460 Mall Boulevard ▪ Savannah, Georgia 31406
ph 912.354.3400 ▪ fax 912.303.0665
**www.ramonramosmd.com**

## Welcome!

We're glad you have chosen us to be your pediatric care provider. At Ramon Ramos, MD, we offer complete medical services for infants, children, and young adults. Our goal is to help maintain our patients' good health, growth, and development. We strive to develop a personal relationship with each family and focus on the unique and individual needs of each patient. Please read the following information regarding our office policies and procedures and if you have any questions, please do not hesitate to ask one of our staff. We look forward to a long and healthy association with your family.

## Office Hours

Our regular office hours are from 8:30 a.m. – 5:00 p.m., Monday thru Friday. Our office is open on Saturday mornings from 8:30 a.m. – 10:00 a.m. to see sick patients by appointment only.

## Appointments

Our office sees patients by appointment only. We do not see walk-ins. Should an illness arise, please contact our office and we will see your child as soon as possible. We recommend that parents schedule Well Child visits while in our office as our appointment schedule tends to fill up quickly and we want to be able to accommodate your needs.

We will only schedule up to two siblings at a time for Well Child appointments. If you have a sick child appointment and you believe a sibling needs to be seen also, please call to make arrangements for that child to be seen. Adding children on once you arrive at our office causes delays and longer waits for other patients with appointments. If you find it necessary to bring several young children to your appointment, please make every effort to have another adult present.

If your child needs vaccines, they will need to have a current physical on file. We will not administer vaccines during a sick appointment. If your child arrives at a Well Child appointment and is found to be ill, we will not administer vaccines at that time.

We will fill out Sports Physical forms if the patient has had a physical within the past 12 months.

At Ramon Ramos, MD, we value your time and will do our best to keep you from having to wait for scheduled appointments. Please understand, however, that emergencies may arise that can cause delays. It is of utmost importance that you arrive on time for your appointment and kindly provide us with 24 hours of notice if you need to cancel or reschedule. This will allow us an opportunity to see another patient in need. Please read and sign our 'No Show Policy' attached.

We understand that unforeseen events may occasionally cause you to be late for your appointment. As a courtesy, we will allow a 15-minute grace period. Please phone our office if you are running a few minutes late. Anyone arriving more than 15 minutes past their scheduled appointment time will be rescheduled for another appointment. This is necessary to avoid long waits for those who are on time.

We will attempt to remind parents of appointments. However, it is your responsibility to know the date and time of all appointments made with us.

## Telephone Calls

Telephone calls are answered from 8:30 a.m. – noon and from 2:15 p.m. – 5:00 p.m. Monday through Friday by dialing 912/354-3400. Our employees have been instructed on how to process incoming calls. This allows the doctor to maintain his focus on patient care with minimal interruption. If you phone with a medical question that needs to be answered, a staff member will take a message and have a nurse call you back as quickly as possible.

If you have an emergency after office hours, our answering service will contact Dr. Ramos or the provider on call and you will receive a call back as quickly as possible. Please restrict after-hours calls to true emergencies (matters that cannot wait until the office is open again). If you are expecting a call back from us after normal business hours, please be sure to remove any blocks from your phone that prevent private or restricted numbers from calling you. If you have left a message with us, we ask that you remain available to answer your phone. If more than 20 minutes pass and you have not received a returned call, please call our service again as there may have been an error in receiving your correct phone information.

## Personal and Insurance Information

It is your responsibility to keep our office updated on your current address, phone number(s), and insurance information. It is important that we are able to reach you by telephone and by mail.

Insurance cards must be presented at every visit. If you do not have insurance or are unable to provide proof of insurance coverage, full payment is required at the time of service. If we are a participating provider for your insurance, all co-pays and deductible amounts are due at the time of service. It is your responsibility to know what services are covered by your insurance plan. It is the responsibility of the parent or adult accompanying the minor patient to pay at the time of service. In the event of separation or divorce, both parents will be held responsible for payment. Insurance companies require that claims be received in a timely manner. Failure to provide accurate and up-to-date information may result in your claim being rejected and you being responsible for all charges.

