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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with your state 's laws and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. Coastal Pediatric Group uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Coastal Pediatric Group.

2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Coastal Pediatric Group

3. I have the right to revoke this authorization at any time by writing to Coastal Pediatric Group. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.

6. This authorization expires one year from the date of my signature below.

7. THIS AUTHORIZATION DOES NOT AUTHORIZE COASTAL PEDIATRIC GROUP TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

_____ _____

Signature of Patient or representative authorized by law Date

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Please note the following updates to our office procedures. There are charges that your insurance allows, but unfortunately, they will not always pay for these services. We will do our best to ensure accurate documentation and coding to your insurance company. Also, please know that we follow the AAP guidelines for the highest standard of care. We will do everything to continue to provide the excellent and personalized care that we always have.

For each new patient to the practice, we collect and thoroughly review past medical records. Some insurance companies pay for all or part of this process; some do not. We will bill you no more than $25 for the remainder of the charges not covered by your insurance company.

You will be offered forms such as school sports physical forms, daycare forms, camp forms, etc. at your physical/well child visit and we will provide complimentary email copies upon request. There will be a $10 fee for any additional paper or fax copied request.

We encourage you to call or email us after hours/weekends if you have an urgent medical question or need immediate advice. Often, we save you a trip to the ER/Urgent Care. Some insurance companies will pay us for telephone patient care, some will not. We will bill you a maximum of $18 for the remainder of the charge that is not covered by your insurance.

If you miss an appointment or call on the same day to cancel, you will be charged $50. Please call no later than 24 hours before an appointment to avoid this charge.

For patients with more complex medical conditions and diagnoses requiring referrals to specialist(s), we will bill your insurance company for time spent coordinating specialists' services. Your insurance company may or may not pay a portion of these fees; you will be responsible for the remaining balance.

We will file your insurance claim to obtain payment for our services. Unfortunately, there are times where your insurance company will delay payment. If your insurance company hasn't made payment to us within 60 days of our claim, you will be responsible for the bill. We will reimburse you if they make a payment to us.

The entire Coastal Pediatric Group team truly appreciates you bringing your child to our practice and trusting your child's healthcare to us.

I have read and understand the above:

Patient(s) name(s) _____

Parent/Responsible and party signature: _____

Date of signature: _____

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Immunization Policy

At Coastal Pediatric Group, Dr. Buchholz and Dr. Sprenkle feel that immunizations are an extremely important part of your child's healthcare. We immunize our patients on time, according to the recommended CDC schedule. Therefore, we have an office policy that children need to be immunized and receive the immunizations on time with no delays.

I plan to immunize my child, _____, according to the recommended CDC schedule. I understand that this is the policy of Coastal Pediatric Group and if I decide not to not immunize him/her or change to an alternate schedule, I will be asked to find another health care provider for my family even if other children in the same family are fully up to date.

Parent signature _____

Date _____

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PARENT'S ACCEPTANCE OF POLICIES

Patient Name: _____

Patient Privacy Practices

By signing here, I am acknowledging that I have received a copy of Coastal Pediatric Group's Patient Privacy Policy. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. I understand that my medical information may be viewed or shared amongst the staff of Coastal Pediatric Group and that every effort will be made by Coastal Pediatric Group to protect my health information as is required by HIPAA regulations. 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 Coastal Pediatric Group' 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 Coastal Pediatric Group's 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 Coastal Pediatric Group 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 Coastal Pediatric Group permission to bill my or my child's insurance company on my behalf. I hereby assign all medical benefit to which I am entitled to Coastal Pediatric Group. I hereby authorize and direct my insurance carrier to issue payment check(s) directly to Coastal Pediatric Group for medical services rendered to my dependents. I 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

Permission to Release Medical Information

By signing here, I authorize Coastal Pediatric Group 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 Coastal Pediatric Group 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

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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 Coastal Pediatric Group 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, Coastal Pediatric Group 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:IF NONE PUT N/A IN ALL FIELDS

Name of Individual	Relationship to Patient	Phone Number
Name of Individual	Relationship to Patient	Phone Number

Signature of Parent **Name of Parent** **Date**

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Coastal Pediatric Group (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.

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

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.

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 Coastal Pediatric Group.

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 Coastal Pediatric Group. To file a complaint with us, contact our office at (850) 659-6556, or info@coastalpediatricgroup.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

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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 compliant 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.

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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 your;
- 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.

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SMS TEXT MESSAGING TERMS and CONDITIONS

By signing up for text messages, you agree to receive informational messages (appointment reminders, account notifications, etc.) from Coastal Pediatric Group at the number provided. Message frequency varies. Msg & data rates may apply. If you require assistance, reply HELP, or you can call (850) 659-6556 or email us at frontdesk@coastalpediatricgroup.com to reach our office. You can opt-out at any time by replying STOP.

