☐ Southeast Las Vegas

☐ Northwest Las Vegas

CHILDREN'S
BONE AND SPINE SURGERY

cbsortho.com

Welcome to our Pediatric Orthopedic Office

Listed below are helpful hints to better understand our orthopedic office and how to complete the patient packets for faster insurance response.

1. Do you have your X-Rays? Current X-Rays are the most important part of the orthopedic diagnostic process. Most insurance will not pay for repeat X-Rays taken within 30 days.
2. Please remember to bring I.D. card and insurance card.
3. Emergency room discharge papers are required (if applicable).
4. Custodial or guardianship papers are needed (if applicable).
5. If you have medical records from another doctor's office, Quick Care, or hospital, please give them to our staff upon arrival. Our doctor will review them for proper diagnosis.
6. Most patient appointments are called back by "appointment time," not arrival time, with the exception of orthopedic trauma cases that need to be seen immediately.
7. The receptionist **will not** know the clinical severity of cases ahead of you, nor will she know exactly how long your wait time will be.
8. Multiple providers see patients at the same time; the X-Ray and Orthotic Departments also maintain appointments. If you have made special arrangements with a doctor's medical assistant, your appointment time will be outside the grid.
9. We only see children. We see patients from infancy to age 18, if they are still in high school. We require parental input in the care of the child.
10. For your convenience we offer pediatric orthotics (DME) in our offices.
11. It is your responsibility to know your insurance. Due to the exactitude of insurances, you will not be seen until *all insurances* have been verified and referrals have been received. If you have more than one insurance, let us know immediately as it can take up to two hours to verify insurance.
12. It is our desire to have your health insurance or government program pay your claims in a timely manner. Your insurance requires detailed and completed information. Often your information must be mailed in as part of the medical record.
13. Health insurance claims are processed due to health issues <u>not</u> associated with workers' compensation claims, auto accidents, legal claims or any other third party liability.
14. If the child had an accident and it is a third party liability, we will provide you with the paperwork that is required. You will have to bill everything on your own, monitor your own case with the third party liability company, and make monthly payments until your case is resolved. You are considered a "private pay."
15. **Please do not leave anything blank in the patient packet.**
16. **Do not use the term N/A (not applicable); instead use "none" or "no" where it is needed.**
17. Please ask us for help if something needs to be clarified. We are here to help you.

PLEASE ASK FOR A COPY OF THIS SHEET FOR YOUR FILES.

POS Reorder # 1503775

☐ **Southeast**
1525 E. Windmill Lane
Suite 201
Las Vegas, NV 89123
Phone - 702-434-6920
Fax - 702-434-1524

Children's Bone and Spine Surgery, LLP

☐ **Northwest**
9050 W. Cheyenne Avenue
Suite 110
Las Vegas, NV 89129
Phone - 702-998-5200
Fax - 702-998-5201

____
TODAY'S DATE (FECHA DE HOY)

Patient: First Name *(Nombre)* ______ **Middle Initial *(Inicial del Segundo)*** ______ **Last Name *(Apellido)*** ______ **Date of Birth *(Fecha de Nacimiento)*** ______ **Age *(Edad)*** ______

[ ] Female *(Femenina)*
[ ] Male *(Masculino)*

Social Security # *(# de Seguro Social del Niño)* ______ **Home Phone *(Telefono de Casa)*** ______

Address *(Dirección)* ______ **City *(Ciudad)*** ______ **State *(Estado)*** ______ **Zip Code *(Código Postal)*** ______

Healthcare Reform Questions: Due to recent reforms mandated by the government American Recovery Reinvest Act (ARRA) legislation, doctors are required to ask all patients for their race and ethnicity regardless of insurance to meet Meaningful Use Requirements.

