Porter Pediatrics
754 Tremont Street, Boston, MA

Patient information:

Last Name:	**First Name:**	**Middle Initial:**	
Date of Birth:	**Sex:**	**Social Security #:**	
Home Street Address:	**City:**	**State:**	**Zip Code:**

Parent/Guardian Information:

Parent/Guardian living with Child:

Last Name:	**First Name:**	**Middle Initial:**	
Date of Birth:	**Social Security #:**	**e-mail address:**	
Home Street Address:	**City:**	**State:**	**Zip Code:**
Employer:	**Home Phone**	**Work Phone**	**Cell Phone**

Other Parent/Guardian

Last Name:	**First Name:**	**Middle Initial:**	
Date of Birth:	**Social Security #:**	**e-mail address:**	
Home Street Address:	**City:**	**State:**	**Zip Code:**
Employer:	**Home Phone**	**Work Phone**	**Cell Phone**

Insurance Information:

Primary Insurance

Company Name:	**Policy ID #:**	**Group #:**	
Address:	**City:**	**State:**	**Zip Code:**
Last Name:	**First Name:**	**Middle Initial:**	

Secondary Insurance:

Company Name:	**Policy ID #:**	**Group #:**	
Address:	**City:**	**State:**	**Zip Code:**
Last Name:	**First Name:**	**Middle Initial:**	

I authorize the release of any medical information necessary to process insurance claims and the release of information back to my physician. I also authorize payment of medical benefits to Porter Pediatrics for services rendered. In the event that my medical insurance does not pay for the services rendered, I agree to pay Porter Pediatrics the usual and customary fees for these services.

Please make sure the front office has a copy of your insurance card.

Signed: _____ Date: _____

Porter Pediatrics is committed to providing you with the best care. Your clear understanding of our Financial Policy is important to our professional relationship. Please feel free to reach out to us if you have any questions regarding our fees, financial policy, and/or your financial responsibility.

ALL FINANCIAL RESPONSIBLE PARTIES MUST READ AND SIGN THIS AGREEMENT BEFORE THE PATIENT CAN BE TREATED BY ONE OF OUR PHYSICIANS.

Please verify, prior to appointment, your individual insurance benefits regarding copays, deductibles, or co-insurance.

Patient's Name: _____ DOB ____/____/_____

APPOINTMENTS: Effective September 1, 2021 If the patient cannot keep their appointment, you must give a 24-hour notice. If the patient does not arrive within the first 10 minutes of your appointment, you will be charged a $25 no show/late cancellation fee. More than 4 no-show appointments could result in being discharged from the practice. This includes in-person and virtual appointments.
_____ By initialing, I agree with the above policy.

CO-PAYMENTS: By law, we must collect your designated co-payment. This payment is expected at the time of service. Please be prepared to pay your co-payment at each visit.
_____ By initialing, I agree with the above policy.

PATIENT BALANCES: You will be responsible for any balance your plan indicates as patient responsibility on their explanation of benefits form. We will adjust the charges to coincide with your plan's charges. All patients will be responsible for their co-insurance and deductible. If your insurance plan does not pay due to an issue with eligibility or you did not inform us within 15 days of a change in your insurance, you will be responsible for the entire balance.
_____ By initialing, I agree with the above policy.

SELF-PAY PATIENTS: Payment is required at the time of service unless other financial agreements have been made prior to your visit.
_____ By initialing, I agree with the above policy.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS: I, _____, am the financially responsible parent and all statements will be paid by me. If I will not be at the appointment, I agree to pay any balances prior

to the appointment via cash, credit card over the phone, or authorizing Porter Pediatrics to keep my credit card on file (see attached authorization form). Porter Pediatrics will not be involved with separation or divorce disputes. It is the responsibility of ALL PARENTS to communicate with each other regarding the patient's care.
_____ By initialing, I (Parent #1) agree with the above policy.
_____ By initialing, I (Parent #2) agree with the above policy.

FORMS/MEDICAL RECORDS: Effective September 1, 2021 All forms that need to be completed and/or signed must be dropped off at the office, faxed, or mailed in. Once received, you may pick up the forms after 3 business days or will be mailed to your home address. A $15 fee must be paid in advance for each form required. All medical records requests will be available for pick up or will be mailed to the patients address after 7 business days. A $25 fee must be paid in advance for each medical records request. No charge if the medical records request is faxed to another treating physician's office. Due to HIPAA regulations, forms and records will NOT be emailed.

WE ACCEPT CASH, CHECKS, AND MOST MAJOR CREDIT CARDS. Thank you for taking the time to review our policies. Please feel free to ask questions or share with us specific concerns.