Please contact your insurance company and ask these questions:

1. Does my policy have a co-pay? Does it have a deductible (family or individual) and how much is it, if so?
2. Is preventive care covered? (well child exams, immunizations, routine labs)
3. Are sick visits covered?
4. Does my policy have a preferred lab? Are lab tests covered?

## Medical Records and Requests for Documents

All requests for medical records and documents need to be made within 24 hours of the need for their completion and pick-up.

We will provide records to other medical professionals upon receipt of a signed Records Release form free of charge. Complete or partial medical records are available to parents following a signed Records Release form for a minimal fee of $35.00.

Immunization forms (Georgia Form 3231) are provided to parents at the time of immunization free of charge. EED (eye, ear, and dental) forms are provided at the time of examination free of charge. All subsequent copies will be provided for a fee of $5.00.

All other forms that must be filled out and/or signed by Dr. Ramos will be provided for a fee of $5.00.

## Prescriptions

If your child has been prescribed a medication, you will receive a written prescription on the days that Dr. Ramos is in the office. Otherwise, one of our nurses will call the medication into the pharmacy of your choice. Please be aware that we are not always able to speak directly to a pharmacist and may leave a message if necessary. If you are calling after hours and think a prescription may be needed, please have the name and phone number of your pharmacy available. Some medications are not allowed to be phoned in by law and they must be signed for when picked up. Please call at least 24 hours in advance to request a written prescription.

## Waiting Rooms

In an effort to avoid well children being exposed to illness, we have separate waiting rooms for well and sick children. Please do not sit in the well waiting room if your child has had any of the following symptoms in the last 24 hours: fever, vomiting, diarrhea, coughing, green or yellow nasal discharge, rashes or other skin eruptions. Many contagious illnesses do not always have pronounced symptoms. The only exceptions will be for infants less than six months old. Please ask a staff member if you any questions regarding this policy.

We understand that no one wants to expose their child to unknown germs. However, we ask that you do not linger in the hallways to avoid the sick waiting room. As we have limited space and a consistent full schedule, please try to avoid bringing friends and family members to appointments. Children are not to be left unattended in the waiting room.

## Parent Behavior

Parents are expected to behave in a polite and courteous manner at all times while at our office. Outbursts, foul language, and disrespectful behavior will not be tolerated. Any of these actions displayed toward another patient or staff member will be grounds for dismissal from the practice. This includes all correspondence with staff, including telephone calls.

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# PATIENT DEMOGRAPHICS

The person completing this form is considered to be the responsible party.
*La persona que rellena este formulario se considera el responsible*

DATE *(Fecha)* _____

## PATIENT INFORMATION *(Informacion del paciente)*

Patient's name (Nombre del paciente) _____,_____
LAST NAME (Apellido) FIRST (Primer nombre) MIDDLE

Date of Birth (Fecha de Nacimiento) _ _/ _ _/ _ _ _ _ ▢ Male (varon) ▢ Female (hembra)

Ethnicity ▢ Hispanic ▢ Non-Hispanic

Language ▢ Arabic ▢ Cantonese ▢ English ▢ Hebrew ▢Japanese ▢Korean ▢Madarin ▢Russian ▢Spanish

Race ▢ American Indian or Alaska Native ▢ Asian ▢ Black or African American ▢ Middle Eastern
▢ Native Hawaiian or Pacific Islander ▢ White or Caucasian ▢ Other _____

Child lives with: (Con quien vive): ▢ mother (madre) ▢ father (padre) ▢ both (los dos) ▢ other (otro) _____

## MOTHER'S INFORMATION *(Informacion del madre)*

Mother's Name (Nombre de la madre) _____Date of Birth ___/___/_____

Social Security Number (Seguro Social #) _____- ____ - _____

Address (Domicilio)_____
Street (direccion) City (ciudad) State (Estado) Zip (codigo)

Home Phone (Telefono) _____ Cell Phone (Telefono cellular)_____

Email _____

Employer (Empleador) _____ Work Phone (Telefono trabajo) _____

## FATHER'S INFORMATION *(Informacion del padre)*

Father's Name (Nombre de la padre) _____Date of Birth ___/___/_____

Social Security Number (Seguro Social #) _____- ____ - _____

Address (Domicilio)_____
Street (direccion) City (ciudad) State (Estado) Zip (codigo)