SMS TEXTING PRIVACY POLICY

USER CONSENT

By using Coastal Pediatric Group's services, including signing up for text message communications, you expressly consent to collecting, using, and sharing your personal information as outlined in our Privacy Policy. You acknowledge that you have read, understood, and agree to our Terms of Service and Privacy Policy, including the terms related to data collection, communication, and security.

You further consent to receive text messages from Coastal Pediatric Group, including general and/or promotional messages. You may opt out of receiving general and/or promotional messages at any time by following the opt-out instructions provided in the messages. Your continued use of our services constitutes your ongoing consent to these terms.

No Mobile information will be shared with third parties or affiliates for marketing or promotional purposes. All the above categories exclude text messaging originator opt-in data and consent; this information will not be shared or sold to any third parties.

OPT-OUT

You may choose to stop receiving general and/or promotional text messages from Coastal Pediatric Group at any time. To opt out, simply reply to any text message you receive from us with the word 'STOP' or 'UNSUBSCRIBE.' Once we receive your opt-out request, we will promptly remove your number from our general and/or promotional messaging list. Please note that opting out of general and/or promotional messages will not affect your ability to receive important service-related communications.

MESSAGE FREQUENCY AND CONTENT

By subscribing to Coastal Pediatric Group's text messaging, you agree to receive messages including but not limited to appointment reminders, billing information, test results, and other medical-related communications. Message frequency may vary based on your preferences or activity. Message and data rates may apply. You can opt out of receiving these messages at any time by following the instructions provided in each message.

LIABILITY and DISCLAIMERS

Coastal Pediatric Group is not responsible for any delays, failures in delivery, or any other issues related to the transmission or receipt of text messages. Delivery of text messages is subject to effective transmission by your mobile carrier and is not guaranteed by Coastal Pediatric Group. By subscribing to our SMS services, you acknowledge and agree that Coastal Pediatric Group will not be liable for any damages, losses, or injuries arising from or related to the use or failure to receive any text messages, including but not limited to, delays, non-delivery, or technical issues. Your use of our SMS services is at your own risk, and we provide our services on an 'as-is' basis without any warranties of any kind, express or implied.

DATA SECURITY and INFORMATION HANDLING

Coastal Pediatric Group is committed to protecting the security of your personal information. We implement industry-standard security measures to safeguard your data against unauthorized access, use, or disclosure. However, it is also your responsibility to protect the confidentiality of your account information and any passwords associated with your use of our services.

You agree to notify Coastal Pediatric Group immediately of any unauthorized use of your account or any other security breach. Coastal Pediatric Group will not be liable for any loss or damage arising from your failure to protect your account or personal information adequately. By using our services, you acknowledge and accept that no data transmission over the Internet

or mobile networks can be guaranteed to be 100% secure, and therefore, you use our services at your own risk.

PRIVACY POLICY

Coastal Pediatric Group collects personal information from you when you interact with our services, including when you sign up or communicate with us via text messages. The types of information we collect may include your name, contact details, and any other information you voluntarily provide.

We use this information to provide, maintain, and improve our services, process transactions, communicate with you, and comply with legal obligations. Your information may be shared with trusted third-party service providers solely for the purpose of operating our business and fulfilling our commitments to you. We do not sell, rent, or share your personal data with third parties for marketing purposes without your explicit consent.

You have the right to access, correct, or delete your personal information at any time, and we are committed to handling your data in a secure and transparent manner.

DATA PROTECTION

Coastal Pediatric Group takes the security of your personal information very seriously. We employ industry-standard security measures, including encryption and secure servers, to protect your data from unauthorized access, alteration, disclosure, or destruction. We continuously monitor our systems to ensure your information is safe and secure, and we are committed to maintaining the highest levels of data protection to safeguard your privacy.

EXPLICIT NON-SHARING OF INFORMATION

Coastal Pediatric Group is committed to upholding the highest standards of privacy for all personal information collected through our text messaging services. We do not sell, rent, distribute, or trade your personal data to third parties without your explicit consent unless legally required to do so. Any information shared with third parties is exclusively for the purpose of delivering our services to you. We assure you that your data will never be shared with third parties for marketing purposes.

OPT-OUT INSTRUCTIONS

If you no longer wish to receive text messages from us, you can opt out at any time by replying with the word ‘STOP’ or ‘UNSUBSCRIBE’ to the number from which you received the message.

Upon receiving your request, we will promptly remove you from our messaging list, and you will no longer receive further text communications from us.

CHANGES TO THE PRIVACY POLICY

Coastal Pediatric Group may update this Privacy Policy from time to time to reflect changes in our practices or legal requirements. When we make changes, we will notify you by updating the "Last Updated" date at the top of this policy. In the event of significant changes, we will provide a more prominent notice, such as sending an email notification or displaying a notice on our website.

By continuing to use our services after these changes, you agree to the revised Privacy Policy. We encourage you to periodically review this policy for the latest information on our privacy practices.

Acknowledgment: By signing below, I acknowledge that I have read and understood the contents of this form, and I consent to receive text messages as described above.