Ethnicity: (Circle One) 1) Hispanic or Latino 2) Non-Hispanic 3) Declined to Report

Primary Race: (Circle One) 1) American Indian or Alaska Native 2) Asian 3) Black or African American 4) Native Hawaiian or other Pacific Islander 5) White 6) Unsure or Declined to Report

Language: (Circle One) 1) English 2) Spanish 3) Arabic 4) Chinese 5) French 6) German 7) Japanese 8) Russian 9) Vietnamese 10) Other

Mother's Name *(Nombre de Madre)* ______

Social Security #
 # de Seguro Social ______

Date of Birth
Fecha de Nacimiento ______

Address
Dirección ______

Home Phone
Teléfono de Casa ______

Work Phone
Teléfono de Trabajo ______ Cell *Celular* ______

Email
Correo Electrónico ______

Employer
Empleador ______

Father's Name *(Nombre de Padre)* ______

Social Security #
 # de Seguro Social ______

Date of Birth
Fecha de Nacimiento ______

Address
Dirección ______

Home Phone
Teléfono de Casa ______

Work Phone
Teléfono de Trabajo ______ Cell *Celular* ______

Email
Correo Electrónico ______

Employer
Empleador ______

Person to contact in case of an emergency: (not in the same home)
Persona a quien contactar en caso de emergencia: *(no en el mismo hogar)*

_______________ Relationship *Relación* _______________ Telephone *Teléfono* _______________

Address *Dirección* _______________ City *Ciudad* _______________ State *Estado* ______ Zip Code *Código Postal* _______________

Other adults authorized to bring child for treatment: **(MANDATORY)**
Otros adultos autorizados para traer al niño/a para tratamiento: ***(MANDATORIO)***

1) _______________ Relationship *Relación* _______________ Telephone *Teléfono* _______________

2) _______________ Relationship *Relación* _______________ Telephone *Teléfono* _______________

Pediatrician, Primary Care Doctor or Referring Doctor
Pediatra, Medico de Cabecera o Medico Referente

_______________ Telephone *Teléfono* _______________ Fax *Fax* _______________

Primary Insurance
Aseguranza Primaria _______________ Telephone *Teléfono* _______________

Address *Dirección* _______________ City *Ciudad* _______________ State *Estado* ______ Zip Code *Código Postal* _______________

Policy Holder *Portador de Póliza* _______________ Date of Birth *Fecha de Nacimiento* __________ ID # *# de ID* __________ Group # *# de Grupo* _______________

Policy Holders Address (if different than above)
Dirección de Portador de Póliza (si es diferente de arriba)

_______________ Telephone *Teléfono* __________ Relationship *Relación* _______________

Secondary Insurance
Aseguranza Secundaria _______________ Telephone *Teléfono* _______________

Address *Dirección* _______________ City *Ciudad* _______________ State *Estado* ______ Zip Code *Código Postal* _______________

Policy Holder *Portador de Póliza* _______________ Date of Birth *Fecha de Nacimiento* __________ ID # *# de ID* __________ Group # *# de Grupo* _______________

Policy Holders Address (if different than above)
Dirección de Portador de Póliza (si es diferente de arriba)

_______________ Telephone *Teléfono* __________ Relationship *Relación* _______________

Siblings that come to the practice: Yes No First and Last Name: _______________ DOB: _______________

First and Last Name: _______________ DOB: _______________

First and Last Name: _______________ DOB: _______________

Hermanos o Hermanas que vienen a la oficina: Si No Nombre y apellido: _______________ Fecha de nacimiento: __________

Si No Nombre y apellido: _______________ Fecha de nacimiento: __________

Si No Nombre y apellido: _______________ Fecha de nacimiento: __________

PLEASE ASK FOR A COPY OF THIS PAGE FOR YOUR RECORDS
FAVOR DE PEDIR UNA COPIA DE ESTA PÁGINA PARA SUS ARCHIVOS

POS Reorder # 1600988

A. X-RAYS: Were X-Rays taken? If yes, where?
Rayos – X: *¿Le an tomado Rayos – X? Si es si, ¿Dónde?*

____

If you did not bring the X-Rays above, please inform receptionist.
Si usted no trae los rayos-x de arriba favor de notificar a la recepcionista.