Home Phone (Telefono) _____ Cell Phone (Telefono cellular)_____

Email _____

Employer (Empleador) _____ Work Phone (Telefono trabajo) _____

## INSURANCE INFORMATION *(Informacion del seguro)*

PRIMARY Insurance (Seguro Primario) _____ ID#_____Group #_____

Subscriber Name (Nombre del suscriptor) _____ SS# _____ DOB ___/___/_____

SECONDARY Insurance (Seguro Secundario) _____ID# _____Group#_____

Subscriber Name (Nombre del suscriptor) _____ SS#_____ DOB ___/___/_____

## EMERGENCY CONTACTS

Name (Nombre) _____ Phone (Telefono) _____ Relationship _____
Name (Nombre) _____ Phone (Telefono) _____ Relationship _____

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# PEDIATRIC NEW PATIENT RECORD

*Welcome to our office. Please complete this form as it will help us learn more about your child and allow us to provide a better examination.*

**DATE** *(Fecha)* _____

Patient's name (Nombre del paciente) _____,_____
LAST NAME (Apellido) FIRST (Primer nombre) MIDDLE

Date of Birth (Fecha de Nacimiento) _ _/ _ _/ _ _ _ _

Current Medications (if any) _____

Drug Allergies (if any) _____

Date of your child's last Well-Child examination _____

Do you vaccinate your child? ▢ Yes ▢ No If NO, explain why _____

## CURRENT INFORMATION

1. List any questions or problems that are concerning you _____
   _____
2. Is your child taking vitamins? ▢ Yes *If yes, what type?* _____ ▢ No

## PATIENT HISTORY

### I. *PREGNANCY, LABOR, BIRTH AND FIRST WEEK OF LIFE:*

1. Did you experience any unusual illness or complications during pregnancy? ▢ Yes ▢ No
   a. If yes, please explain: _____
2. Where was your baby born? ▢ Hospital ▢ Clinic ▢ Home ▢Other _____
3. Was your child born pre-term? ▢ Yes ▢ No
   a. If yes, by how many weeks?_____
4. What was your baby's weight at birth? _____lbs. _____ oz.
5. Did your baby have any unexpected hospitalizations during the first week of life? ▢ Yes ▢ No
   a. If Yes, please explain: _____

### II. *ILLNESSES, ALLERGIES AND DEVELOPMENT:*

1. Does your child suffer from any chronic conditions? ▢ Yes ▢ No
   a. If Yes, please explain: _____
2. Does your child have any special needs? ▢ Yes ▢ No
   a. If Yes, please explain: _____
3. Has your child ever been hospitalized? ▢ Yes ▢ No
   a. If Yes, please explain: _____
4. Has your child had any surgeries? ▢ Yes ▢ No
   a. If YES, please explain: _____
5. Does your child have any allergies other than drug allergies ▢ Yes ▢ No
   a. If YES, please explain: _____
6. As far as you know, is your child's development normal? ▢ Yes ▢ No
   a. If NO, please explain: _____

**FAMILY HISTORY**

1. Is this child's father living? ▢ Yes ▢ No What is his age? _____ In good health? ▢ Yes ▢ No
2. Is this child's mother living? ▢ Yes ▢ No What is his age? _____ In good health? ▢ Yes ▢ No
3. How many other children are in the family? _____ What are their ages? _____
4. Are your other children in good health? ▢ Yes ▢ No
    a. If NO, please explain: _____
5. Is there a family history of any type of illness or disease ▢ Yes ▢ No
    a. If YES, please explain: _____
6. Are there significant family or marital problems? ▢ Yes ▢ No
7. Are there significant problems in income, housing, or sleeping arrangements affecting your child? ▢ Yes ▢ No
    a. Please list any additional problems _____
8. Do the adults in the family usually agree on the raising of this child? ▢ Yes ▢ No
    a. If NO, please explain: _____

