PATIENT AGREEMENT
DOCKSIDE PEDIATRICS, PLLC

This is an Agreement between Dockside Pediatrics, a North Carolina Limited Liability Company (Clinic, Us or We), and You (Guardian) on behalf of your child(ren) (Patient(s)).

Background

The CLINIC is a Direct Primary Care (DPC) practice, which delivers primary care services through its physicians, Dr. Nathan Cook and Dr. Marc Yandle (Physicians), at 5710 Oleander Drive, Suite 207, Wilmington, North Carolina 28403. In exchange for certain fees, the CLINIC agrees to provide You with the Services described in this Agreement on the terms and conditions contained in this Agreement.

Definitions

1. Patient. In this Agreement, "Patient" means the child(ren) for whom the Physicians shall provide care and services set forth in Appendix A, and who are incorporated by reference to this Agreement.

2. Services. In this Agreement, "Services," means the collection of services, offered to You by Us in this Agreement. These Services are listed in Appendix A(1), which is attached and a part of this Agreement.

Agreement

3. Term. This Agreement shall commence on the date signed by the parties below and will continue for a period of one year.

4. **Renewal.** The Agreement will automatically renew each year on the anniversary date of the agreement unless either party cancels the Agreement by giving 30 days written cancellation notice.

5. Termination. Regardless of anything written above, You always have the right to cancel this agreement. Either party can end this agreement at any time by giving the other party 30 days written notice.

6. Payments and Refunds – Amount and Methods. In exchange for the Services (see Appendix A(1)), You agree to pay Us, a monthly fee in the amount that appears in Appendix B, which is attached and is part of this Agreement.

a) The Enrollment Fee is payable when you sign the Agreement.

b) The monthly fee is due no later than the 25th day of each month. Fees for the first month of services will be prorated on a per diem basis.

c) The Parties agree that the required method of monthly payment shall be by automatic payment, through a debit or credit card, or automatic bank draft.

d) If this Agreement is cancelled by either party before the Agreement ends, We will review and settle your account as follows:

(i) We will refund to You the unused portion of your fees on a per diem basis; or

(ii) If Value of the Services you received over the term of the Agreement exceeds the amount You paid in membership fees, You shall reimburse the CLINIC in an amount equal to the difference between the value of the services received and the amount You paid in membership fees over the term of the Agreement. The Parties agree that the value of the services is equal to the CLINIC's usual and customary fee-for-service charges. A copy of these fees is available on request.

7. Non-Participation in Insurance. You acknowledge Your understanding on behalf of the Patient that neither the CLINIC, nor its Physicians, participate in any health insurance or HMO plans or panels and cannot accept Medicare-eligible patients. We make no representations that any fees that You pay under this Agreement are covered by your health insurance or other third-party payment plans. It is Your responsibility to determine whether reimbursement is available from a private insurance plan and to submit any required billing.

8. WE CANNOT Accept Medicare Patients. You acknowledge Your understanding on behalf of the Patient that at this time, Medicare Patients are not eligible to be treated by the CLINIC or its Physicians, and Medicare cannot be billed for any services performed by the same. Therefore, You acknowledge that Patient is neither a Medicare beneficiary nor Medicare-eligible. You agree that if Patient will become eligible during the term of this Agreement, s/he will notify the CLINIC within 60 days of becoming eligible and this agreement will be terminated upon Medicare eligibility. Any excess fees will be refunded to You, and the CLINIC will make every effort to provide the You with names and contacts for primary care alternatives for Patient.

9. This Is Not Health Insurance. You acknowledge Your understanding on behalf of the Patient that this Agreement is not an insurance plan or a substitute for health insurance. You understand that this Agreement does not replace any existing or future health insurance or health plan coverage that You may carry. The Agreement does not include hospital services, or any services not personally provided by the CLINIC, or its employees. You acknowledge that the CLINIC has advised You to obtain or keep in full force, health insurance that will cover Patient for healthcare not personally delivered by the CLINIC, and for hospitalizations and catastrophic events.

10. Communications. You acknowledge on behalf of Patient that although Clinic shall comply with HIPAA privacy requirements, communications with a Physician using e-mail, facsimile, video chat, cell phone, texting, and other forms of electronic communication can never be absolutely guaranteed to be secure or confidential methods of communications. As such, **You, on behalf of Patient, expressly waive the Physicians' obligation to guarantee confidentiality with respect to the above means of communication and acknowledge that all such communications may become a part of the medical record.**

By providing an e-mail address and cell phone number registered with the CLINIC, You authorize the CLINIC, and its Physicians to communicate with You by e-mail or text message regarding the Patient's "protected health information" (PHI).[1] You further acknowledge that:

(a) E-mail and text message are not necessarily secure mediums for sending or receiving PHI, and there is always a possibility that a third party may gain access;

