JACOB'S LADDER
DEVELOPMENTAL
PEDIATRICS

Julie Jacob, M.D., FAAP
8501 Wade Blvd, Suite 330
Frisco, TX 75034
(P) 469-476-1444 (F) 972-987-5969
www.jacobsladderdevpeds.com
"Helping Children Reach New Heights"

Developmental Intake Form Date: _____

Name of child: _____ Preferred name: _____
Date of birth: _____ Age: _____ yrs _____ mo
Gender preference: _____
Name of person completing form/relationship to child: _____
Home address: _____
Home phone: _____ Mobile phone: _____
Email address: _____
Lives with: _____ Relationship to child: _____
_____ _____
_____ _____
_____ _____
Legal Guardian(s) _____
Parents' marital status (circle): Married Single Divorced Widowed
Languages spoken in the home: _____
Are there are any special considerations you would like us to know about your family?
_____
Reason for referral: _____
Referring party: _____
Primary Care Physician (PCP): _____
PCP address: _____
PCP office phone _____

What are your concerns about your child? _____
_____
_____
_____
What would you like to accomplish during this evaluation? _____
_____
_____
_____

Pregnancy History:

Is your child adopted? ▢ Yes ▢ No If yes, at what age?_____

Is your child in foster care? ▢ Yes ▢ No If yes, at what age? _____

Any difficulty conceiving? ▢ Yes ▢ No Fertility methods used? _____

In what month was the pregnancy discovered? _____

When was the first prenatal visit? _____

Mother's age at conception: _____ Father's age at conception:_____

Total number of pregnancies: _____

Any miscarriages? ▢ Yes ▢ No If Yes, how many?_____

Number of living children: _____

Complications during pregnancy? _____

Medications taken during pregnancy? _____

Smoking during pregnancy? ▢ Yes ▢ No How much? _____

Drug use during pregnancy? ▢ Yes ▢ No How much? _____

Alcohol use during pregnancy? ▢ Yes ▢ No How much? _____

Birth History:

Birthing facility: _____

Was labor spontaneous or induced? _____ Length of labor: _____

Complications during labor/delivery?_____

Method of delivery: ▢ Vaginal ▢ C-section

▢ Full-term ▢ Premature

(weeks at birth) _____ Apgar scores: _____

Birth weight: _____ pounds _____ ounces

Birth length: _____ inches Birth head circumference: _____ inches

Did the baby or mother have problems during or after the delivery?_____

_____

_____

Newborn screen normal? _____ Discharge date?_____

Neonatal History:

Method of feeding: ▢ breast _____ months

▢ bottle ▢ formula

Did the baby have any feeding/elimination problems? _____

sleeping problems? _____

First Year Of Life:

Was it difficult to get your child on a schedule? _____

Did your child have colic or gastroesophageal reflux? _____

Difficulty gaining weight? _____

Take any medications? _____

Have any other health problems? _____

What type of child care was used? _____

Medical History:

Major illnesses: _____

_____

Hospitalizations: _____

Surgeries: _____

Injuries: _____

Birthmarks: _____ Immunizations up to date?_____

Medications/supplements - past: _____

Medications/supplements - current: _____

Hearing problems? _____ Vision problems? _____

Allergies: to foods? _____ to medications? _____

What other physicians/medical specialists has your child seen? _____

_____

Developmental History:

At what age in months did your baby:

Smile? _____ Recognize parents? _____

Coo? _____ Babble? _____

Roll over? _____ Sit up? _____

Crawl? _____ Stand? _____

Walk? _____ Run?_____

Climb up stairs? _____ Jump? _____

Say mama/dada? _____ First word? _____

Put 2 words together? _____ Speak in sentences? _____

Speak clearly? _____ Point for "wants/needs"? _____

Point to "show"? _____ Follow 1-step directions? _____

Follow 2-step directions? _____

Has your child lost any abilities? _____

Has your child had previous evaluations for developmental delays? (if yes, please explain and include copies with this form) _____

_____

_____

Self-Help Skills:

Toileting: ▢ Fully trained - when?_____ ▢ In-training ▢ Not ready yet

▢ Accidents - how often? _____

▢ Bedwetting - how often? _____

Frequency of bowel movements: _____

▢ Constipation ▢ diarrhea

Urinary tract infections - when? _____

Any concerns regarding your child's toileting habits? _____

_____

Eating: Age when weaned from bottle/breast _____

Does your child feed him/herself? ▢ yes ▢ no

▢ With fingers?

▢ With spoon?

▢ With fork?