**PLEASE BRING YOUR CHILD'S IMMUNIZATION RECORD TO THE OFFICE VISIT.**

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# NO SHOW POLICY

*This policy was established in an effort to reduce the number of appointment no-shows so that we are able to provide service to as many patients as possible each day. Exceptions to this policy will be few and limited to true emergencies.*

| **APPOINTMENT NO-SHOW DEFINITION:** | **Anytime a patient has an appointment scheduled and either does not come for the appointment or cancels less than one hour prior to their scheduled appointment.** |
|---|---|
| FIRST NO-SHOW: | No action is taken but the event is noted in the patient's record and a $25 no-show fee is charged. |
| SECOND NO-SHOW: | A letter is sent to the patient/guardian and their insurance carrier documenting two incidences of not coming for scheduled appointments. A $25 no-show fee is charged. |
| THIRD NO-SHOW: | The patient (and entire family) will be discharged from our care and a letter is sent to the patient/guardian and their insurance carrier. A $25 no-show fee is charged.<br><br>*NOTE: Dr. Ramos does not reinstate families that have been discharged from the practice.* |

**LIST EACH CHILD IN YOUR FAMILY**

| | **Name of Child** | **Date of Birth** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

Parent/Guardian's Signature _____ Date _____

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# ASSIGNMENT AND RELEASE
# (Conocimiento del contratrato)

I hereby authorize my insurance benefits to be paid directly to Dr. Ramon Ramos. I hereby authorize the release of pertinent medical information to insurance carriers. I understand that all charges for professional services here are my financial responsibility regardless of whatever insurance coverage that I may have. I agree to pay any and all co-pays and deductibles at the time of service. I understand that it is my responsibility to be aware of my insurance policies regarding payment for services including office procedures and lab fees. I am aware that any balance unpaid by insurance is my responsibility. I understand that unwillingness to resolve any balance within 90 days from the date of service will result in dismissal from the practice and legal action.

NAME OF RESPONSIBLE PARTY _____

Relationship to Patient _____

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

Yo autorizo a mi compania de seguro quele pague directamente a Dr. Ramon Ramos. Yo autorizo que se le de informacion medica pertinenete a companias de seguro. Yo comprendo que todos los cobros por scruicios profesionales son mi responsabilidad, a pesar de tener cobertura de seguro. Yo accepto pagar cualquier y todos los cobros por co-pago y deducibles al tiempe de recivir el servico. Yo comprendo que es mi responsabilidad estar al tanto de mi poliza de seguro incluyendo pagos por servicios y procedimientos en la officina y tarifas de laboratorios. Yo comprendo que cualquier balance no pagado por el seguro es mi responsibilidad. Yo comprendo que desde la fech del servicio hasta 90 dias si no he hecho el pago correspondiente esta officina y tomaremos accione legales.

RESPONSIBLE _____

Relacion con el paciente _____

FIRMA DEL RESPONSIBLE _____FECHA _____

## ACKNOWLEDGEMENT OF OFFICE POLICIES AND PROCEDURES

**I, _____, have read, understand, and agree to Dr. Ramos's office policies and procedures regarding: appointments, telephone calls, financial responsibilities, medical records, documents, and prescriptions.**

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# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of the named individual's health information as described below:
***Please read and complete all areas***

Patient's Name _____ Date of Birth _____/_____/_____
(First, Middle, Last)

Address _____ Phone _____

_____

_____

I am requesting medical records to be obtained **FROM:** Please send records **TO:**

_____ _____

_____ _____

_____ _____

_____ _____

**REASON FOR THE REQUEST:** _____

The following information is to be disclosed: *check the box(es) that apply*

- ▢ All medical records
- ▢ Daycare Forms
- ▢ Immunization Records
- ▢ X-rays
- ▢ Lab Results
- ▢ Sports/Camp Forms
- ▢ Other _____

**Sensitive Information:** I understand that the information in my record may include information relation to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavior or mental health services or treatment for alcohol and drug abuse.

**Re-disclosure:** I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules.

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

**Other Rights:** I understand that I may refuse to sign this authorization and it is strictly voluntary. I do not need to sign this form to assure treatment. I also understand that I may inspect and obtain a copy of the information to be used or disclosed for a reasonable fee.

**Expiration Date** _____ *Unless otherwise revoked, this authorization will expire on this expiration date.*

_____
**Signature of Parent or Guardian** ***(if patient is over 18 years of age, they must sign for themselves)***

_____ _____
**Relationship to Patient** **Date**

# HIPAA Notice of Privacy Practices

Ramon Ramos, M.D., P.C.
460 Mall Blvd., Savannah, GA 31406

**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.**

## About This Notice

This notice 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" 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.