(b) Although the Physicians will make all reasonable efforts to keep e-mail and text communications confidential and secure, neither the CLINIC, nor the Physicians can assure or guarantee the absolute confidentiality of these communications;

(c) At the discretion of the Physicians, e-mail and/or text communications may be made a part of Patient's permanent medical record; and

(d) You understand and agree that e-mail and text messaging are not an appropriate means of communication in an emergency, for time-sensitive problems, or for disclosing sensitive information. **In an emergency, or a situation that You could reasonably expect to develop into an emergency, You understand and agree to call 911 or go to the nearest emergency room, and follow the directions of emergency personnel.**

(e) Email/Text Messaging Usage. **If You do not receive a response to an e-mail or text message within 24 hours, You agree that you will contact a Physician by telephone or other means.**

(f) Technical Failure. Neither the CLINIC, nor the Physicians will be liable for any loss, injury, or expense arising from a delay in responding to You, when that delay is caused by technical failure. Examples of technical failures: (i) failures caused by an internet or cell phone service provider; (ii) power outages; (iii) failure of electronic messaging software, or e-mail provider; (iv) failure of the CLINIC's computers or computer network, or faulty telephone or cable data transmission; (iv) any interception of e-mail communications by a third party which is unauthorized by the CLINIC; or (v) Your

[1] as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations.

failure to comply with the guidelines for use of e-mail or text messaging, as described in this Agreement.

11. Physician Absence. From time to time, due to vacations, illness, or personal emergency, a Physician may be temporarily unavailable to provide the services referred to in Appendix A. In order to assist You in scheduling non-urgent visits, CLINIC will notify You of any planned Physician absences as soon as the dates are confirmed. In the event of a Physician's unplanned absences, You will be given the name and telephone number of an appropriate provider for You to contact. Any treatment rendered by a substitute, non-CLINIC provider is not covered under this Agreement, but may be submitted to Patient's health plan.

12. Change of Law. If there is a change of any relevant law, regulation or rule, federal, state or local, which affects the terms of this Agreement, the parties agree to amend this Agreement to comply with the law.

13. Severability. If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part will be amended to the extent necessary to be enforceable, and the remainder of the contract will stay in force as originally written.

14. Reimbursement for Services Rendered. If this Agreement is held to be invalid for any reason, and the CLINIC is required to refund fees paid by You, You agree to pay the CLINIC an amount equal to the fair market value of the medical services You received during the time period for which the refunded fees were paid.

15. Amendment. Except for amendments made in compliance with Section 12, above, no amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties.

16. Assignment. This Agreement, and any rights Patient may have under it, may not be assigned or transferred by You or Patient.

17. Legal Significance. You acknowledge that this Agreement is a legal document and gives the parties certain rights and responsibilities. You also acknowledge that You have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

18. Miscellaneous. This Agreement shall be construed without regard to any rules requiring that it be construed against the party who drafted the Agreement. The captions in this Agreement are only for the sake of convenience and have no legal meaning.

19. Entire Agreement. This Agreement contains the entire agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.

20. **No Waiver.** In order to allow for the flexibility of certain terms of the Agreement, each party agrees that they may choose to delay or not to enforce the other party's requirement or duty under this agreement (for example notice periods, payment terms, etc.). Doing so will not constitute a waiver of that duty or responsibility. The party will have the right to enforce such

terms again at any time.

21. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of North Carolina. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the CLINIC in Wilmington, North Carolina.

22. Service. All written notices are deemed served if sent to the address of the party written above or registered with the CLINIC by first class U.S. mail.

The parties may have signed duplicate counterparts of this Agreement on the date first written above.


_____ and


_____, for

DOCKSIDE PEDIATRICS, PLLC

APPENDIX A
SERVICES

1. **Medical Services.*** "Medical Services" under this agreement are those medical services that the Physicians are permitted to perform under the laws of the State of North Carolina, are consistent with Physicians' training and experience, are usual and customary for pediatricians to provide, and include the following:[2]

    - Acute and Non-acute Office Visits
    - Well-Baby Care, including home visits for infants up to two months old
    - Lactation Services up to 3 visits (additional visits may incur additional fees)*
    - Well-Child Care
    - School/Athletic/Camp Physicals
    - Breathing Treatments (nebulizer or inhaler with spacer)*
    - Urinalysis*
    - Rapid Test for bacterial and viral illness (as available and appropriate)*
    - Removal of begin skin lesions/warts (as appropriate)*
    - Circumcision*
    - Minor Wound Repair and Sutures (as appropriate)*
    - Basic Hearing and Vision Screening
    - At Physicians' discretion, additional services may be offered for an additional fee.
    - Labs and testing that cannot be performed in-house will be offered at a discounted rate through select vendors (as available)*
    - The convenience of access to many commonly prescribed prescription medications at greatly reduced prices, dispensed on premises (as available and appropriate)**

*You are responsible for all costs associated with any procedure, laboratory testing, and specimen analysis.
**Prescription medications dispensed by the CLINIC pharmacy are subject to an additional charge, for which You are responsible.

