# Coker Pediatrics, LLC

## Patient Information Form

### Patient Information

Child's Name _____ □ Male □ Female
(First) (Middle) (Last)

Name preferred _____ Child's DOB _____

Child's Street Address _____

Child's Mailing Address_____

City _____ State _____ Zip _____ Home # _____

**Ethnic group** (please select one): □ Hispanic/Latino □ Non Hispanic/Latino

**Race (please select one or more of the following racial categories):**

□ American Indian or Alaska Native □ Asian □ African American

□ Native Hawaiian or Pacific Islander □ Caucasian □ Other

**Preferred Language:** _____

With whom does child live with? □ Mom and Dad □Mom □Dad □Other
Who has legal custody? □ Mom and Dad □Mom □Dad □Other
Who is responsible party? □ Mom and Dad □Mom □Dad □Other

List all household members and their relationship to patient:

_____

_____

### Emergency Contact & Relationship (Someone Not in Home)

1. Name _____ Phone # _____

2. Name _____ Phone # _____

### Pharmacy Information

Our office prefers to fax medications to the pharmacy. Please list your preferred pharmacy. If you prefer the prescription to be hand written so that you can take it to the pharmacy of your choice, please inform our staff.

Preferred Pharmacy _____

## Mother/Guardian Information

Name _____ Maiden Name _____

Address (if different than patient's) _____

Phone # _____ ____ Cell # _____ Work #_____

Employer _____ Employer Address _____

DOB _____ SS # _____ **Email** _____

Relationship to patient _____

## Father/Guardian Information

Name _____

Address (if different than patient's) _____

Phone # _____ ____ Cell # _____ Work #_____

Employer _____ Employer Address _____

DOB _____ SS # _____

Relationship to patient _____

## Child's previous pediatrician

Name _____ Phone # _____

## Insurance Information (Please give card to receptionist)

Insurance Company name _____ Co-pay amount $ _____
Policy/ID _____ Group # _____
Policy holder's full name _____ DOB_____
Policy holder's relationship to patient: _____ Effective date _____

I understand that payment of all medical care is ***due at the time of service***. In case of divorced parents, responsibility and payment shall be ***that of the guardian bringing the child in for treatment***. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my Insurance authorizes and to inform the staff of Coker Pediatrics, LLC as to which laboratory my insurance covers.

I hereby grant permission to Coker Pediatrics LLC to release any pertinent information to my insurance company upon request, and I also assign and authorize payment directly to Coker Pediatrics LLC. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____

Coker Pediatrics, LLC

## RELEASE OF MEDICAL RECORDS

I request that: _____
(Physician)

_____
(Practice)

_____
(Address)

_____

_____

_____ _____
(Telephone) (Fax)

Please release the complete medical records including progress notes, nurse notes, labs/x-rays reports, hospital records, immunizations and any referral/consult notes on the following patient(s) from their birth to present:

Child's Full Name: _____ DOB: _____

Please send the records to:

Coker Pediatrics LLC
14557 Highway 19, Suite A
Griffin, GA 30224-9582
Phone (678) 688-1580 Fax (678) 688-1594

I understand that the release or transfer of the information specified above to any person or entity not specified above is prohibited.

- I understand that this form does NOT authorize the release of any medical information concerning HIV test results and/or treatments, sexually transmitted diseases, generic testing, psychiatric care, psychological assessment and/or treatment, drug or alcohol abuse testing and/or treatment or pregnancy treatment. Consent to release this information requires a separate form and signature.
- I understand that I may revoke this consent at any time except to the extent that this action has already been taken and that it expires 90 days from the date indicated below.

Parent/Guardian: _____ Date: _____
Relationship to Patient: _____ (Patient must sign if 18 years or older)

## Pregnancy history with this child

| | | |
|---|---|---|
| Have you had breast surgery? | □ Yes | □ No |
| Did you take hormones during pregnancy? | □ Yes | □ No |
| Did you take any drugs during pregnancy? | □ Yes | □ No |
| Did you smoke during pregnancy? | □ Yes | □ No |
| Did you drink any alcoholic beverages during pregnancy? | □ Yes | □ No |
| Has the child's mother had any miscarriages, still births, or abortions? | □ Yes | □ No |
| If yes, please list _____ | | |
| Was the child the product of artificial insemination or donor egg? | □ Yes | □ No |
| Did mother see a perinatologist during pregnancy? | □ Yes | □ No |
| If mother did see a perinatologist, was there an abnormal ultrasound? | □ Yes | □ No |

