

# Almaden Pediatrics

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## THANK YOU!

We would like to extend to you a warm welcome to Almaden Pediatrics. We are very excited that you have chosen us, and we are confident that you will be very pleased with the service and care we provide to your family. Please take a moment to read this short letter in order to get to know us a little better.

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## OUR PEDIATRICIANS

We have two highly qualified and well-respected pediatricians on staff to care for your children—Dr. Michelle Record Contini and Dr. Peter Contini.

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## MAKING APPOINTMENTS

We are in the office Monday-Friday between 8:00am and 5:00pm, and see patients beginning at 9:00am. The office staff breaks for lunch between 12:00pm and 1:30pm.

Appointments are available for same day sick visits. Call early as these do fill up quickly.

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## APPOINTMENT DETAILS

### *Well Care Appointments*

Please schedule check-ups 2 to 4 weeks in advance. For children over the age of 12 we recommend that you schedule well care appointments for boys with Dr. Pete and girls with Dr. Michelle. However, please feel free to schedule your appointment with whomever you feel most comfortable.

### *Other Appointments*

Less urgent issues such as acne, warts or more chronic conditions (long standing abdominal pain or headaches, constipation, behavioral problems, eczema, etc.), should be scheduled in advance.

We will make every effort to have your child's care provided by his/her pediatrician. If your doctor is not available, we will set up an appointment with our available doctor.

### *Cancellations*

Your appointment time has been reserved exclusively for you. Therefore, we require 24 hour notice for cancellations. A fee may be charged for late cancellations.

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## TIMING IS EVERYTHING!

### *Please Arrive On-Time*

We understand that your time is valuable. We make every effort to see all of our patients on time. In order to provide you with prompt service, we need you to arrive 5-10 minutes prior to your scheduled appointment *for every appointment*. If you are more than 10 minutes late, you may be asked to wait or to reschedule your appointment.

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## HEALTH FORMS

We are happy to complete forms for school, camp, etc. The charge is \$10 for most forms. If your child has not had a physical within the last year, please schedule a 10 minute appointment so that we can complete the form with current information.



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## MEDICAL ADVICE

During business hours, we are happy to answer general questions over the phone. For more complex questions, please make an appointment so that we may evaluate your child and provide you with the most accurate information and the best care. Urgent matters will be addressed before the day is over. For less urgent matters we will return your call within 24-48 hours.

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## NIGHTTIME & WEEKEND COVERAGE

For after hours advice, we offer our patient's a nurse line that can answer most of your questions. In the event a doctor is needed, there is always a doctor on-call and available to consult with the nurse. The number to the advice line is 1-800-472-2472.

If your child needs to be seen at night, we will refer you to a local urgent care or the emergency department at Good Samaritan Hospital.

On most weekends we may see patients on an as needed basis. When we are not available, you will be directed to an urgent care center.

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## URGENT CARE

Almaden Family Physicians provides urgent care to both SCCIPA and PPO patients (408-997-9155). They are located in our same complex.

For our patients with PPO insurance, we also recommend South Bay Children's Urgent Care (408-370-0110).

For a list of other urgent cares for SCCIPA patients go to [www.sccipa.com](http://www.sccipa.com).

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## HOSPITAL CARE

Almaden Pediatrics is associated with Good Samaritan Hospital. If your child needs to be admitted to the hospital, in most instances we will manage the admission and hospital stay. However, under certain circumstances we will have the Pediatric Hospitalist (a doctor who specializes in caring for hospitalized patients) care for your child while he/she is hospitalized. In those instances we will remain in close contact with you and the Pediatric Hospitalist during the stay, and will see you in the office after discharge.

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## INSURANCE—THE DETAILS

Please bring your insurance card to every visit so that we may verify your coverage. If we do not have the proper insurance information at the time of the visit you may be charged for the visit.

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## IT'S THE LAW

The law requires that all patients be accompanied by parent or legal guardian to every appointment. We can accept a written note with your signature allowing a friend or family member to authorize care for your child. Patients between the ages of 16-18 years may be seen unaccompanied by an adult with the parents written permission (which must be received before the appointment).

