Divino Niño Pediatrics, PLLC

HIPPA (Health Insurance Information & Portability Act)
Receipt of Notice of Privacy Polices & Consent forms

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow up care from another professional. Similarly, the use and disclosure of your health information for purposes of payment includes:

1. Our submission of your health information for processing claims of obtaining payment.
2. Our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment
3. Our submission of your health information to auditors hired by third-party payers and insurers and,
4. Other aspects of payments described in our ***Notice of Privacy Practices.*** Our ***Notice of Privacy Practices'*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can use and disclose your health information to treat you, to obtain payment for services and to perform health care operations. You also signify that you have received a copy of our ***Notice of Privacy Practices.***

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received the, Notice of Privacy Practices.

Patient name	**Last Name**	**DOB**
_____		

Parent/Guardian Signature: _____ **Date:** _____