We are required by law to maintain the privacy of your protected health information; give you this notice of our legal duties and privacy practices with respect to your protected health information; and follow the terms of our notice that are currently in effect. 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 the time as well as any information we receive in the future. You can obtain any revised Notice of Privacy Practices by contacting our office.

## How we may use and disclose your Protected Health Information

The following examples describe different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office. We are permitted to use and disclose your protected health information for the following purposes. However, our office may never have reason to make some of these disclosures.

***For Treatment***

We will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and any related services. We may also disclose protected health information to other physicians who may be treating you. For example, your protected health information 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.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a 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.

***For Payment***

Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health plan to obtain approval for hospital admission.

***For Health Care Operations***

We may use and disclose your protected health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use your protected health information to review the treatment and services you receive to check on the performance of our staff in caring for you. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for educational and learning purposes. The entities and individuals covered by this notice also may share information with each other for purposes of our joint health care operations.

***Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services***

We may use and disclose your protected health information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

***Plan Sponsors***

If your coverage is through an employer sponsored group health plan, we may share protected health information with your plan sponsor.

***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.

***Required by Law***
We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

***Public Health***
We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

***Business Associates***
We may disclose your protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

***Communicable Diseases***
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

***Health Oversight***
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

***Abuse or Neglect***
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

***Food and Drug Administration***
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

***Legal Proceedings***
We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

***Law Enforcement***
We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

***Coroners, Funeral Directors, and Organ Donation***
We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

***Research***
We may disclose your protected health 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 protected health information.

***Criminal Activity***
Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

***Military Activity and National Security***
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

***Workers' Compensation***
Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

***Inmates***
We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

***For Data Breach Notification Purposes***
We may use or disclose your protected health information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan, if applicable, through which you receive coverage.

***Required Uses and Disclosures***
Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

## Special protections for HIV, Alcohol and substance abuse, mental health and genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

## Uses and disclosures of Protected Health Information based upon your written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization.

Additionally, if a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

## Your rights regarding Health Information About you

The 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 your protected health information that is contained in your designated file for as long as we maintain the protected health information.
A "designated file" contains medical and billing records and any other records that your physician and the office uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You must make a written request to inspect and copy your designated file. We may charge a reasonable fee for any copies.

Additionally, if we maintain an electronic health record of your designated file, you have the right to request that we send a copy of your protected health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your protected health information.

Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our office if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

This office is not required to agree to a restriction that you may request. If this office believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If this office does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our office.

**You have the right to restrict information given to your third party payer if you fully pay for the services out of your pocket.** If you pay in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third party payer since no claim is being made against the third party payer.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office.

**You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in your designated file for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our office if you have questions about amending your medical record. Your request must be in writing and provide the reasons for the requested amendment.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records.

**You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice electronically.

**You have the right to receive notice of a security breach.** We are required to notify you if your protected health information has been breached. The notification will occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your protected health information. The notification requirements under this section only apply if the breach poses a significant risk for financial, reputational, or other harm to you. The notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

Not every impermissible use or disclosure of protected health information constitutes a reportable breach. The determination of whether an impermissible breach is reportable hinges on whether there is a significant risk of harm to you as a result of impermissible activity. For example, if your protected health information was inappropriately shared with a billing clerk and she understood her confidentiality obligations, you would not need to be notified of the breach. If we inadvertently disclosed that you received services at our facility, without more specifics, this also may not be a reportable breach because it may not have been a significant risk of financial or reputational harm. The key to determining potential harm is whether sufficient information was released that would allow identity theft or harm you because of the likelihood of sharing sensitive health data.

## Complaints or Questions

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a written complaint with us by notifying our office of your complaint. We will not retaliate against you for filing a complaint. You may reach out office by calling: (912) 303-4200. If you have a question about this privacy notice, please contact our Privacy Officer at (912) 303-4200.

**Effective Date:** This notice is effective as of 2/1/2013.

# Patient Acknowledgment of Receipt of Privacy Practices Notice

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

RAMON RAMOS, MD, P.C.
460 Mall Blvd.
Savannah, GA 31406
Phone 912.354.3400

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

## Patient or Personal Representative

Signature:_____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

## For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by:_____ Date: ___/___/___