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## ALMADEN PEDIATRICS

Dr. Michelle Record Contini  
Dr. Peter C. Contini



### Location

6489 Camden Avenue  
Suite 102  
San Jose, CA 95120

### Contact Information

Day: 408/268-1122  
After hours: 800/472-2472  
Fax: 408/268-5215

### Hours

Monday through Friday  
8:00 AM - 5:00 PM



## Almaden Pediatrics, Inc

### What You Can Expect at an Appointment

We want you and your child to be as comfortable as possible at each visit. One way we can do this is by minimizing surprises. Here is a brief description of a typical appointment so you can prepare yourself and your child for the visit.

We require that all of our patients be accompanied by parent or legal guardian to every appointment. In the event a parent or legal guardian is not able to accompany the child we will accept a written note with your signature allowing a friend or family member to authorize care for your child. Patients between the ages of 16-18 yrs may be seen unaccompanied by an adult with the parent's written permission. We must receive written permission prior to seeing the child. **All patients under the age of 16 years must be accompanied by an adult in order to be seen.**

**Arrival.** Upon your arrival we will ask for your insurance card to verify your coverage (for returning patients we will offer you an opportunity to update your contact information).

**Getting Started.** After you and your child are called back to one of our exam rooms by one of our assistants, your child will be weighed and temperature taken.

**Physicals.** Depending on the age of your child, in addition to height and weight, we will evaluate hearing and vision and take a blood pressure reading. During the appointment your child will need to remove clothing down to underwear so that we may perform a thorough exam.

If your child is particularly self-conscious we are happy to provide a gown. For older children and teenagers, a gown will be provided. For patients 14 years and older, your physician will be alone with your child in order to give them an opportunity to discuss any issues in confidence.

**Shots.** The most common question we get is whether there will be any shots at a particular check up. Due to the extensive and complicated vaccine schedule these days, our reception staff may not be able to provide you with accurate information. Therefore, we suggest that you prepare your child for the possibility of shots for every check-up.

**Urgent and follow-up visits.** Depending on the problem, your child may be asked to put on a gown. We understand that putting on a gown can be stressful for many kids but sometimes it is required. This can often be avoided by dressing your child in only one layer of loose fitting clothing such as shorts or sweats.

**Questions.** You will be given sufficient time to ask any questions you may have. Take a few moments before the appointment to gather your thoughts and develop your questions for the doctor. We suggest you write down your questions so you don't forget them.



# Almaden Pediatrics Patient Information Form 2010

Dr. Pete     Dr. Michelle

## Patient Information

First and Last Name (please list names of all siblings in the family)

Sex

Birth date

- |          |                                                       |                   |
|----------|-------------------------------------------------------|-------------------|
| 1. _____ | <input type="checkbox"/> M <input type="checkbox"/> F | ___ / ___ / _____ |
| 2. _____ | <input type="checkbox"/> M <input type="checkbox"/> F | ___ / ___ / _____ |
| 3. _____ | <input type="checkbox"/> M <input type="checkbox"/> F | ___ / ___ / _____ |
| 4. _____ | <input type="checkbox"/> M <input type="checkbox"/> F | ___ / ___ / _____ |
| 5. _____ | <input type="checkbox"/> M <input type="checkbox"/> F | ___ / ___ / _____ |

## Parent or Guardian Information

Responsible Party Name \_\_\_\_\_

Other Parent or Guardian \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Birth date \_\_\_ / \_\_\_ / \_\_\_    SS# \_\_\_ - \_\_\_ - \_\_\_\_\_

Birth date \_\_\_ / \_\_\_ / \_\_\_    SS# \_\_\_ - \_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address \_\_\_\_\_

Email Address \_\_\_\_\_

Patient(s) Lives With \_\_\_\_\_

Referred by \_\_\_\_\_

## Emergency Contact Information

In an emergency please contact (other than above) \_\_\_\_\_

Relationship \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Consent for Use and/or Disclosure of Information:** I hereby give consent to Almaden Pediatrics, Inc to use and disclose my protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent. We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by requesting it at the time of your appointment or submitting a written request to the address below. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us. You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the foot of this form. You may deliver your revocation by any means you choose, but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we, or others have acted in reliance upon this consent.

Parent/ Guardian Signature \_\_\_\_\_

Date \_\_\_ / \_\_\_ / \_\_\_\_\_



# Almaden Pediatrics, Inc

## Credit and Financial Policy

In compliance with the Federal Consumer Protection Act, Almaden Pediatrics wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member of your household/family.

### **Insurance**

Co-payments are due and payable at the time of visit. As a courtesy to you, we will bill your insurance company provided we have the correct billing information at the time of service. If a claim is denied because you have not provided correct information, the charges will transfer to your responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your particular coverage and any requirements for pre-authorization, deductibles, and limitations on well child visits, lab services, immunizations, and other procedures.