B. Medical and Surgery History with Dates:
Historial Médico y Quirúrgico con Fechas:

____

____

C. Use of Tobacco products? Yes / No **If yes, how much per day?**
¿Usa productos de tabaco? Si / No ***Si es si, ¿Cuantos por dia?***______________________
(Children 13 and older) *(Niños 13 y adelante)*

D. Allergies and Any Type of Reaction to Medications.
Alergias y Cualquier Tipo de Reacción a Medicamentos:

Name / *Nombre*	**Name / *Nombre***
1. ______________________	3. ______________________
2. ______________________	4. ______________________

E. Current Medications (Include Vitamins & Supplements)
Medicamentos Actuales (Incluyendo Vitaminas y Suplementos):

Name *Nombre*	Purpose / Reason taken *Propósito / Razón por tomar*	Name *Nombre*	Purpose / Reason taken *Propósito / Razón por tomar*
1. ______________________		3. ______________________	
2. ______________________		4. ______________________	

F. Pharmacy of Choice: (Required) ***Farmacia de Preferencia: (Requerido)***

Name ***Nombre***	**Address** ***Dirección***	**City** ***Ciudad***	**State** ***Estado***	**Phone** ***Teléfono***

Medical Records/X-Ray Requirements for Minors

- Medical record releases for children require proper identification of the parent, foster parent, or guardian. All records must be picked up in person due to the Federal genetics, HIPAA HITECH, and identity theft rulings.
- Please call our office for hours when the "Custodian of Records" is available to process your requests, as all requests need to be verified and signed in person. We also require a 5 day notice as some records and most X-Rays are off site.
- Once the child has reached the age of 18, the parents and/or guardians will no longer be able to pick up records. The exception would require custodial or power of attorney papers because of a disability.
- In most cases, X-Rays are originals and copies cannot be made. Originals must be signed out and returned. They are never mailed. We comply with Federal Section NRS 629.51, Section 7 and maintain records and X-Rays until age 23.
- A reasonable fee may be charged for digital x-ray reproductions. After the first request, additional x-ray copies of the same exam, there will be a $5 charge per CD.

Archivos Médicos / Rayos – X Requerimientos para Menores

- *Liberación de archivos médicos de menores requiere identificación de padre, padres temporales, o tutor. Todos los archivos deben de ser recogidos en persona debido a genéticas Federales, HIPAA HITECH, y fallo de robo de identidad.*
- *Favor de llamar a nuestra oficina cuando la persona "Custodio de Archivos" esté disponible para procesar su solicitud ya que todas las solicitudes deben de ser verificadas y firmadas en persona. También requerimos un aviso de 5 días para solicitar los rayos-x.*
- *Ya que el niño haya llegado a la edad de 18 anos, los padres y/o tutor no podrán recoger los archivos que estan fuera de sitio. La excepción requiere custodia o poder legal debido a alguna discapacidad.*
- *En la mayoría de los casos, Rayos-x son originales por lo tanto no es posible reproducirlas. Los originales se deben alquilar y devolver. Nunca son enviados. Nosotros cumplimos con la Sección Federal NRS 629.51, Sección 7 y mantenemos archivos y rayos-x hasta los 23 anos.*
- *Una cuota razonable puede ser cobrada por reproducción de rayos-x digital.*

"No Show" Policy

- **Appointment Reminder Preference:** Cell Phone__________________ OR Home Phone__________________ with message machine.
- Automated courtesy confirmations arrive two days before an appointment and require your response. It is your responsibility to provide us with current telephone numbers. The answering service is also open 24/7 to accept your cancellations. A 24 hour notice is required.
- Unfortunately, we have found it necessary to charge $50.00 for missed appointments. Families that do not show up for their scheduled appointments are preventing us from scheduling other injured children.
- Missing two or more appointments may result in dismissal.

Initials __________

Póliza de "No Presentarse"

- ***Preferencia de Recordatorio de Cita:*** *# Celular__________________ Telefono de Casa__________________ con contestadora.*
- *Confirmación de cortesía son automatizadas y llegan dos días antes de su cita que requieren su respuesta. Es su responsabilidad proporcionar números actuales. El servicio de contestación telefónico está abierto los 24 horas y 7 semanas 24/7 para aceptar sus cancelaciones. Se requiere un aviso de 24 horas.*
- *Desafortunadamente, hemos considerado necesario cobrar $50.00 por citas falladas. Familias que no se presentan a sus citas nos están privando de programar citas a otros niños lesionados.*
- *Fallar a dos o más citas puede resultar en despido procedente.*

Iniciales __________

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POS Reorder # 1600989

CHILDREN'S BONE AND SPINE SURGERY
FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

All fees for medical care are based on the usual, reasonable, and customary fees charged in this area by physicians of equal training and experience.

