services

If you have severe pain, an injury, or sudden illness that convinces you that your health is in serious jeopardy, you have the right to receive screening and stabilization emergency services whenever and wherever needed, without prior authorization or financial penalty.

IV. Participation in Treatment Decisions

You have the right to know all your treatment options and to participate in decisions about your care. Parents, guardians, family members, or other individuals that you designate can represent you if you cannot make your own decisions.

V. Respect and Nondiscrimination

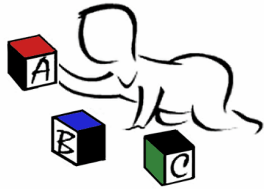
You have a right to considerate, respectful and nondiscriminatory care from your doctors, health plan representatives, and other health care providers.

VI. Confidentiality of Health Information

You have the right to talk in confidence with health care providers and to have your health care information protected. You also have the right to review and copy your own medical record and request that your physician amend your record if it is not accurate, relevant, or complete.

VII. Complaints and Appeals

You have the right to a fair, fast, and objective review of any complaint you have against your health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the conduct of health care personnel, and the adequacy of health care facilities.



Premier Care Pediatrics

Patient Responsibilities

Created on 01/12/2007
Modified on 01/13/2007

A patient is responsible for:

- Providing to your healthcare provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his health;
- Reporting unexpected changes in your condition to his healthcare provider;
- Reporting to your healthcare provider whether he comprehends a contemplated course of action and what is expected of you;
- Following the treatment plan recommended by your health care provider;
- Keeping appointments and, when you are unable to do so for any reason, for notifying the healthcare provider or healthcare facility;
- Assuring that the financial obligations of your healthcare are fulfilled as promptly as possible;
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow your healthcare provider's instructions.
- Following healthcare facility rules and regulations affecting patient care and conduct.

You may request a copy of this law from your health care provider.