### **Cash Account**

If proof of insurance is not provided, your account will be considered a cash account and payment in full of all charges will be required at the time of service. If you subsequently provide verifiable insurance information, and the time frame for billing the insurance has not expired (generally 45 days), we will bill the charges to your insurance company for you. If we then receive insurance payment we will promptly issue a refund to you of any credit on your account.

### **Billing**

The billing statement you receive will show patient balances due, in addition to insurance company payments and pending amounts. Patient balances are due from you upon receipt of the statement. A \$25.00 per month late charge is assessed on all delinquent patient balances.

### **Appointments**

Please remember that your appointment time is reserved just for you. Our schedules are full each day and we must leave enough room in our schedule to bring in sick children on the same day. If your appointment is missed or cancelled with less than 24 hour notice, consider that another child could have been seen at that time. We reserve the right to charge a \$40 cancellation or 'no show' fee. In order to see each patient on time, your appointment may need to be rescheduled if you arrive 10 minutes or more late.

### **Urgent Care Appointments**

There is an extra fee charged for urgent care appointments outside of our regular Monday – Friday business hours. This includes urgent care Saturday morning appointments.

### **Returned Checks**

There is a \$25 returned check fee in the event a patient's personal check is returned to us for any reason.

The undersigned has read and agrees to the above financial credit and payment policies of Almaden Pediatrics, Inc.

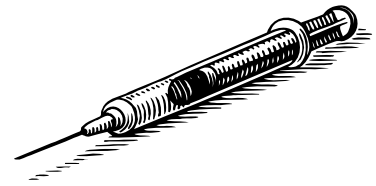
**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent / guardian/ responsible party)



# Almaden Pediatrics, Inc

## Immunization Policy



Childhood immunization was one of the greatest advances in public health in the 20<sup>th</sup> century. It has saved millions of children and adults throughout the world from developing meningitis, encephalitis, brain damage, severe respiratory problems, poliomyelitis, paralysis, and other severe illnesses, which can require hospitalization or cause death. And to this day, childhood immunization remains a cornerstone of pediatric care and public health.

Immunizations are most effective when an entire community participates. In recent years, localized outbreaks of mumps, measles, whooping cough and polio have occurred in the United States in communities with low vaccination rates. When you immunize your child, you are not only protecting your child from serious disease but you are also helping to protect your entire family, your friends and your neighbors.

At Almaden Pediatrics, Inc, we strongly believe in the importance of immunizations and fully support the childhood immunization schedule established by the American Academy of Pediatrics. Therefore, **our policy requires that every patient within our group receive the vaccinations listed below:**

**By 18 months of age, your child will receive the following:**

**Type of Immunization**

<b>Hepatitis B:</b>	3 doses
<b>Diphtheria, Tetanus and Pertussis (DTaP):</b>	4 doses
<b>Inactivated Polio Vaccine (IPV):</b>	3 doses
<b>Haemophilus influenza (HIB):</b>	4 doses
<b>Pneumococcal conjugate vaccine (Prevnar):</b>	4 doses
<b>Varicella vaccine (Chicken Pox):</b>	1 dose
<b>Measles, Mumps and Rubella(MMR):</b>	1 dose

**By the age of 5 years your child will receive these additional vaccines:**

- A fifth dose of **DTaP**
- A fourth dose of **IPV**
- A second dose of **MMR**
- A second dose of **Varicella (Chicken Pox)**

**In addition, we highly recommend (but do not require) the following vaccinations:**

- Hepatitis A:** 2 doses, beginning at 12 months of age
- Influenza vaccine:** 2 doses first year received and 1 dose annually
- For Preteen/Teens:** 1 dose of **Meningococcal Vaccine**, 3 doses of **HPV vaccine (Gardasil)**, and 1 dose of **Tetanus, Diphtheria, Pertussis (Tdap)**.

We are aware of the concerns about vaccine safety that has been voiced by a **very small** yet vocal minority. These claims have no scientific or statistical basis. To date, there have been over 30 scientific studies, which have proven, conclusively, that vaccines are safe.