Payments for medical services rendered are due at the time of service unless prior arrangements have been made.

Our office verifies eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your status. We will do all we can to assist you with your insurance claims; however, insurance is a contract between you and your insurance carrier. Final responsibility for payment of your account rests with you.

Prior authorizations obtained for procedures by this office on your behalf do not guarantee payment but rather are based on medical necessity. Claims are subject to policy provisions, and your insurance carrier determines final payment. A deposit is required if you are being scheduled for surgery.

Having read the above, I hereby authorize payment by my insurance carrier, Medicare, Medicaid or other designated payers of medical benefits to Children's Bone and Spine Surgery for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of the assignment is considered as valid as the original.

I also authorize Children's Bone and Spine Surgery to release to my insurance carrier or their agents any medical information about me needed to determine these benefits payable for service.

I understand that if my account becomes delinquent and is assigned to an outside collection agency, that an additional mark up of 100% will be added to the amount I owe. I understand the adding of this collection fee as well as the accrual of interest at the statutory rate should my account be assigned to a collection agency. I agree to pay to Children's Bone and Spine Surgery for the medical services provided, collection fees if added and interest.

I hereby consent to and authorize medical treatment, tests, and procedures performed in this office that my physician deems advisable and necessary based on his/her judgment. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

Initials _________

INSURANCE INFORMATION

The specialty of orthopedics (dealing with injuries or broken bones) requires additional paperwork for your insurance company. Please be aware that you may receive special forms in the mail from your insurance company requesting:

- Accident Information
- Coordination of Insurance Benefits Information

Please respond immediately or bring the forms into us and we will help you complete them free of charge.

If you do not respond to the insurance company within 30 days, they will delay your case and will not pay any claims. You will end up responsible for 100% of billed charges and will have no recourse to appeal.

Initials _________

I have read and understand the above statements:

____

Date   Parent or Guardian

____

Patient Name

PLEASE ASK FOR A COPY OF THIS SHEET FOR YOUR FILES.

ORTHOPEDIC CARE

Dear Parent or Guardian:

Our office makes every effort to follow the current coding practices for reporting medical services as dictated by the Federal Government (CMS) and the American Medical Association (the AMA). These regulations can be quite complicated and generate many questions. The purpose of this handout is to clear up any confusion caused by these complicated rules regarding the billing of fracture care services.

A fracture or "broken bone" is most often diagnosed by X-Ray and can vary greatly in severity and treatment options. However for billing and insurance coding purposes, fracture care is listed in the surgery section of the AMA's coding book (CPT-4.......20000 code series) and is subject to global or surgical rules regardless of whether these services were provided at the hospital or in the office.

An insurance claim for fracture care will typically appear as follows:

1) An *Exam* (99200 code series) at the document level for diagnosis and decisions about the best treatment options.
2) An *X-Ray* (70000 codes) often is used to diagnose the fracture and/or a post fracture treatment X-Ray to ensure proper alignment.
3) A *Fracture Code* (20000 codes) will be assigned based on the site, type of fracture and whether the treatment is closed or open. Open treatment most often is performed in an Operating Room at the hospital or out patient surgery facility. Closed treatment often is done at the Emergency Room or in the office. However, all fracture treatment is considered "major surgery" by the Federal and AMA coding systems and will often times be reported as surgery on your insurance company's "Explanation of Benefits." This includes clavicles, hands and feet.
4) The Cast Application (29000 codes) for the initial work of applying the cast is included in the above Fracture Code at no charge. Subsequent applications are separately reportable and billable.
5) *Cast Supplies* (A4580, A4590, new Q codes or 99070) are reported separately. You are responsible for casting materials not covered by your insurance.
6) *Subsequent Fracture care:* Most "routine" fractures will require several post operative visits which are included at no charge in the fracture/surgical fee if related to the same diagnosis. The post operative/global days vary dependent on the insurance company. Subsequent X-Rays (70000 codes), cast applications (29000 codes) and supplies are not covered under the global period and are billable.