## Birth history of child

Where was your child born? _____ □ Full term □ Pre term at ____ weeks
Was the baby adopted? □ Yes □ No If yes, at what age? ____
Type of delivery: □ vaginal □ C-section Birth weight _____ lb ____oz Birth length _____ in
Were there any birth complications? (If so, please explain) _____
_____
_____
_____
_____
Is the baby breast fed or bottle fed? (If bottle fed, what formula?) _____

## Family history

| | DOB | HT. | Alive/Deceased | Medical Problems |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |

*Is there a family history of any of the following? (Include mother, father, siblings, grandparents, aunts and uncles)*

Please check all that apply:

| | | |
|---|---|---|
| Diabetes □ | Bleeding Tendencies □ | Birth Defects □ |
| Asthma/Wheezing □ | High Cholesterol □ | Cancer □ |
| Vision or hearing □ | High Blood Pressure □ | Seizures□ |
| Thyroid Disease □ | Early Heart Attacks □ | Kidney Disease □ |
| Mental Problems □ | Other Heart Disease □ | Migraines □ |
| Emotional Problems □ | Hip Disorders in Birth □ | Other Illnesses □ |
| Hyperactivity or learning disabilities □ | | |

If answered yes to any of the above, please explain_____
_____
_____
_____
_____
_____

## Social History

Marital status of parents: □Married to each other □Married to others □Single
Has there been a separation, divorce or death? Specify: _____
What has been the attitude of your child to this situation? _____
Will the child attend daycare? □ Yes □ No
Is there a gun in your home? □ Yes □ No
Are there any pets at home? □ Yes □ No
Does anyone in your home smoke? □ Yes □ No
What type of water do you have at home? □ City □ County □Well
House type: □ House □ Modular home □ Apartment □Other
Have you or anyone in your family used any alternative forms of therapy such as chiropractic, homeopathy, megavitamins, acupuncture or herbal medicine: □ Yes □No

## Child's Development

Please list age of child when the following milestones were reached

Sat alone @ ____mos. Walked @_____mos. Words @ _____ mos. Sentences @ _____ mos.
First teeth @ _____mos. Bladder trained @_____mos. Bowel trained @ _____mos.
Does the child have any handicap? □ Yes □ No Please specify_____
Is there a bed-wetting problem? □ Yes □ No
Is there a family history of bed-wetting? □ Yes □ No

## School performance

Scholastic performance: Academic _____
Behavior _____
Has child ever been in a special education class? □ Yes □ No
Has the child had a learning problem? □ Yes □ No
If yes, what type of learning problem? _____

## Past illnesses

*Please mark date or frequency of illness or specify substance causing allergy.*

Ear infections _____ Chicken Pox _____ Allergic to Medication _____
Tonsillitis _____ Urinary infections _____ Allergic to Foods _____
Pneumonia _____ Heart Murmur _____ Allergic to Insect Bites _____
Convulsions _____ RSV _____ Asthma _____
Eye Problem _____ Has he/she received allergy shots? □ Yes □ No
Bronchitis/Wheezing _____ Other _____

## Medications

Is your child taking any medication on a regular basis? □ Yes □ No
Please specify _____

## Surgeries and Hospitalizations

*Please specify date or reason.*

Appendectomy_____ Tonsils and Adenoids _____ Ear tubes _____

Other operations _____

List all past hospitalizations, reason for hospitalization and dates _____

_____

_____

_____

## Review of Symptoms

**(Please check all that apply)**

**Constitutional**
__Fever/chills/excessive Sweating
__Unexplained weight loss

**Eyes**
__Squinting/crossed eyes/ Crooked gaze

**Ears/Nose/Throat**
__Unusually loud voice/ Hard of hearing
__Mouth breathing/snoring
__Bad Breath
__Frequent runny nose
__Problem with teeth/gums