By signing, I agree to follow Almaden Pediatrics Inc. s' policy to fully immunize my child(ren) by 18 months:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date



# Almaden Pediatrics, Inc.

## Authorization to Release Patient Medical Information

I hereby authorize the release of Medical Records, excluding protected records as follows:

**Please Limit to the LAST 2 YEARS Information Only:**

- Chart Notes/ Medical Summary
- Immunization Records
- Growth Records
- Laboratory and/or X-Ray Reports
- Other: \_\_\_\_\_

**Records to be released from:**

Name: \_\_\_\_\_ Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Records to be released for:**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please send records to:**  
**Almaden Pediatrics, Inc**  
**6489 Camden Ave, Suite 102**  
**San Jose, CA 95120**  
**(408) 268-1122**  
**Fax (408) 268-5215**

**Authorization to Release Medical Information:**

\_\_\_\_\_  
 Name (please print) of Parent/Guardian Phone Number  
 \_\_\_\_\_  
 Signature of Parent/Guardian Relationship to Patient Date

Authorization valid for 90 days only, and may be revoked in writing at any time prior to 90 days by notifying the office.

Almaden Pediatrics, Inc.  
6489 Camden Avenue, Suite 102  
San Jose, CA 95120  
(408) 268-1122

Carina L. Armann, Office Manager/Privacy Officer

## **NOTICE OF PRIVACY PRACTICES**

Effective Date: January 5, 2009

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions regarding this Notice, please contact our Privacy Officer listed above.

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**A. How this Medical Practice May Use or Disclose your Health Information:**

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical records. The medical record is the property of this medical practice, the information in the medical records belongs to you. The law permits us to disclose your health information for the following purposes:

1. **Treatment:** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide or when we are unable to provide it. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. **Payment:** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided for you.
3. **Health Care Operations:** We use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and medical information with our "business associates" such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information, which is disclosed to someone other than another healthcare providers, health plan or healthcare clearinghouse, under California law all recipients of health care, information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with the quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and about detection and compliance efforts. We may also share medical information about you to all the other health care providers, clearinghouses, and health plans who participate in any healthcare operations activities including all contracted insurance plans and the Santa Clara County IPA
4. **Appointment Reminders:** We may use and disclose medical information to contact and remind you about appointments. If you are not home or at your place of work, we may leave this information on your personal or business answering machine or in a message left with the person answering the telephone.

5. **Sign in Sheets:** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family:** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health care professionals will use their best judgment in communication with your family and others.
7. **Required by Law:** As required by law, we will use and disclose your health information, but we limit our use or disclose to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
8. **Public Health:** We may and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder, child, dependent abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment we believe the notification would place you at risk or serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
9. **Health Oversight Activities:** We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
10. **Judicial and Administrative Proceedings:** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
11. **Law Enforcement:** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

12. **Coroners:** We may, and are required by law, to disclose your health information to coroners in connection with their investigations of death.
13. **Organ or Tissue Donation:** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
14. **Public Safety:** We may, and are sometimes required by law to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
15. **Specialized Government Functions:** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
16. **Worker's Compensation:** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by worker's compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or worker's compensation insurer.
17. **Change of Ownership:** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

**B. When This Medical Practice May Not Use or Disclose Your Health Information:**

Except as described in the Notice of Privacy Practices, this medical practice will not use or disclose health information, which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

**C. Your Health Information Rights:**

1. **Right to Request Special Privacy Protections:** You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.
2. **Right to Request Confidential Communications:** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account, to your work address or on a specified voice mail. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Inspect and Copy:** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want to access to and whether you want

to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal or decision.

4. **Right to Amend or Supplement:** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practices denial and how you can disagree with the denial. We may deny your request if you do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as it. You may also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.
5. **Right to an Accounting of Disclosures:** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described the paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of the Notice of Privacy Practices or disclosures for purposes of research or public health with exclude direct patient identifiers, or which are incident to a use or disclose otherwise permitted by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. **Right to A Paper Copy:** You have a right to a paper copy of the Notice of Privacy Practices, even if you have previously requested it. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed on this Notice of Privacy Practices.

#### **D. Changes to this Notice of Privacy Practices:**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posed in our reception area, and will offer you a copy at your appointment.

#### **E. Complaints:**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed on this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services  
Office of Civil Rights  
Hubert H. Humphrey Bldg.  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

You will not be penalized for filing a complaint.

**Almaden Pediatrics, Inc.,  
6489 Camden Avenue, Suite 102  
San Jose, CA 95120  
(408) 268-1122  
Fax (408) 268-5215**

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name of Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Name(s) of patient(s) in practice:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_