Initials ________

Some of the more serious type of fractures need additional surgery or procedures. There are special rules and modifiers our office is required to use to report those services.

This office is required by the Federal Compliance laws to report the services provided based on the documentation in the medical records. As a matter of policy, we cannot improperly alter a claim for the purpose of obtaining payment. If you discover a bona fide billing error, duplicate charge or other posting error, we would greatly appreciate bringing the matter to the attention of our business office staff for further investigation and proper corrective action. Due to our contract with your insurance we can not discount patient copays and deductibles.

As you well know, coverage and payment amounts vary greatly by payer. If you have any questions about your particular coverage, it is best to check with your company's representative. Our business office staff will be happy to assist you in the claims filing process for prompt adjudication and payment of your insurance claim.

Parent or Legal Guardian Initials____________________________ Date______________________

PLEASE ASK FOR A COPY OF THIS SHEET FOR YOUR FILES.

POS Reorder # 1600991

Insurance Information

Dear Parent or Guardian:

A. This office does not have a contract with or participate with the following HMOs and PPOs:

- HPN – Sierra Choice HMO
- St. Mary's HMO
- HMA/HMN Network Product Line
- United Healthcare HMO
- California Medicaid
- Other

B. Commercial HMO's and Medicaid HMO's Rules

- You, your employer, or the State of Nevada has chosen an HMO for your family's insurance.
- You must have a referral or "permission slip" from your primary care doctor before your child can be seen in our orthopedic specialist office for all new and follow-up appointments. These are the rules of your insurance company and not ours. Please read your insurance manual or contact your Human Resource department.
- Hospital Discharge papers are not considered referrals or "permission slips" by most insurance companies.
- "Out of State" HMOs are not valid in the State of Nevada.
- The most common HMOs that require referrals in Southern Nevada are:
    - Smart Choice – HPN Medicaid
    - Blue Cross/Blue Shield HMO
    - Cigna HMO
    - Arizona Medicaid
    - Tricare/Triwest (Prime - UHC Military)
    - South Point
    - Aetna HMO

____

Parent or Guardian Signature Patient Name

____

Witness Date

PLEASE ASK FOR A COPY OF THIS SHEET FOR YOUR FILES.

POS Reorder # 1600992

INSURANCE MEDICAL QUESTIONNAIRE
QUESTIONARIO DE ASEGURANZA MÉDICA

(Your Insurance Company Will require a copy of this form completed by you in full.)
(Su compañía de aseguranza requiere una compia de este formulario completo)

Parent or Guardian Please Provide:
Padre o Tutor favor de proveer:

Insurance Company Name:
*Nombre de Compañia de Seguro:*____

Insurance Policy Holder: ID #:
*Portador de Póliza de Aseguranza:*____________________ *# de ID:* __________________

Other Insurance Company Name:
Otro nombre de Compañía de Aseguranza: _______________________________________

1. Patient Name:
   *Nombre del Paciente:*____

2. Circle Reason for Visit: Accident Injury Condition Other

   Circular la Razón por su Visita: Accidente Lesión Condición Otro

3. Explain:
   Explicar: ____

   ____

4. Date you first observed/noticed the above issue:
   Fecha en que primero observo/noto los problemas anteriores: _____________________________

5. Area of the body being treated today:
   *Área del cuerpo siendo tratada hoy:*____
   Right or Left (circle) *Derecha o Izquierda (circular)*

Complete the following: (circle Yes or No)
Completar lo siguientes: *(circular Si o No)*

1. Was a police report completed? YES NO
   ¿Hubo un reporte de policía? SI NO

2. If yes do you have the police report with you? YES NO
   Si es sí, ¿Tiene el reporte do policía con usted? SI NO

3. Who caused or may have caused this condition?
¿Quién causo o pudo haber causado esta condición?

Name:
Nombre: ____

Address:
Dirección: ____

Insurance Company:
*Compañía de Aseguranza:*____

4. Have you contacted an attorney or do you plan on contacting one? YES NO
¿Ha contactado un abogado o planea en contactar alguno? SI NO

If yes, complete the following:
Si es sí, complete lo siguiente:

Your Attorney's Name:
*Nombre de su abogado:*____

Attorney's Address:
*Dirección de su abogado:*____

Attorney's Phone:
*Numero de su abogado:*____

I hereby acknowledge that the above information is true and complete to the best of my knowledge.
Yo por lo presente reconozco que la información arriba es verdadera y correcta a mi mejor conocimiento.