_____ Date Signed: ____/____/____
Parent/Legal Guardian's Signature

Relationship to Patient: _____

Phone #: _____

_____ Date Signed: ____/____/____
Parent/Legal Guardian's Signature

Relationship to Patient: _____

Phone #: _____

Porter Pediatrics
354 Tremont St
Boston, MA 02116
Phone: 617-426-9200
Fax: 617-426-9201
www.porterpeds.com

Notice of Privacy Practices

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in regard to your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Devina Aggarwal, Practice Manager
frontdesk.porterpeds@gmail.com 617-426-9200

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice will use and disclose your PHI to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party that already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We will also disclose PHI to other physicians who may be treating you when we have the necessary permission from you to disclose your PHI. 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 diagnosis or treat you. In addition, we may disclose your PHI from time-to-time to another physicians or health care provider (such as specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

2. Payment. Our practice will use and disclose your PHI to obtain payment for your health care services. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we use a sign-in sheet at the registration desk where you will be asked to sign your name. We will also call you by name in the reception area when you physician is ready to see you. Our practice may use and disclose your PHI to contact you and remind you of an appointment. Additionally, any pictures sent to the office during the year may be posted on the picture board located near checkout, which is changed annually in December. We will share your PHI with third party "business associates" that perform various activities for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that will protect the privacy of your PHI.

4. Authorized Release of Information. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care.

5. Treatment Options/Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives. Also, our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to

send you a newsletter about our practice and the services we offer. You may contact our HIPAA Manager to request that these materials not be sent to you.

6. Release of Information to Family/Friends. If a parent or guardian is unable to accompany their child(ren) to a scheduled appointment and choose to send a personal representative (a member of your family, a relative, a close friend or any other person you identify) we may share PHI that is directly related to the visit and that member's involvement in your child(ren)'s care. For example, a parent or guardian may ask that a babysitter take their child(ren) to the pediatrician's office for treatment of a cold. In cases where there is a request for medical information from a non-custodial parent, the custodial parent shall be notified provided documentation supporting sole custody of the child(ren) is on file with our office.

7. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law. You will be notified, as required by law, of any such uses or disclosure.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your PHI:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

• maintaining vital records, such as births and deaths
• reporting child abuse or neglect
• preventing or controlling disease, injury or disability
• notifying a person regarding potential exposure to a communicable disease
• notifying a person regarding a potential risk for spreading or contracting a disease or condition
• reporting reactions to drugs or problems with products or devices
• notifying individuals if a product or device they may be using has been recalled
• notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
• notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if requested to do so by law enforcement official:
• Regarding a crime victim in certain situations, if we are unable to obtain the personal representative's agreement, if appropriate
• Concerning a death we believe has resulted from criminal conduct
• Regarding criminal conduct at our offices
• In response to a warrant, summons, court order, subpoena or similar legal process
• To identify/locate a suspect, material witness, fugitive or missing person
• In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. Coroners, Funeral Directors, and Organ Donation. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
6. Research. Our practice may disclose your PHI 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 you PHI.
7. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
8. Military and National Security. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
9. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
10. Workers' Compensation. Our practice may disclose your PHI for workers' compensation and similar programs as required to comply with workers' compensation laws.

E. YOUR RIGHTS REGARDING YOUR PHI
You have the following rights regarding the PHI that we maintain about you:
1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to our HIPAA Manager specifying the requested method of contact, or

the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to our HIPAA Manager. Your request must describe in a clear and concise fashion:
(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes, information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. You must submit your request in writing to our HIPAA Manager in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our HIPAA Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our HIPAA Manager. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the

same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our HIPAA Manager.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our HIPAA Manager. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our office 354 Tremont Street, Boston, MA 02116

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CREDIT CARD AUTHORIZATION FORM

Patient Name: _____ DOB ___/___/____

Address: _____

City: _____ State: _____ Zip Code: _____

Credit Card Information:

____ Visa ____ MasterCard ____Discover

Credit Card Number: _____

Expiration Date/Year: _____/_____ CVV: _____ Zip Code: _____

Amount Paid: $_____ One-Time Payment: ____ -OR-

Recurring Payment: _____ Weekly (every Tuesday) _____ Monthly (__1st ____ 15th)

- If payment date falls on a weekend or holiday, payment will be run the business day prior

Please mail a receipt to the above address _____ YES _____ NO

I, _____, authorize Porter Pediatrics to run my credit card for the above noted payment agreement.

_____ _____

Signature Date