**Blood/Lymph**
__Unexplained lumps
__Easy bruising/bleeding

**Cardiovascular**
__Tires easily with exertion
__Shortness of Breath
__Fainting

**Respiratory**
__Cough/wheeze
__Chest Pain

**Gastrointestinal**
__Nausea/vomiting/diarrhea
__Constipation
__Blood in bowel movements

**Genitourinary**
__Bedwetting
__Pain with urination
__Discharge, penis or vagina

**Musculoskeletal**
__Muscle/joint pain

**Skin**
__Rashes
__Unusual Moles

**Allergy**
__Hay fever/itchy eyes

**Neurological**
__Headaches
__Weakness
__Clumsiness

**Psychiatric/Emotional**
__Speech Problems
__Anxiety/stress
__Problems with sleeping
__Nail biting/thumb sucking
__Bad temper/breath holding

## Sibling Information

Name _____ DOB _____ Name _____ DOB _____

Name _____ DOB _____ Name _____ DOB _____

Name _____ DOB _____ Name _____ DOB _____

Name _____ DOB _____ Name _____ DOB _____

How did you hear about us, or who referred you to us? _____

Name of person completing this form _____ Date _____

MD/PNP Reviewed: _____ Date _____

## Permission for Telephone Messages

*Patient confidentiality is a top priority at Coker Pediatrics LLC. Therefore, it is important that parents or patients over 18 years of age provide us with the following information to ensure there is no violation of your or your child's privacy.*

*Please name all persons and places where we may leave health information including return phone messages, lab and test results, and scheduling:*

Name: (Mother) _____
Email address: _____
Home phone #:_____
Cell phone #:_____
Work phone #:_____

Name: _____
Email Address: _____
Home Phone #: _____
Cell Phone#: _____
Work Phone#: _____

Name: (Father) _____
Email Address: _____
Home phone #:_____
Cell phone #:_____
Work phone #:_____

Name: _____
Email Address: _____
Home Phone#: _____
Cell Phone#: _____
Work Phone#: _____

I understand that if the status of any of above information changes, it will be my responsibility to inform the staff of Coker Pediatrics LLC.

Parent signature: _____ Date: _____

## Treatment Authorization

I (We) _____authorize Coker Pediatrics and its personnel to deliver
Print Name of Legal Guardian(s)

medical services to my child, _____.
Child's Name and Date of Birth

I (We) authorize the following people to bring my child in for treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Coker Pediatrics, LLC

14557 Highway 19, Suite A
Griffin, GA 30224-9582

## NEW OFFICE POLICIES
## EFFECTIVE MAY 1, 2011

**No Show Appointment Policy-** In consideration of other patients, we ask you to notify our office at least 24 hours in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient, who needs to see the doctor. **THREE** consecutive missed appointments will result in dismissal from the practice.

**Late Policy-** When you are more than 30 minutes late for your child's appointment, our front office staff will ask your doctor to help determine when best to see your child. You may be worked into the schedule with a wait, or you may be asked to reschedule, especially if it is a well-child visit. We are always trying our best to balance your needs with the needs of our other patients.

**Transfer Policy-** When a parent/guardian (also known as guarantor) transfers one child to another practice, then all children associated to that parent/guardian are made inactive and in effect transferred. A letter will be sent to the parent/guardian confirming transfer of medical records and notice of all children being made inactive. Coker Pediatrics will release all medical records to the new provider once the signed release request (must have request on all children) has been received from the new provider. **Once the confirmation letter has been sent, we will see the child and associated children on an emergency basis for 30 days.**

Please remember we are always looking for ways to improve our practice and provide high-quality healthcare to your children.

I, _____, have read and understand the policies above.

Signature _____ Date _____

Coker Pediatrics, LLC

# FINANCIAL AGREEMENT

Patient Name _____ DOB _____

As a member of _____ insurance plan, I am aware of the responsibility that certain services rendered to my child/children by my physician may be considered non-covered or deemed not necessary by my insurance plan.

If my insurance denies payment to Coker Pediatrics, LLC, because the services rendered to the patient are considered non-covered or deemed not medically necessary, I agree to be personally and fully responsible for payment of these services.

I understand that I am responsible for all co-pays, deductibles and coinsurance amounts that are made my responsibility by the insurance company. *I understand that if my co-pay is not paid at the time of service, that there will be a $25 processing fee due in addition to the visit co-pay.*

I understand that failure to pay any patient balance due from me will result in the account being turned to an outside collection agency and a fee of **35%** of the balance will be assessed on the account, in addition to the balance owed. I also understand that I will be responsible for all court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on my account.