Any concerns with your child's diet? _____

_____

Sleeping: Bedtime? _____ Waking time?_____

Daytime naps: ▢ yes ▢ no

Sleeps

▢ in crib? ▢ Bed? ▢ Co-sleeps?

Routines associated with bedtime? _____

▢ Snoring? ▢ Night waking? ▢ Sleep walking?

Any concerns with your child's sleeping habits? _____

_____

Day Care/School History:

Is your child currently enrolled in: ▢ DayCare ▢ School ▢ Home-Schooled

Name of current school_____ Grade _____

Please list all past schools your child has attended:

1. _____
2. _____
3. _____
4. _____

Any problems in school currently or in the past? _____

_____

_____

_____

Previous evaluations through the school district? (if yes, please explain and include copies with this form) _____

_____

Social and Behavioral History:

Play:

Does your child play ▢ independently? ▢ with other children? ▢ both

What are your child's favorite toys/preferred activities? _____

Does your child seek you out to share experiences?_____

Social:

Describe your child's personality:

▢ easy-going ▢ strong willed ▢ shy/slow to warm up

How does your child react to new experiences?

▢ normally curious ▢ clings to parent ▢ runs off to explore

React to strangers?

▢ normally curious ▢ clings to parents ▢ runs off to explore

How does your child typically interact with other children of the same age?

▢ plays well ▢ shy/quiet

▢ cries easily ▢ watches but won't join in

▢ loud/outgoing ▢ aggressive ▢ grabs toys/doesn't share

Who does your child relate best to?

▢ same-aged peers ▢ younger children ▢ older children ▢ adults

Does your child have any friends? ▢ yes ▢ no Explain? _____

How well does your child get along with siblings? ▢ good ▢ fair ▢ poor

Does your child miss or misinterpret social cues? ▢ yes ▢ no

Are you concerned about your child's social skills? ▢ yes ▢ no

Emotional:

What is your child's general mood?

▢ happy ▢ sad ▢ irritable ▢ anxious/fearful

What is your child's general activity level?

▢ low ▢ medium ▢ high ▢ extremely high

Does your child cry easily? ▢ yes ▢ no

Have temper tantrums? ▢ yes ▢ no

Have difficulty calming down? ▢ yes ▢ no

Describe: _____

Behavioral:

Does your child show any of the following behaviors?

▢ hitting ▢ biting ▢ self-injury ▢ lying ▢ fighting

▢ eating non-food items ▢ unusual habits ▢ destructiveness

▢ impulsivity ▢ hyperactivity ▢ short attention span

Discipline:

What methods do you use to discipline your child?

▢ rewards ▢ time out ▢ talking/explaining

▢ ignoring bad behavior ▢ loss of privileges ▢ spanking

Parenting Help:

Have you ever obtained counselling to help address areas of difficulty?

▢ yes ▢ no

If yes, please explain: _____

_____

Does your child currently receive any therapies or educational services? _____

_____

_____

_____

Family Medical History:

Biological Mother	*Age*	*Health*
_____	____	_____

Biological Father	*Age*	*Health*
_____	____	_____

Siblings names	Age	M/F	Health/Development
_____	____	___	_____
_____	____	___	_____
_____	____	___	_____

Do any family members/relatives have any of the following conditions?
Attention Deficit/Hyperactivity Disorder? _____
Autism Spectrum Disorder? _____
Learning Disabilities? _____
Speech/Language Disorders? _____
Muscular/Motor Disorders? _____
Congenital/Genetic Conditions? _____
Seizure Disorder? _____
Cardiac abnormalities? _____
Bipolar Disorder? _____
Schizophrenia? _____
Obsessive Compulsive Disorder? _____
Tics/Tourette Syndrome? _____
Depression and/or Anxiety? _____

******In order to properly prepare your child for their consultation appointment, please make sure they get plenty of sleep the night before and eat a healthy breakfast/lunch that day. Bring their favorite snacks and drinks as well as a cherished toy/game as it will be a long appointment. Whenever possible, it is best that all parents/guardians accompany the child to the appointment (but not mandatory). Siblings may be distracting and are best left with a caregiver at home.

Please arrive 15 minutes prior to your scheduled appointment in order to check-in. We look forward to meeting your family!

_____ _____

Signature of Patient, Parent or Legal Guardian **Date**

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Office Policies/Procedures

Please review carefully

We are honored to serve your healthcare needs!