______________________________ ______________________________

Parent or Guardian Signature
Firma de Padre o Tutor

Date
Fecha

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POS Reorder # 1600990

Children’s Bone and Spine Surgery, LLP

Date

Social Media

We appreciate your feedback on how your experience with us was before, during and after your child’s treatment. In an effort to ensure fair and honest patient feedback, and prevent the publishing of false content in any form, we respectfully request that you allow us to address your concerns/complaints.

By accepting and signing this clause, you agree not to post any complaint or negative review to any platform of social media without allowing us 90 days from date of service to resolve any issues pertaining to any service, including but not limited to: billing issues, medication requests, consultation issues, X-ray testing, MRI testing, clinical procedures, problems with attending physicians or any problems with clinic staff. Should you violate these terms, you will be provided a seventy-two (72) hour opportunity to retract the content in question. If the content remains, in whole or in part, it is hereby agreed that the dispute shall be referred for binding arbitration.

Our goal is for patients to get the best treatment possible and for parents to have a positive experience from beginning to end.

Treatment and Payment Responsibility

By signing below, the adult who signs a minor child into our practice accepts responsibility for treatment and payment. We will communicate about treatment and payment with the parent that is present. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

____ ____

Signature of Parent or Guardian Printed Name

____ ____

Patient Name Date of Birth

Social Media 2018

POS Reorder # 1814276

Children's Bone and Spine Surgery, LLP
Privacy Notice - HIPAA

Your Child's Information. Your Rights. Our Responsibilities

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.

Effective Date: September 23, 2013

Summary Overview

Your Child's Rights
When it comes to your child's health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your child's medical record
- You can ask to see or get an electronic or paper copy of your child's medical record and other health information we have. Ask us how to do this.
- We will provide a copy or a summary of your child's health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your child's medical record
- You can ask us to correct health information about your child that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your child's care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your child's health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

File a complaint if you feel your child's rights are violated
- You can complain if you feel we have violated your child's rights, by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you or your child for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your child's information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your child's care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unavailable, we may go ahead and share your child's information if we believe it is in your child's best interest. We may also share your child's information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your child's information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your child's health information?
We typically use or share your child's health information in the following ways.

Treat your child
We can use your child's health information and share it with other professionals who are treating your child.

Residents, Interns or Medical Students
I understand residents, interns, medical students and other health care professional students may observe and participate, under the supervision of an attending physician or other health care professional in my child's care. Upon execution of this document, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms.

Bill for your services
We can use and share your child's health information to bill and get payment from health plans or other entities.
Example: We give information about your child to your health insurance plan so it will pay for your child's services.

How else can we use or share your child's health information?
We are allowed or required to share your child's information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your child's information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about your child for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use to share your child's information for health research.

Comply with the law
We will share information about your child if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about your child with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about your child:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about your child in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your child's protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your child's information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your child's information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www/hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. Or you may contact our practice's Privacy Officer at 1525 E. Windmill Lane, Suite 201, Las Vegas, NV 89123. Telephone: 702-434-6920

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about your child. The new notice will be available upon request, in our office, and on our web site.

I understand and agree this document will remain in effect for all future outpatient or physician office visits to Children's Bone And Spine Surgery, unless specifically rescinded in writing by me. A copy of this document shall be as valid as an original.

I acknowledge receipt of this Notice of Privacy Practices.

______________________________	______________________________
Patient Name (please print)	Date
______________________________	______________________________
Patient Signature	Parent or Guardian Signature

POS Reorder # 1600993