



Your family matters

10330 Meridian Ave N, Ste 210
Seattle, WA 98133

t : 206.368.6080 f : 206.368.6088
northseattlepeds.com

Dear Patient:

When you turn 18 years old, seeking medical care is a new responsibility. Your parents can help guide you in this, but now that you are an adult, you have the right and responsibility for your own medical care. This means that you may now seek medical care without your parents knowledge or consent. This also means that you become responsible for your medical records, outstanding balances, and understanding our office policies.

In this packet are a few things you need to know about being responsible for your own medical care and necessary forms you will need to complete.

FORMS:

Patient Portal Registration (included below):

- Please complete this form so that we can create your own patient account on our Patient Portal system. All communication through the portal will come to your email address.

Consent to Use & Disclose Information (included below):

- This form needs to be completed ***only if you want your parent or guardian to have access to your medical record.*** If we do not have this form on file, we will not disclose any medical information to anyone other than you. This form may be rescinded by you at any time.

Policies & Procedures (download separately):

- This form needs to be read and understood by you. By signing this form, you acknowledge that you, as an adult, are responsible for following our policies as outlined in this form. While you may still be on your parent or guardian's insurance policy, any billing statement will be mailed to you under your name.

THINGS TO KNOW:

- Under the Federal Health Information Portability and Accountability Act, or HIPAA, medical records are now records between you and your doctor. Access to your health records and any discussion about your health is only provided to people that you consent to, including your parents. If you wish your parents to discuss your medical concerns with your doctor, you must provide written consent. This form is the Consent to Use & Disclose Information and is in this packet.
- At this age, we encourage you to begin seeking out an adult care provider to take over your medical needs, but we are able to see you at North Seattle Pediatrics until you reach the age of 21.
- Your parents may come to the appointment with you but you will need to check in and sign forms yourself. We will need you to have an insurance card and picture ID at check in time for each visit.
- You will be responsible for any copay and/or outstanding balances to be paid.

Please feel free to talk to your doctor or the staff about any concerns you may have about these changes. We are here to help and are happy to offer assistance if you need it.

The Physicians and Staff of
North Seattle Pediatrics



Your family matters

10330 Meridian Ave N, Ste 210
Seattle, WA 98133

t : 206.368.6080 f : 206.368.6088
northseattlepeds.com

Dear Parent:

Turning 18 years old is an exciting time in your child's life. We would like to help your family through this transition and hope the information provided helps you to understand what it now means for them to be an adult and what that means for your child's health care. We have provided your child with information regarding turning 18 years old, and in order to help you through this process, we are providing you with information as well.

Upon turning 18 years old, your child is considered an adult and is responsible for his or her own health care. We have asked your child to complete a few forms in order to treat them appropriately as an adult. Your child will be given a new patient account, separate from your family account. That account will contain all of his or her medical history and visit details from the time your child turns 18 years old. Their previous medical history and visit details will remain with the family account.

THINGS TO KNOW:

- In the past, we were able to talk with you about your child's health. Now that your child is 18 years old, they are considered an adult and, due to Federal laws, we are not able to discuss anything with you without your child's consent. Your child has been given a Consent to Use & Disclose Health Information form that will allow us to discuss medical concerns with you. Please note, your child does not have to complete the consent form, but if it is not completed we will only be able to talk with your child about his or her care.
- Your child has been given a form to sign up for the Patient Portal. They will be given their own account and any communication through the portal will come to their email address.
- You are still able to call and schedule appointments for your child, and are welcome to attend any appointments with your child, but we are unable to discuss health issues with you without their consent.
- We will still bill your insurance for your child as long as they are eligible for coverage. However, any bills that are sent to your address, will be under your child's name as they are legally responsible for making sure these bills are paid promptly.

These changes are not intended to cause difficulty, however, due to Federal laws, when your child turns 18 years old they become a legal adult. All of these changes are designed to appropriately treat your child as an adult. We recommend you talk with your child about what it means to be responsible for their healthcare.

Please feel free to talk to your doctor or the staff about any concerns you may have about these changes. We are here to help and are happy to offer assistance if you need it.