Due to inconsistent reimbursement for developmental, behavioral and mental health services by insurance carriers, we are not in network with any insurance carriers at this time: All fees are on a self-pay basis and due prior to the appointment (non-refundable deposit fees are required for initial consultation appointments). We will provide you with a billing statement or Superbill at the conclusion of your appointment that you can submit to your insurance carrier for reimbursement of the fees you incurred. The amount of payment you may or may not receive varies from one insurance carrier to another and whether they offer out-of-network coverage. We advise that you contact your insurance carrier prior to your appointment to discuss possible reimbursement of fees if this is a concern.

Fee Schedule:

1. **Consultation appointment - This is a 3 hour long evaluation divided over 2 appointments - total fee $800.00.** A non-refundable deposit fee of $250.00 will be collected when your consultation is scheduled. This fee will later be applied toward your total fee. The first appointment is 2 hours long and a fee of $300.00 will be collected just prior to that appointment. The second appointment is 1 hour long and the balance of $250.00 will be collected just prior to that appointment.
2. **Neonatal consultation appointment - This is a 90 minute long appointment - total fee $375.00.** A non-refundable deposit fee of $150.00 will be collected when your consultation is scheduled. This fee will later be applied towards your total fee. The balance of $225.00 will be collected just prior to your appointment.
3. **Follow-up appointment - This is a 1 hour long appointment - fee $250.00.** This fee will be collected just prior to your appointment.

4. **Medication follow-up appointment - This is a 45 minute appointment - fee $200.00.** This fee will be collected just prior to your appointment.

Appointment cancellations/missed appointments: An appointment time with the physician is being reserved for you. Out of consideration for another patient who may have needed that time slot, and out of respect for the physician who designated that time slot for you, please arrive on time or notify our office of any appointment cancellations at least 48 hours in advance by calling **469 - 476 -1444**. We reserve the right to charge you for a missed appointment. The charges are as follows:

a. Consultation appointment - Non-refundable deposit fee of $250.00
b. Neonatal consultation appointment - Non-refundable deposit fee of $150.00
c. Follow-up appointment - $125.00
d. Medication follow-up appointment - $100.00

We understand that unforeseen circumstances may arise. However, if you are more than 15 minutes late to your scheduled appointment, we reserve the right to reschedule you to another day to insure that there is enough time to properly complete your full evaluation.

Returned Checks: All returned checks will incur a fee of $35.00.

Copies of Medical Records: A consultation report will be sent to you via the patient portal as well as to your primary care provider within 2 weeks of the conclusion of your consultation at no charge to you. If you need copies of your medical records at a later time, there will be a fee of $25.00.

Forms: Miscellaneous forms that need to be completed by our office will incur a fee of $15.00.

Medication Refills: In order to continue receiving refills on your prescriptions, it is our office policy that you come for your regularly scheduled medication follow-up appointments at least once every 3 months. We cannot continue to refill your prescriptions if you do not show for your regularly scheduled medication follow-up appointments. Medication refills requested in between appointments will incur a fee of $10.00. (Note: for controlled substances, monthly prescriptions are required in most cases). For medication refills, please call our practice at **469-476-1444** and leave a message on our medication mailbox at least one week prior to when you will run out of medications. We will process your request in 3-5 business days. If your prescription cannot be sent electronically to your pharmacy, you will be responsible for picking it up at our office.

I have read the above policies/procedures and agree to accept full responsibility as described:

_____ _____

Signature of Patient, Parent or Legal Guardian Date

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Consultation appointment cancellation/missed appointments:

A consultation appointment time with the physician is being reserved for you. A non-refundable deposit fee of **$250.00** is due at the time your appointment is scheduled and will be applied towards your consultation charge. Out of consideration for another patient who may have needed that time slot, and out of respect for the physician who designated that time slot for you, please notify our office of any appointment cancellations at least 48 hours in advance by calling **469 - 476 -1444**. Failure to do so will result in forfeiting the full $250.00 amount of your deposit.

Please indicate how you would like to be notified for appointment reminders:
(please choose one)

▫ SMS Text message (_ _ _) _ _ _ - _ _ _ _

▫ Phone Call (_ _ _) _ _ _ - _ _ _ _

▫ Voicemail (_ _ _) _ _ _ - _ _ _ _

▫ Email _____ @ _____

Reason for Referral

_____, _____, is being referred to Dr. Julie Jacob, Jacob's
(Patient name) (D.O.B)

Ladder Developmental Pediatrics, by _____, for evaluation of _____
(Referral source)

_____

_____
Patient, Parent or Legal Guardian if patient is a minor (please print)

_____
Signature of Patient, Parent or Legal guardian:

_____
Date:

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REQUEST FOR RELEASE OF MEDICAL RECORDS

In order to legally transfer your medical records from one provider/physician's office to another, please complete this form and fax/email/hand-deliver this form to the office from which you would like your records transferred.