_____
Parent/Guardian Printed Name

_____
Parent/Guardian Signature Date

Coker Pediatrics, LLC

## RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the Coker Pediatrics Privacy Officer at **678-688-1580**; by submitting a written request to **14557 Highway 19, Griffin, GA 30224**; or from any of our office locations.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name _____

Signature of Patient/Personal Representative _____

Date _____

Coker Pediatrics, LLC

# NOTICE OF PRIVACY PRACTICES

*Effective Date: April 16, 2007*

**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.**

If you have any questions about this notice, please contact The Coker Pediatrics Privacy Officer at **678-688-1580.**

## WHO DOES THIS NOTICE APPLY TO?

This Notice of Privacy Practices applies to the patient and his/her medical information. Each reference in this notice to "you" is a reference to the patient. If the patient is a minor (under 18 years old) the patient's parent, guardian or legal representative has certain rights under Georgia law to the access, control and other rights to the patient's medical information. In general, a parent, guardian or legal representative may access and control a minor's medical information, however, there are exceptions. If the patient or the patient's parent, guardian or legal representative has questions about this notice or his/her rights under Georgia law, please contact our Privacy Officer.

## WHO WILL FOLLOW THIS NOTICE?

This notice describes our practice's procedures and that of:

Any health care professional authorized to enter information into your medical record.

All departments and units of our practice.

Any member of a volunteer group we allow to help you while you are in our practice.

All employees, staff and other practice personnel.

## OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that information about you is personal. We are committed to protecting health information about you. We create a record of the care and services you receive at our practice, as well as records regarding payment for those services. We need these records to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our practice doctors and/or personnel working for the practice.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights, and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;

- give you this notice of our legal duties and privacy practices with respect to medical information about you; and

- follow the terms of the notice that is currently in effect?

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to 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 information will fall within one of the categories.

**For Treatment. We may use health information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For instance, we may need to share information about your condition with another doctor if you have complications and need a specialist. Our practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions and lab work.**

**For Payment.** We may use and disclose health information about you so that the treatment and services you receive at our practice may be billed, and that payment may be collected from you, an insurance company or another third party. For example, we may need to give you health plan information about services that you received at our practice so your health plan will pay us or reimburse you for those services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

**For Health Care Operations.** We may use and disclose medical information about you for the practice's health care operations. These uses and disclosures are necessary to run our practice and to make sure that all patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services our practice should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, residents, and other practice personnel for review and training purposes. We may also disclose your information, in conducting or arranging other business activities of the practice. We may disclose information as part of a sale, transfer, merger or consolidation of our practice to another entity. We may also combine the medical information we have with medical information from other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

**Appointment Reminders**. We may disclose information, if necessary, to contact you to remind you about your appointments.

**Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may release medical 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. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be informed about your condition and location.

**As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

## SPECIAL SITUATIONS

**Research. We may also do certain kinds of research using your records, but only if a legally authorized review board gives us permission to use your information and provided that the researcher says he/she will use safeguards to protect your information.**

**Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans**. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose information to the Department of Veterans Affairs to determine whether you are eligible for certain benefits.

**Workers' Compensation.** If applicable, we may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report deaths;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with applicable civil rights laws.**

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if we receive satisfactory assurances that the party seeking the information has made efforts to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena (after we attempt to notify you), warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our offices; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of our practice to funeral directors as necessary to carry out their duties.**

**National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**.

You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes and other mental health records in certain cases.**

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer or designee. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed if the denial is made for certain reasons. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our practice.

To request an amendment, your request must be made in writing and submitted to our Privacy Officer or designee. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer or designee. Your request must state a time period which may not start more than six years in the past and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations purposes. You may also request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about an illness you had to a specific family member.

***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to a grandparent.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate your request if it is reasonable. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice contact our Privacy Officer or designee at 678-688-1580; or in writing at 14557 Highway 19, Griffin, GA 30224. You may also request and obtain a copy of this notice when you receive care at any of our office locations.

## CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our practice. The notice will contain on the first page, in the top right-hand corner, the effective date of that notice.

## COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Coker Pediatrics LLC Privacy Officer at 678-688-1580. All complaints must be submitted in writing.

**You will not be penalized in any way for filing a complaint.**

## OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.