North Shore Children's Healthcare

Catherine Screnci, M.D.

3 School Street Glen Cove N.Y. 11542

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** involves providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** involves activities such as obtaining reimbursements for services, confirming medical insurance coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company.

- **Health care operations** include the business aspects of running our practice such as conduction of quality assessment, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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

Any other uses and disclosures will be made only with your written authorization. We are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respects to your protected health information, which you can exercise by presenting a written request to the privacy officer.

- You have the right to request restrictions on certain uses and disclosures of protected health information, including that of family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- You have the right to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- You have the right to inspect and copy your protected health information.
- You have the right to amend your protected health information.
- You have the right to receive an accounting of disclosures of protected health information.
- You have the right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice was effective 4/14/2003, and we are required to abide by the terms of the Notice Of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post a notice, and you may request a written copy of the revised Notice of Privacy Practices from this office.

If you feel that your privacy protections have been violated, you have the right to file a written complaint with our office, or with the Department of Health & Human Services Office of Civil Rights regarding the violations of the provisions of this notice, or of the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information.

For more information about HIPAA or to file a complaint, contact:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
Phone: (202) 619-0257
Toll Free: (877) 696-6775

CATHERINE SCRENCI M.D.

I HAVE READ AND AGREE TO.....

HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan, and direct my child's treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, as well as conduct normal healthcare operations such as quality assessments and physician certifications. I hereby authorize you to treat my child when other caretakers (grandparents, family members, etc) escort them to your office. I give permission for my child who is above 16 to be treated without being accompanied by an adult. I have received, read and understand the Notice of Privacy Practices of Catherine Screnci M.D.P.L.L.C. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment and payment of my health care operations. I also understand you are not required to agree to requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient(s) Name: _____

Signature of Patient(s) Caretaker (parent, grandparent, etc.): _____

Relationship to the Patient: _____ Date Signed: _____

Office & Financial Policies

I authorize Catherine Screnci MD PLLC to apply for insurance benefits on my behalf for services rendered to me or my dependents and request that payments made by my insurance company be sent directly to this medical office. I have read and understand the office and financial policies of Catherine Screnci M.D.P.L.L.C. I agree to comply and accept the responsibility for any payment that becomes due as outlined in these policies.

Patient(s) Name: _____

Signature of Patient(s) Caretaker (parent, grandparent, etc.): _____

Relationship to the Patient: _____ Date Signed: _____

Patient Portal

We encourage you to sign up for our Patient Portal! This is where you would be able to have access to pertinent information in your child's health record. You can obtain a copy of your child's immunization record, school/camp forms, allergies, and a list of medications prescribed. You can also request referrals online, print office forms, and send messages that are non urgent to our office. Please inquire within to complete this process. We just need your email to get you started! Please include below. Thank you!!!

Email preferred for Patient Portal:

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