Patient information (please print or type):

Patient Name _____ Date of Birth: _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

I request and authorize Julie Jacob M.D., Jacob's Ladder Developmental Pediatrics, to release and exchange confidential information with the following entity:

Provider Name/Practice: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

This request and authorization applies to:

- ▢ Office visit Notes/Report
- ▢ Laboratory Results
- ▢ Pathology Results
- ▢ Full Medical Records

I understand that all information obtained by the recipient will be held confidential in accordance with HIPAA privacy laws (copy of Notice of Privacy Practices of Protected Health Information available upon request). I may revoke this consent at any time. BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS.

Signature _____ Date: _____

Patient Preferences Regarding Communication
of PHI. (Patient Health Information)

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Method of Communication

My **preferred** method of communication regarding my medical conditions is indicated below **(check one)**:

☐ Home Phone ☐ Work Phone ☐ Cell Phone
☐ Mailed Letter ☐ Guardian ☐ Patient Portal

If the above method of communication is by phone, please check the appropriate box below **(check one)**:

☐ Leave a message with detailed information

☐ Leave a message with call-back number only

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be called at all.

Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient or legal guardian) that Jacob's Ladder is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like Jacob's Ladder to list as your Emergency Contact in the event an emergency situation was to take place at our office.

1. Contact Name _____ Relationship to Patient _____ Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

2. Contact Name _____ Relationship to Patient _____ Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

Please indicate if you would allow us to communicate medical and behavioral information to the following:

1. Patient's Primary Care Physician _____ Name of Physician's Practice _____ Phone Number _____

2. Patient's Teacher/Therapist _____ Teacher/Therapist's email address _____ Phone Number _____

3. Patient's Teacher/Therapist _____ Teacher/Therapist's email address _____ Phone Number _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for health information from persons not listed on this form will require my specific authorization prior to the disclosure of my health information.

_____ _____

Patient Name (please print) Signature of Patient, Parent or Legal Guardian

Date: _____

Acknowledgement of The Receipt of
Jacob's Ladder Developmental Pediatrics
Notice of Health Information Practices

JACOB'S LADDER
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Acknowledgement of Receipt

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Jacob's Ladder Developmental Pediatrics (JLDP) is furnishing you with the attached notice (version effective Septemper 1, 2017), which provides information about how JLDP and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of JLDP's Notice of Health Information Practices.**

_____
Patient Name (please print)

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

Effective Date of this Notice: 01/10/2019

Consent to Treat

I hereby authorize employees and agents of Jacob's Ladder Developmental Pediatrics (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____
Patient Name (please print)

_____ _____
Signature of Patient, Parent or Legal Guardian Date

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____
Signature of Parent or Legal Guardian Date

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 **HIPAA Compliance Officer at Jacob's Ladder Developmental Pediatrics, PLLC.**

OUR OBLIGATIONS: We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

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

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 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. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Health Oversight Activities. We may disclose Health 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 civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency 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 Health 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 also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

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

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization: 1. Uses and disclosures of Protected Health Information for marketing purposes; and 2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to ***Jacob's Ladder Developmental Pediatrics, PLLC, 8501 Wade Blvd., Suite 330, Frisco, Texas 75034***. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have 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 office. To request an amendment, you must make your request, in writing, to ***Jacob's Ladder Developmental Pediatrics, PLLC, 8501 Wade Blvd., Suite 330, Frisco, Texas 75034***.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to ***Jacob's Ladder Developmental Pediatrics, PLLC, 8501 Wade Blvd., Suite 330, Frisco, Texas 75034***.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to ***Jacob's Ladder Developmental Pediatrics, PLLC, 8501 Wade Blvd., Suite 330, Frisco, Texas 75034.***. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

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 by mail or at work. To request confidential communications, you must make your request, in writing, to ***Jacob's Ladder Developmental Pediatrics, PLLC, 8501 Wade Blvd., Suite 330, Frisco, Texas 75034.*** Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

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, you must make your request, in person or in writing, to ***Jacob's Ladder Developmental Pediatrics, PLLC, 8501 Wade Blvd., Suite 330, Frisco, Texas 75034***.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the ***Practice Manager at Jacob's Ladder Developmental Pediatrics, PLLC. All complaints must be made in writing. You will not be penalized for filing a*** **complaint**.