The Patient is also entitled to a personalized, annual in-depth "wellness examination and evaluation," which shall be performed by a Physician, and may include the following, as appropriate:

- Detailed review of medical, family, and social history and update of medical record;
- Personalized Health Risk Assessment utilizing current screening guidelines;
- Preventative health counseling, which may include:
    - Age-appropriate development;
    - Diet, nutrition and exercise;
    - Weight management;
    - High-risk behavior;

[2] As deemed appropriate and medically necessary by the Physician.

    - School preparedness and performance;
    - Attention problems;
    - Smoking, alcohol, and substance use.
  - Custom Wellness Plan to include recommendations for immunizations, additional screening tests/evaluations, fitness and dietary plans;
  - Complete physical exam & form completion as needed.

2. **Non-Medical, Personalized Services**. CLINIC shall also provide Patient with the following non-medical services ("Non-Medical Services"), which are complementary to our members in the course of care:

a. ***After Hours Access*.** You shall have direct telephone access to a Physician seven days per week. You shall be given a phone number where You may reach a Physician directly for guidance regarding concerns that arise unexpectedly after office hours. Video chat and text messaging may be utilized when You and the Physician agree that it is appropriate.

b. ***E-Mail Access*. You shall be given a Physician's e-mail address** to which non-urgent communications can be addressed. Such communications shall be dealt with by a Physician or staff member of CLINIC in a timely manner. **You understand and agree that e-mail and the internet should never be used to access medical care in the event of an emergency, or any situation that You could reasonably expect may develop into an emergency.** You agree that in such situations when You cannot speak to a Physician immediately in person or by telephone, that You shall call 911 or go to the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel.

c. ***No Wait or Minimal Wait Appointments.*** Reasonable effort shall be made to assure that Patient is seen by a Physician immediately upon arriving for a scheduled office visit or after only a minimal wait. If Physicians foresee an extended wait time, You shall be contacted and advised of the projected wait time.

***d.* *Same Day/Next Day Appointments*.** When You call or e-mail a Physician prior to noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule an appointment with a Physician on the same day. If You call or e-mail a Physician after noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule Patient's appointment with a Physician on the following normal office day. In any event, however, CLINIC shall make every reasonable effort to schedule an appointment for the Patient on the same day that the request is made.

e. ***Specialists Coordination.*** CLINIC and Physicians shall coordinate with medical specialists to whom Patient is referred to assist Patient in obtaining specialty care. **You understand that fees paid under this Agreement do not include and do not cover specialist's fees or fees due to**

any medical professional other than CLINIC Physicians.

APPENDIX B
FEE ITEMIZATION

Monthly fees are as follows, not to exceed $220 per family:

<2 years of age	$120 per month
2-5 years of age	$80 per month
6-18 years of age	$60 per month
Enrollment Fee	$150 per family*
Re-enrollment Fee	$300 per family*

*Non-refundable fee. Should your membership lapse or be terminated, the re-enrollment fee must be paid for membership to become active.

DOCKSIDE PEDIATRICS, PLLC

5710 Oleander Drive, Suite 207
Wilmington, NC 28403
(910) 399-1954

NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- how we may use and disclose your IIHI
- your privacy rights in your IIHI
- our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
DOCKSIDE PEDIATRICS, PLLC

Attn: Privacy Officer
5710 Oleander Drive, Suite 207
Wilmington, NC 28403

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI, unless you object:

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including, but not limited to, our doctors and nurses—may use or disclose your IIHI in order to treat your or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as other healthcare providers, your spouse, your children or your parents.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may use and disclose your IHII to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, to develop protocols and clinical guidelines, to develop training programs, and to aid in credentialing, medical review, legal services and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for

treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury, or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

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

    - regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - concerning a death we believe has resulted from criminal conduct

- regarding criminal conduct at our offices
- in response to a warrant, summons, court order, subpoena or similar legal process
- to identify/locate a suspect, material witness, fugitive or missing person
- in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs.

6. **Organ and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI:

The health and billing records we maintain are the physical property of Dockside Pediatrics. The information in it, however, belongs to you. You have a right to:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may 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 the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of this Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

7. Right to File a Complaint. If you believe 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:

DOCKSIDE PEDIATRICS
Attn: Privacy Officer
5710 Oleander Drive, Suite 207
Wilmington, NC 28403

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have questions regarding this notice or our health information privacy policies, please contact the Privacy Officer listed above.

Acknowledgement

I hereby acknowledge that I have received and read Dockside Pediatrics, PLLC HIPAA Privacy Policy Notice. I understand that I may request additional copies of this notice at any time.