The Physician and Staff of
North Seattle Pediatrics



Your family matters

10330 Meridian Ave N, Ste 210
Seattle, WA 98133

t : 206.368.6080 f : 206.368.6088
northseattlepeds.com

My Kid's Chart Registration

for 18 years and older

Patient Email address: _____

Patient first name: _____

Patient last name: _____

Phone Number: _____

Once your account is created, you will receive an email with a temporary password that is active for 1 week. You will need to sign into the portal in order to complete your account setup. Be sure to verify that your name appears correctly. You are able to send and receive messages from the staff through this website. Any communication will come to the email address above.

Patient Signature (type your name to sign) :

Date:

THIS FORM CAN BE FAXED TO 206-368-6088 IF COMPLETED OUTSIDE OF THE OFFICE

For office use only

Date account set-up	
Initials	



Your family matters

10330 Meridian Ave N, Ste 210
Seattle, WA 98133

t : 206.368.6080 f : 206.368.6088
northseattlepeds.com

Consent to Use and Disclose Health Information

1) My Authorization

North Seattle Pediatrics may disclose and discuss the following health care information (check all that apply):

All health care information

Health care information relating to these health concerns (ie; ADHD, depression, etc):

Health care information in my medical record for a specific date (ie; well check from 02/25/2016):

These items require specific authorization:

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check any that apply):

HIV/AIDS

Sexually Transmitted Diseases

Mental Health or Illness

Drug and/or Alcohol Abuse

You may disclose this health care information to: _____
(List the names of anyone who may have access to your health information)

This authorization ends:

On this date: _____

When the following event occurs: _____

In 90 days from the date signed

2) My Rights

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by North Seattle Pediatrics in reliance on this authorization before it receives my written revocation. Two ways to revoke this authorization are:

- fill out a revocation form –a form is available from North Seattle Pediatrics **or**
- write a letter to North Seattle Pediatrics.

3) Protection after Disclosure.

I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

Patient signature (type your name to sign)

Date



PATIENT DEMOGRAPHICS

Patient Information

Patient's First Name _____ Middle _____ Last _____ Birth Date _____

Nickname _____ Male _____ Female _____ Preferred Pronouns _____ Primary Physician _____

Parent 1 Name _____ Date of Birth _____

Parent 2 Name _____ Date of Birth _____

Patient lives with: Name(s) _____ Relationship(s) _____

Patient lives at _____
Street Address City State Zip Code

Bills are sent to _____
Name Street Address City State Zip Code

Email Address _____ Owner of Email Address _____

Primary Phone Number _____ Owner of Phone Number _____

2nd Phone Number _____ Owner of Phone Number _____

3rd Phone Number _____ Owner of Phone Number _____

4th Phone Number _____ Owner of Phone Number _____

-
- ☐ I authorize North Seattle Pediatrics to leave a detailed message on my voicemail.
- ☐ I **do not** authorize North Seattle Pediatrics to leave a detailed message on my voicemail.
- ☐ I give permission for North Seattle Pediatrics to text me a message to call back.
-

Ethnicity: Hispanic/Latino Not Hispanic/Latino Prefer not to answer

Race: White _____ American Indian/Alaskan Native _____ Asian _____ Black/African American _____ Native HI/Pacific IS _____ Prefer not to answer _____

Preferred Language _____ Other Language _____

Do you need an interpreter? Yes No What Language _____

Insurance Information

Primary Insurance Name _____ Copay _____

ID Number _____ Group Number _____

Subscriber's Name _____ Birth Date _____ Start Date _____

Employer _____

Secondary Insurance Name _____ Copay _____

ID Number _____ Group Number _____

Subscriber's Name _____ Birth Date _____ Start Date _____

Employer _____

Insurance Authorization and Assignment (Please read and Sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my visits to my insurance carrier.
I understand that I am responsible for my entire bill unless this form is complete.

Parent/Guardian/Patient Signature _____ Date _____

Sign by typing your name for electronically submitted form



Thank you for choosing North Seattle Pediatrics for your medical care.
Please review our policies and procedures below and sign where indicated.

