Briarcliff Pediatrics, P.C.
2849 Henderson Mill Rd, Suite A
Atlanta, GA 30341 (770) 939-7676

HOW DID YOU HEAR ABOUT BRIARCLIFF PEDIATRICS? _____

PATIENT'S NAME: _____ TODAY'S DATE: _____

BIRTHDATE: _____ SEX: _____ PHONE: (_____) _____

STEET ADDRESS: _____

CITY/STATE: _____ ZIP CODE: _____ COUNTY: _____

PARENTS/GUARDIAN

PARENT'S NAME (1):_____ BIRTHDATE: _____ MARITAL STATUS: _____

STREET ADDRESS: _____ PHONE: (_____) _____

CITY/STATE: _____ ZIP CODE: _____ COUNTY: _____

EMPLOYER: _____ WORK PHONE: (____) _____ EXT: _____

PARENT'S NAME (2): _____ BIRTHDATE: _____ MARITAL STATUS: _____

STREET ADDRESS: _____ PHONE: (_____) _____

CITY/STATE: _____ ZIP CODE: _____ COUNTY: _____

EMPLOYER: _____ WORK PHONE: (____) _____ EXT: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____ POLICY HOLDER: _____

MEMBER ID# _____ GR. # _____

CLAIMS ADDRESS: _____ PHONE: (____) _____

CITY/STATE: _____ ZIP CODE: _____

METHOD OF PAYMENT: ___ VISA/MC ___ CASH

COPAY $ _____ DEDUCTIBLE $ _____ ___ AMEX ___ CHECK

AUTHORIZATION & RELEASE

I AUTHORIZE THE DOCTOR TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENTS OR EXAMINATIONS RENDERED TO MY CHILD DURING THE PERIOD OF SUCH CARE TO THE THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. MY SIGNATURE BELOW INDICATES THAT I HAVE BEEN PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DOCTOR INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR ALL SERVICES RENDERED ON MY BEHALF OR FOR MY DEPENDENTS.

I ALSO UNDERSTAND THAT BRIARCLIFF PEDIATRICS HAS A NO SHOW POLICY REGARDING MISSED APPOINTMENTS, WHICH IS ON THEIR WEBSITE, AND AGREE TO ABIDE BY THIS POLICY.

THE PARENT/LEGAL GUARDIAN MUST ACCOMPANY CHILD FOR ALL WELL CHILD CHECK UPS.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

***By submitting your completed forms via email , you are acknowledging that you are sending protected health information via non-encrypted email and there is a risk that your health information could be compromised.

Briarcliff Pediatrics, P.C.
2849Henderson Mill Rd.
Suite A
Atlanta, GA 30341
(770) 939-7676

AUTHORIZATION FOR TREATMENT OF A CHILD (for Sick visit only)
IN THE ABSENCE OF PARENT OR LEGAL GUARDIAN

Parent/Legal Guardian must accompany child for all Well Child Check-ups.

Child's name: _____ Date of Birth: _____

Authorization given to:

1. Adult's name: _____ Relation to Child: _____

2. Adult's name: _____ Relation to Child: _____

I, the undersigned parent or legal guardian of the above named child, give permission to the adult(s) named above to act on my behalf to obtain medical care and treatment needed for my child as deemed advisable by Dr. Raymond Deeb, M.D.

Parent or Legal Guardian: _____ Signature: _____

Relationship to Child: _____ Date: _____

***By submitting your completed forms via email , you are acknowledging that you are sending protected health information via non-encrypted email and there is a risk that your health information could be compromised.

Briarcliff Pediatrics, P.C.

"For A Healthy Journey Through Childhood"

Raymond Deeb, M.D.

Ashley Brown, M.D.

2849 Henderson Mill Road
Suite A
Atlanta, GA 30341
Phone (770) 939-7676
Fax (770) 939-7620

Medical Records Request Form

Previous Doctor Info:

Patient Name/ D.O.B

I, _____, Authorize _____

TO FORWARD MY CHILD'S RECORDS TO: **Briarcliff Pediatrics, P.C.**
2849 Henderson Mill Road, Suite A
Atlanta, GA 30341
Phone 770-939-7676

Please mail the records to us. Thank you.

I understand this authorization includes releases of all medical records including HIV records, Psychiatric Mental Illness, Drug/Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof.

Parent/ Guardian Signature: _____Date: _____

***By submitting your completed forms via email , you are acknowledging that you are sending protected health information via non-encrypted email and there is a risk that your health information could be compromised.

Briarcliff Pediatrics' Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW 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 Dr. Raymond Deeb at 770.939.7676 or 2244 Henderson Mill Rd. Suite 108, Atlanta GA, 30345.

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by healthcare providers you consult with by telephone (when your regular healthcare provider from our office is not available) who provide "call coverage" for your healthcare provider.

Understanding Your Health Record/Information

Each time you visit Briarcliff Pediatrics a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third party payer can verify that services billed were actually provided
- a tool in educating heath professionals;
- a source of data for medical research;
- a source of information for public health officials charged with improving the health of the nation;
- a source of data for facility planning and marketing and
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.
- ensure its accuracy

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact our Privacy Official, Dr. Raymond Deeb at 770.939.7676.

If you believe your privacy rights have been violated, you can file a complaint with the Director of Health Information Management or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of the members of your healthcare team. Members of your healthcare team will then record

***By submitting your completed forms via email , you are acknowledging that you are sending protected health information via non-encrypted email and there is a risk that your health information could be compromised.

the actions they took and their observations. In that way the physician will know how you are responding to treatment.

We will also provide your consulting physicians and/or consulting healthcare providers with copies of various reports that should assist him/her in treating you as we see best for your optimal care.

We will use your health information for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations. For example: Members of the Briarcliff Pediatrics staff, or the risk or quality improvement manager, may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

We will use your health information for appointment reminders. We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Other Uses or Disclosures

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you/your child in response to a court or administrative order. Subject to all applicable legal requirements, we may disclose health information about you in response to a subpoena.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fund Raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

_____
Signature of Patient or Legal Representative

_____**Date**

If signed by legal representative, relationship to patient:

_____

Effective Date:

Distribution: Original to provider; copy to patient if requested.

***By submitting your completed forms via email , you are acknowledging that you are sending protected health information via non-encrypted email and there is a risk that your health information could be compromised.