PATIENT NAME: _____

- Patients must arrive 15 minutes before their scheduled appointment time and provide their insurance card, photo ID and insurance copay if applicable at check-in. We have a contractual obligation to your insurance company to collect copays at time of service. Copays not paid at time of service will be assessed a \$15.00 fee.
- A no show or late cancellation fee of \$50 will be charged to patients who do not provide 24 hour notification to cancel an appointment or for patients who miss their appointment. After 3 no shows or late cancelled appointments you may be discharged from the practice.
- If you arrive 15 or more minutes late to your appointment you may be asked to reschedule.
- **If your child is being seen for a Well Child Check and you have other concerns that are not related to routine, wellness care, those concerns may generate other charges to your insurance.**
- Any outstanding balances due to deductibles, co-payments, and services not covered by your insurance are your responsibility. All balances must be paid promptly. If you are unable to pay the balance in full please contact our billing department to make payment arrangements. Non-payment of charges will result in the account being turned over to a collections agency and your family will be discharged from the practice.
- Our phones are open 8:00am-6:00pm Monday-Friday, and 9:30am-12:00pm on Saturdays. After hours, we offer a telephone triage consultation service that puts you in touch with a pediatric-trained triage nurse at Seattle Children's Hospital. Our office is charged for each call placed to this nurse triage service. In order to offset this expense we charge \$10.00 per call which is a portion of this fee. Your insurance will not be billed for this fee and it will be your responsibility.
- Please allow 3 business days for all forms and prescription refill requests.
- North Seattle Pediatrics will use and disclose health information about the patient in compliance with the HIPAA Act. You are entitled to receive a copy of the Notice of Privacy Practices as outlined by Federal Regulations. You have the right to ask that some or all of the patient's health information may not be used or disclosed in the manner described in the Notice of Privacy Practices. North Seattle Pediatrics is not required by law to agree to such requests. Your signature below acknowledges that you are aware of your rights in accordance to HIPAA.
- We keep a record of the health care services we provide your child. You may ask us to see and copy that record (copy charges may apply). You may also ask us to correct that record. We will not disclose your child's record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Contact the Record's Custodian to see the record or to get more information about it.

I, _____, the parent or legal guardian of _____ authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

I acknowledge with my signature that I have read and understand the information above.

Parent/Guardian/Patient Signature

Date



Notice of Privacy Practices

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.

North Seattle Pediatrics respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

1. Your health information rights.

The health and billing records we create and store are the property of **North Seattle Pediatrics**. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices (“Notice”).
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information that is inaccurate or incomplete. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:

Shirley Wirkala, Clinic Administrator
206-368-6079

2. Our responsibilities.

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice for as long as it is in effect.
- Notify you if we become aware of a breach of your unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice, and to make the new privacy practices and notice provisions effective for all of the protected health information we maintain. If we make material changes, we will update and make available to you the revised Notice upon request. You may receive the most recent copy of this Notice by calling and asking for it, by visiting our **office** to pick one up, or by visiting our Web site, if we maintain one.

3. To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Shirley Wirkala
206-368-6079

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to **Shirley Wirkala** at **North Seattle Pediatrics**. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

4. How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information without your permission. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For treatment:

- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
 - Medical quality review by your health plan,
 - Accounting, legal, risk management, and insurance services; and
 - Audit functions, including fraud and abuse detection and compliance programs

For fund-raising communications:

- We may use certain demographic information and other health care service and health insurance status information about you to contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows.

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others:** Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
 - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
 - To public health or legal authorities:
 - To protect public health and safety.
 - To prevent or control disease, injury, or disability.
 - To report vital statistics such as births or deaths.
 - To report suspected abuse or neglect to public authorities.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.

- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA):** For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law.
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

5. **Uses and disclosures that require your authorization.**

Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:

- **Psychotherapy Notes:** if we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.
- **Marketing Communications:** we must obtain your authorization to use or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs, such as refill reminders.
- **Sale of Health Information:** disclosures that constitute a sale of your health information require your authorization.

In addition, other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You have the right to cancel prior authorizations for these uses and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

6. **Web site**

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: **www.northseattlepediatrics.com**

7. Effective date

This Notice is effective as of **September 23, 2013**.